

Q-287

Q-322

Q-323

Q-026

Q-100

Q-1675-41

~~Q-148~~

~~Q-142~~

90 ~~Q-2079~~ R

30 ~~Q-1179~~ R 229

~~Q-148~~

W-146

I-157

JUL 20 1953

100 D193

AIR 23 248

MAGIC 2

DEC 15 1953

ABSTRACT

ABORTION: A PSYCHOLOGICAL STUDY

By

David Kirk Michelman

In the United States, abortion appears to be a "dilemma" whose solution has been made difficult by a religiously anchored shroud of mystic moralism and public ignorance. This work attempts to cut through these irrational barriers. It presents a pragmatic, rational resolution of the abortion "dilemma." In developing the thesis that legislative and judicial law should make abortion a personal decision, prior abortion studies and original research are examined in broad and encompassing detail. A discussion of the causes, incidence, and consequences of abortion is integrated with a critical examination of the effects of restrictive abortion legislation, public needs, and public wants to arrive at this solution of chosen parenthood.

Women seek abortion to maintain their psychological integrity. Despite restrictive laws and great personal danger, abortion is sought for a variety of psychological, physical, socio-economic, and eugenic

reasons. Only about one abortion seeker per hundred in the United States, or about 10,000 per year, have received legal abortions from 1950 to 1970. The majority of these operations are received by wealthier women for psychiatric reasons. Medical abortion presents little risk of mortality or physiological impairment when induced during the initial trimester of pregnancy. Psychological complications in a previously well-adjusted woman also seem rare when abortion is socially acceptable.

Because of the prohibitive barriers to legal abortion, an estimated one million or more United States women obtain illegal abortions. These operations are performed by persons from many diverse walks of life, frequently possessing little or no medical training, and often being of sadistic, unscrupulous character. Their abortion techniques range from dilatation and curettage to goose feathers dipped in kerosene. The total monetary cost of illegal abortion is estimated to exceed \$350,000,000 annually. Roughly 10,000 of these women are estimated to die from such operations and countless others are physiologically impaired. A disproportionate number of these women come from the lower socio-economic strata.

The restrictive laws which force women to the illegal abortionist can be traced through Hebrew, Greek, Roman, early Christian, English, Catholic and American traditions. Current United States laws which permit

abortion only if necessary to save the woman's life date back 100 years and were based on the social ethics and short-range national needs of that time.

Contemporary attitudes are becoming increasingly more favorable toward permissive abortion in the United States. The general public clearly favors abortion when the pregnancy threatens the mother's physical or mental health, would result in a defective baby, or resulted from rape or incest. Approval is also mounting to permit abortion for socio-economic circumstances. A significant minority to a majority of the public favors such a policy. Religious leaders, physicians, legislators, and judicial officials also display this growing approval of permissive abortion.

In an empirical study of abortion attitudes, knowledge, and personality correlates, a majority of 131 Michigan State University students and Lansing area residents favored permissive abortion when: (1) the pregnancy presents a risk to maternal physical or mental health, (2) there is the risk of a defective child, (3) conception resulted from rape, (4) the child would be raised by a court-judged unfit mother, or (5) the child would be unwanted and treated as such. A "strong" minority (40 percent or more) favored abortion when: (1) the woman is pregnant but unmarried, (2) the woman is pregnant and obtaining a divorce, (3) the woman is 45 years of age or older, and (4) the wife is from a poverty stricken home.

Abortion attitudes were also found related to personality attributes. Individuals scoring higher on measures of Original Thinking ($p < .001$), Independence ($p < .001$), Ascendancy ($p < .05$), Leadership ($p < .06$), and Sociability ($p < .11$) were more favorable toward permissive abortion than those scoring lower. Persons holding a more permissive stance toward abortion were significantly more knowledgeable of abortion than those holding a less permissive stance, even though the total group did not exceed the chance level in the abortion knowledge measure. For demographic subgroups, the relationship between their abortion attitudes and their personality traits suggests partial explanations of why these people take their particular stance toward abortion.

Among a Michigan sample of businessmen, legislators, religious leaders, and physicians (obstetricians and/or gynecologists), businessmen were clearly the most favorable while religious leaders were the least favorable toward permissive abortion. Only physicians correctly answered abortion knowledge items above the chance level.

While the abortion "dilemma" is being debated among various professionals, restrictive abortion laws continue to foster the tragedy of unwantedness, poverty, emotional turmoil, death, and physical impairment. Legislators and judicial officials must resolve this

"dilemma" through policies consistent with the needs and wants of the people they have been delegated to represent rather than through action or inaction which meets the personal beliefs and needs of the lawmaker. The peoples' desires and needs clearly point to abortion being a personal decision and obtained by a woman upon her request. The people have voiced their desire for more permissive abortion laws through their response to opinion surveys. Their needs for permissive statutes have been demonstrated by the current restrictive laws' adverse effects upon women, men, families, and societies which produce unwanted offspring, as well as the manifold destructive consequences of subsequent social rejection for the unwanted conceptus.

Financial programs enabling the poor as well as the wealthy to obtain legal abortions are in the public interest, as are counseling services to nondiscriminately safeguard the physical and mental well-being of all abortion-seeking women. Establishing permissive abortion policies in the context of concomitant family planning programs of contraceptive, sex, and parenthood education, would be a notable step toward the reduction of tragic unwantedness and toward the fruits of a responsible, harmonious, and wanted society.

ABORTION: A PSYCHOLOGICAL STUDY

By

David Kirk Michelman

A THESIS

**Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of**

DOCTOR OF PHILOSOPHY

Department of Psychology

1971

Copyright by
DAVID KIRK MICHELMAN

1971

ACKNOWLEDGMENTS

The author expresses his appreciation to Dr. John Hurley whose extensive investment of time, energy, and concern in the form of guidance, evaluation, suggestion, and friendship were invaluable in the development and completion of this work.

Appreciation is also extended to Drs. Henry Smith, Dozier Thornton, and John Wakeley for their suggestions and thorough evaluation of the manuscript.

TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION	1
II. A WOMAN'S MOTIVATION TO INTERRUPT HER PREGNANCY	10
Primitive Societies	10
Modern Society.	12
The Causation of Induced Abortion	14
III. LEGAL ABORTION	18
Incidence	19
Indications.	20
Physical Indications	22
Psychiatric Indications	24
Fetal Indications	27
Recipients	28
Age.	28
Marital Status	30
Parity.	31
Socio-economic Status.	33
Socio-economic Status and Abortion Incidence	34
Socio-economic Status and Abortion Indications	36
Race	37
Religion	39
Medical Procedures	43
Consequences	45
Physical Consequences.	46
Mortality	46
Impairment.	51

Chapter	Page
Sterility	51
"Minor Problems".	56
Psychological Consequences.	59
IV. ILLEGAL ABORTION	76
Incidence	76
Recipients.	79
Age	79
Marital Status.	82
Parity	84
Socio-economic Status, Education, and Race.	85
Religion.	89
Abortionists	92
Physicians	94
Persons with Limited Medical Training .	96
"Quacks," "Amateurs," and Self- Abortionists	97
Techniques.	100
Monetary Cost.	102
Consequences	104
Physical Consequences	104
Mortality.	104
Trends in Incidence of Abortion Mortality	107
Characteristics of the Fatality Victim	110
Causes of Death and the Techniques Used to Induce Abortion Resulting in Death	115
Physiological Impairment.	117
Psychological Consequences.	118

Chapter	Page
V. A HISTORICAL PERSPECTIVE OF ABORTION	
LAW-MORTALITY	122
Hebrews	123
Greeks.	125
Romans.	126
Christianity.	130
English Common Law.	137
Catholicism	138
British Legislation	141
United States Legislation	144
VI. ATTITUDE TOWARD ABORTION	149
General Public	150
Attitudes Determined from National Surveys.	150
Attitudes Determined from a State Survey	152
Attitudes Determined from "Local" Surveys.	152
Chicago, Illinois.	152
Metropolitan New Orleans	153
Good Housekeeping Poll	158
Attitudes and Demographic Characteristics	160
Religion.	161
Education and Social Class.	162
Sex	164
Marital Status.	164
Age	165
Race	166
Parity	167
Interaction of Demographic Variables and Attitudes Toward Abortion	168
Trends in Attitude Change.	170
Law.	171
Legislative Acts.	173
Court Decisions	174
Recommendations of Legal Bodies.	180
Confusion Within the Law	180
Trends in the Attitude of the Law	182

Chapter	Page
Medicine	183
Attitude Surveys.	184
National Survey	184
State Surveys	185
New York	185
New Hampshire	187
Illinois	188
South Dakota.	188
Local Survey	192
Recommendations of Medical Organi- zations.	193
Religion	195
Catholicism	195
"Double Effect"	195
"Mediate" versus "Immediate Animation"	198
Judaism.	201
Orthodox Judaism	201
Reform Judaism.	203
Maternal Life and Physical Health.	203
Psychological Health	204
Defective Fetus.	204
Illegitimacy.	205
Conservative Judaism.	206
Protestantism.	208
Interdenominational--National.	208
Interdenominational--State.	209
Interdenominational--Local.	210
Denominations	210
United Church of Canada	210
United Presbyterian Church	211
American Baptist	211
Unitarian-Universalist	211
American Lutheran Church.	212
Episcopal Church and The Church of England	213

Chapter	Page
Attitude Toward Abortion: Recent Developments	216
General Public.	216
Law	218
Legislative Acts	218
Court Decisions.	220
VII. A STUDY OF INDUCED ABORTION: ATTITUDES, KNOWLEDGE, PERSONALITY CORRELATES.	223
Phase I.	223
Statement of the Problem	223
Materials	225
Information Face Sheet	225
Abortion Attitude Inventory.	225
General Attitude Item.	226
Abortion Questionnaire	226
Gordon Personal Profile, Gordon Personal Inventory, and Survey of Interpersonal Values	227
Gordon Personal Profile	228
Gordon Personal Inventory.	228
Survey of Interpersonal Values	229
Procedure	230
Hypotheses	234
Attitude Toward Abortion and Demographic Variables	234
1. Residential Status.	234
2. Sex.	234
3. Marital Status	234
4. Religious Preference	234
5. Socio-economic Status.	235
6. Age.	235
Knowledge of Abortion.	235
Attitude Toward Abortion and Personality Attributes	235
Phase II	236
Statement of the Problem	236
Procedure	237

Chapter		Page
	Religious Leaders	237
	Physicians	238
	Legislators	238
	Businessmen	238
	Hypotheses	239
VIII.	A STUDY OF INDUCED ABORTION: ATTITUDES, KNOWLEDGE, PERSONALITY CORRELATES-- RESULTS	240
	Phase I.	240
	Attitude Toward Abortion	240
	Attitude Toward Abortion and Demographic Variables.	244
	Residential Status	244
	Sex	244
	Marital Status	244
	Religious Preference	245
	Socio-economic Status	246
	Age	247
	Interaction Effects Between Attitude Toward Abortion and Paired Demographic Variables	247
	Knowledge of Abortion	250
	Knowledge of Abortion Related to Attitude Toward Abortion	250
	Personality Attributes and Attitude Toward Abortion	252
	A Comparison of Knowledge of Abortion and Personality Traits Between Persons Most Favorable and Least Favorable Toward Permissive Abortion.	256
	Phase II	257
	Attitude Toward Abortion and Knowl- edge of Abortion Among Businessmen, Legislators, Physicians, and Religious Leaders.	257

Chapter	Page
Attitude Toward Abortion.	257
Knowledge of Abortion.	259
Knowledge of Abortion and Attitude Toward Abortion.	260
IX. A STUDY OF INDUCED ABORTION: ATTITUDES, KNOWLEDGE, PERSONALITY CORRELATES-- DISCUSSION	262
Phase I.	262
Attitude Toward Abortion Among the General Sample.	262
An Account of the Present Findings .	265
1. Characteristics of the Measuring Instrument	265
2. Characteristics of the General Sample.	268
3. Changing Attitudes.	270
Knowledge of Abortion	271
Attitude Toward Abortion Related to Knowledge of Abortion	272
Attitude Toward Abortion and Knowledge of Abortion Among Demographic Groups of the General Sample	273
Residential Status.	273
Marital Status	274
Sex.	276
Interaction Between Respondent's Sex and Marital Status.	279
Age.	280
Religious Preference	282
Socio-economic Status.	287
Personality Attributes and Attitude Toward Abortion	291
Personality Attributes and Attitude Toward Abortion Among Demographic Classifications	295
Catholics.	295
Protestants	298
Jews	300
Females	301
Class V	302

Chapter	Page
Phase II	304
Attitude Toward Abortion and Knowledge of Abortion Among Businessmen, Legis- lators, Physicians, and Religious Leaders.	304
Attitude Toward Abortion	304
Knowledge of Abortion	308
Attitude Toward Abortion Related to Knowledge of Abortion	309
X. A REALISTIC SOLUTION OF THE ABORTION DILEMMA	311
The Peoples' Needs.	318
Detrimental Effects of Current Restrictive Laws Upon Women	318
Death, Physical Impairment, and Psychological Disturbance in Pro- curing an Illegal Abortion.	319
Suicide	320
Emotional Disturbance	323
"Post-partum Psychosis"	323
Psychosomatic Complications.	327
The Fate of the Unwanted Conceptus.	331
Maternal Stress and the Fetus.	333
Parental Reaction to Unwanted Births	335
Infanticide.	335
Abuse.	335
Neglect	336
The Feelings and Behavior of the Unwanted Child	337
Unsocialized Aggressive Child.	338
Overinhibited Child	338
Schizoid Child.	339
Detrimental Effects of an Unwanted Conception Upon the Father	341
Detrimental Effects of an Unwanted Conception Upon the Family	345

Chapter	Page
Illegitimacy and its Detrimental Consequences	346
She Can Marry	347
She Can Raise the Child Herself as an Unwed Mother	349
She Can Give the Child up for Adoption.	351
She Can Seek Illegal Abortion.	355
Detrimental Effects of Unwanted Conception Upon the General Public.	355
The Peoples' Wants.	361
Recommendations.	362
Conclusion	371
BIBLIOGRAPHY	373
APPENDICES	
Appendix	
A. INFORMATION FACE SHEET	399
B. ABORTION ATTITUDE INVENTORY	400
C. ABORTION QUESTIONNAIRE	403
D. PERSONALITY TRAITS DEFINED.	406
Gordon Personal Profile	406
Gordon Personal Inventory	407
Survey of Interpersonal Values.	408
E. INTRODUCTORY FORM LETTER	409
F. SCORABLE RETURNS FROM SPECIFIED RELIGIOUS DENOMINATIONS	410
G. GENERAL SAMPLE'S SPECIFIC ATTITUDES TOWARD ABORTION	411
H. RESPONSE PERCENTAGES OF PERSONS CLASSI- FIED BY THE DEMOGRAPHIC VARIABLES OF RESIDENTIAL STATUS, SEX, MARITAL STATUS, RELIGIOUS PREFERENCE, SOCIO-ECONOMIC STATUS FOR EACH AAI ITEM	415

Chapter	Page
Appendix	
I. KNOWLEDGE OF ABORTION AND DEMOGRAPHIC VARIABLES	435
Residential Status	435
Sex	435
Marital Status.	436
Religious Preference.	436
Socio-economic Status	438
J. MULTIPLE REGRESSION AND FACTOR ANALYSIS OF PERSONALITY TRAITS WITH ATTITUDE TOWARD ABORTION	440
Multiple Regression of Personality Traits	440
Factor Analysis of Personality Traits	444
K. PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY ATTRIBUTES AND ATTITUDE TOWARD ABORTION BY DEMOGRAPHIC CLASSI- FICATION	447
Residential Status	447
Sex	448
Marital Status.	451
Religious Preference.	451
Socio-economic Status	455
L. PROFESSIONALS' RESPONSES TO AAI ITEMS.	458
M. CONTRACEPTIVE AND EDUCATIONAL PROGRAMS TO PREVENT UNWANTED CONCEPTIONS.	463
Contraceptive Programs	464
Contraceptive Advice When Obtaining the Premarital Physical Examination and the Marriage License.	467
Contraceptive Advice Following the Delivery of a Child or an Abortion	469
Contraceptive Advice Offered in Clinic Settings.	471
Contraceptive Advice Offered to Poor and Wealthy	472
Contraceptive Advice Offered to Married and Single Persons	473

Chapter	Page
Appendix	
Educational Programs Providing Responsible and Realistic Meaning to Contraception, Sexuality, and Parenthood . . .	475
Research Programs to Develop Safer and More Effective Contraceptives. . . .	479

LIST OF TABLES

Table	Page
1. Attitude Toward Abortion in Specified Circumstances Among Respondents in National Surveys.	151
2. Attitudes of Residents Viewing Televised Abortion Symposium	154
3. Attitudes of New Orleans Women Toward Permissive Abortion.	156
4. Attitudes of "Good Housekeeping Consumer Panel" Toward Permissive Abortion . . .	159
5. Percentage of Persons Categorized by Religious Preference Favoring Permissive Abortion in Specified Circumstances (National Surveys)	172
6. Physicians' Attitudes Toward Permissive Abortion in Specified Circumstances . .	186
7. The Attitudes of 3,000 Illinois Physicians Toward Legalized Abortion in Specified Circumstances.	189
8. The Attitudes of 256 South Dakota Physicians Toward Legalized Abortion in Specified Circumstances	190
9. Response Percentage for the General Sample (<u>N</u> = 131) for Each AAI Item	242
10. Religious Preference and Attitude Toward Abortion Scores	246
11. Socio-economic Status and Attitude Toward Abortion Scores	247

Table	Page
12. Interaction Effects Between Attitude Toward Abortion and Paired Categories of Demographic Variables	249
13. Marital Status of Males and Females and Attitude Toward Abortion Scores.	250
14. Product-Moment Correlations Between Abortion Knowledge and Attitude by Demographic Classifications	253
15. Product-Moment Correlations Between Personality Attributes and Attitude Toward Abortion	255
16. One-Way Analysis of Variance of Attitude Toward Abortion Among Professional Groups .	257
17. Attitude Toward Abortion Among Professional Groups	258
18. One-Way Analysis of Variance of Knowledge of Abortion Among Professional Groups.	259
19. Knowledge of Abortion Among Professional Groups	260
20. Product-Moment Correlations Between Knowledge of Abortion and Attitude Toward Abortion Among Professional Groups.	261
F1. Religious Denominations Returning Scorable AAI's	410
G1. Percentage of General Sample ($N = 131$) Giving Specific Attitude Rating to Each AAI Item	413
H1. Percentage of Lansing Area Residents ($N = 89$) and Michigan State University Students ($N = 42$) Giving Specific Attitude Rating to Each AAI Item.	416
H2. Percentage of Females ($N = 71$) and Males ($N = 60$) Giving Specific Attitude Rating to Each AAI Item.	419
H3. Percentage of Married ($N = 83$) and Single ($N = 43$) Persons Giving Specific Attitude Rating to Each AAI Item	422

Table	Page
H4. Percentage of Individuals Among Catholic (<u>N</u> = 32), Protestant (<u>N</u> = 82), Jewish (<u>N</u> = 7), Agnostic (<u>N</u> = 5), and Unclassified (<u>N</u> = 5) Religious Classifications Giving Specific Rating to Each AAI Item . . .	425
H5. Percentage of Individuals Among Socio-economic Classes I (<u>N</u> = 32), II (<u>N</u> = 36), III (<u>N</u> = 23), IV (<u>N</u> = 33), and V (<u>N</u> = 7) Giving Specific Attitude Rating to Each AAI Item	430
I1. One-Way Analysis of Variance of Knowledge of Abortion Among Individuals with Different Religious Preferences	437
I2. Knowledge of Abortion Among Individuals with Different Religious Preferences.	437
I3. One-Way Analysis of Variance of Knowledge of Abortion Among Socio-economic Classes.	438
I4. Knowledge of Abortion Among Socio-economic Classes.	439
J1. Multiple Regression of Personality Traits with Attitude Toward Abortion--Analysis of Variance for Overall Regression.	440
J2. Multiple Regression of Personality Traits with Attitude Toward Abortion	442
J3. Factor Analysis of Personality Traits	445
J4. Intercorrelation Matrix of Personality Traits	446
K1. Product-Moment Correlations Between Personality Attributes and Attitude Toward Abortion Among Lansing Area Residents (<u>N</u> = 89) and Michigan State University Students (<u>N</u> = 42)	449
K2. Product-Moment Correlations Between Personality Attributes and Attitude Toward Abortion Among Males (<u>N</u> = 60) and Females (<u>N</u> = 71)	450

Table	Page
K3. Product-Moment Correlations Between Personality Attributes and Attitude Toward Abortion Among Married (<u>N</u> = 83) and Single (<u>N</u> = 43) Persons	452
K4. Product-Moment Correlations Between Personality Attributes and Attitude Toward Abortion Among Individuals Stating a Preference for Protestantism (<u>N</u> = 82), Catholicism (<u>N</u> = 32), Judaism (<u>N</u> = 7), or Agnosticism (<u>N</u> = 5)	454
K5. Product-Moment Correlations Between Personality Attributes and Attitude Toward Abortion Among Socio-economic Classes I (<u>N</u> = 32), II (<u>N</u> = 36), III (<u>N</u> = 23), IV (<u>N</u> = 33), and V (<u>N</u> = 7).	457
L1. Percentage of Individuals Within Professional Groups of Businessmen (<u>N</u> = 79), Legislators (<u>N</u> = 39), Physicians (<u>N</u> = 98), and Religious Leaders (<u>N</u> = 73) Giving Specific Attitude Rating to Each AAI Item.	459

LIST OF FIGURES

Figure	Page
1. Total Number of AQ Items Answered Correctly by Each Individual in the General Sample . .	251

CHAPTER I

INTRODUCTION

During the past decade, the occurrence of induced abortion has emerged from centuries of denied awareness to become an issue of international concern. In the United States, estimates have been presented that each year more than 1,000,000 abortions are being performed illegally and that possibly as many as 10,000 of these operations end in a woman's death. Proposals that abortion be legalized were, and continue to be, shrouded in controversy. Authorities from various professional fields, as well as laymen, differ in their attitudes and beliefs toward permissive abortion. Advocates for and against legalized abortion have often clouded the issue through their use of inappropriate analogies and excessive emotionalism. Those favoring permissive statutes are quick to point out the butcher abortionist who hacks pregnant women to death and dumps their bodies into a remote back alley. Persons opposed to more permissive laws also are quick to claim that abortion is "murder," an unjustified act of killing a God-given life. The need for this book is dictated by

this excessive and inappropriate emotionalism, unresolved controversy, lack of integrated factual data, and the possible threat of abortion to human fulfillment and integrity.

Although interested in abortion, individuals, as well as professional bodies, often attempt to avoid personal involvement in this controversial issue by asserting that it is the responsibility of others to lead the "abortion dilemma" to its conclusion. Frequently this responsibility is assigned to the medical profession on the assumption that physicians have greater knowledge of this problem. Those physicians who accept this position are divided as to whether the medical profession as a whole, or obstetricians as a specialized subgroup, should assume the leadership. Many other medical practitioners feel that the abortion problem lies largely outside the domain of medicine, and is more suitably assigned to either the legal profession, the realm of social policy, or individual morals.

Due to the existence of laws regarding induced abortion in each of the fifty states, the functional responsibility for clarifying or changing these laws ultimately resides either in the individual state legislatures or in the high courts. Presently many legislative bills concerned with abortion fail to even get out of committee because the abortion problem is inaccurately

defined or misunderstood; also because the legislative representatives are only vaguely acquainted with the desires of the people. The representative's or senator's anxiety about openly opposing the desires of those who elect and pay him can even prevent the simple clarification of existent abortion laws, as well as inhibit action on more permissive statutes.

Similarly, judicial officials may have difficulty in rendering an objective, clear decision as to the circumstantial legality of a woman's obtaining an abortion. This action might be hindered by the judge's uncertainty of the public's attitudes, doubting the support he would receive for his position, and his finding it difficult not to interpret abortion law from a personalized, moralistic viewpoint. Also, because of these factors and because of its controversial nature, such a decision would be subject to numerous courts of appeal for an indefinite period of time.

The immoral label attached to abortion by important religious groups and the traditionally severe legal sanctions against abortion have restricted and made difficult any systematic investigation and fact finding concerning the causes, prevalence, and consequences of induced abortion. Yet, such information is essential for an accurate assessment of the scope and severity of the problem. Individuals' biases have further distorted and

misrepresented even the available evidence. Sanctions or biases which range from denying the issue to extreme overstatements of the abortion situation hinder constructive solutions to this problem. They function to limit and obscure the knowledge of the issue and to contribute to an attitude that induced abortion is an "unsolvable dilemma" rather than an issue subject to rational solution.

The present study calls attention to the realities of induced abortion--its causes, occurrences, and consequences. It assumes that the availability of valid information can meaningfully contribute to a rational solution of this phenomenon. Induced abortion has long existed in an aura of taboo and did not significantly emerge until the rubella (measles) and thalidomide tragedies of the early 1960's. The existence, incidence, and complications of induced abortion must be placed and maintained in realistic perspective until the issue is legally resolved. The present work, unique in its broad scope and in its depth coverage, clearly unveils the causes, incidence, and consequences of induced abortion, and integrates these findings with the public's needs and attitudes toward abortion to arrive at a responsible, pragmatic solution of the "abortion dilemma."

Nine chapters follow this introduction.

Chapter II. A woman's reasons for wanting to terminate her pregnancy are examined. Circumstances

resulting in abortion in primitive societies are discussed and are related to the circumstances in which modern women seek abortion. The maintenance of a woman's psychological well-being is identified as the primary factor underlying all stated reasons for seeking abortion.

Chapter III. Legal abortion is viewed from the perspective of: (1) its incidence, (2) the indications permitting the operation, (3) the recipients of legal abortion, (4) the medical procedures used to induce abortion, and (5) its physical and psychological consequences.

Chapter IV. In the treatment of illegal abortion, topics of primary concern are: (1) its incidence, (2) the recipients of the operation, (3) the abortionists, (4) the techniques used to induce illegal abortion, (5) its cost, and (6) its consequences, physical and mental.

Chapter V. The origins of contemporary abortion laws are traced through their development, beginning with the laws and the morality of the ancient Hebrews. In this developmental history, the law, morality, and practice of abortion are examined in Jewish, Greek, Roman, early Christian, English, Catholic, and American "traditions." Where historical data permits, reasons are offered to explain the various positions taken toward the practice of induced abortion.

Chapter VI. Existing research explorations of the attitude toward abortion held by the general public, the law, medicine, and religion are reviewed.

Chapter VII. The design and procedures employed of an original research study are described. Attitude toward abortion, knowledge about abortion, and personality attributes associated with attitude toward permissive abortion were investigated in a 1968 Michigan sample from the general public. The variables age, sex, marital status, religious preference, and social class status are evaluated in relationship to attitude toward abortion. Knowledge of abortion and attitude toward abortion are also evaluated and compared among Michigan samples of legislators, clergymen, businessmen, and physicians.

As the legislatures of each state may ultimately determine the status of the abortion problem, individual legislators must be aware of the attitudes of the public they represent. Hopefully, laws more congruent with the desires of the majority will be constructed by these democratic bodies. This study purports to determine the attitudes of the majority. Also, specific personality traits of persons holding majority and minority viewpoints are investigated to assess if one of these factions possess psychological traits which would make legislation consistent with their attitudes more or less plausible in relation to the welfare of total society.

The general public's knowledge of induced abortion is assessed to explore the possible need of increased dissemination of information. This assessment also indicates whether such attitudes are based solely on emotion.

An evaluation of the knowledge and attitudes about abortion for the Michigan samples of legislators, clergymen, businessmen, and physicians is of importance as these specific groups represent factions currently engaged in the abortion controversy. Additionally, they are potent influencers of the attitude of the general public as well as potential contributors of solutions of the abortion problem.

Chapter VIII. The findings of these Michigan studies are examined.

Chapter IX. The results of this Michigan research and the implications drawn from the comprehensive review of previous attitude studies are integrated and applied to a clarification of the public's stance toward permissive abortion. The public's lack of factual knowledge of abortion is discussed and implications of this deficit are presented. Also considered are the abortion attitudes and abortion knowledge of persons specifically categorized by demographic variables.

Personality attributes of persons more opposed and those of persons more favorable toward legalized abortion are discussed. This treatment is broadened to demonstrate

the relationship between personality attributes and abortion attitudes for individuals categorized by specific demographic characteristics.

Also, the abortion attitudes and abortion knowledge of physicians, legislators, clergymen, and businessmen are compared and discussed.

Chapter X. State legislatures and/or the courts are discussed as the sources ultimately responsible for revising or clarifying abortion laws. These laws are described as needing to meet the current needs and desires of the general public. Present restrictive laws are considered detrimental to the public's welfare and contrary to the public's wants. Prohibitive abortion laws are found to have destructive consequences for women, men, the unwanted rejected child, the family, and society. Also, the public is shown to be asking for permissive abortion policies. From this consideration of public needs and wants, granting an abortion to a woman upon her request is considered the most appropriate legal method of meeting the needs and desires of individuals and society.

Possible approaches to the implimentation of permissive abortion laws are outlined. The procedures are viewed as beneficial in enhancing and maintaining the physical and mental well-being of women who seek and/or

have an abortion, and in making these permissive laws and related services available to all persons regardless of their social class standing.

CHAPTER II

A WOMAN'S MOTIVATION TO INTERRUPT HER PREGNANCY

Primitive Societies

Although an occasional reference asserts that some particular society has not practiced abortion (Murdock, 1934), most authorities (Devereux, 1955; Lecky, 1929) regard abortion as a universal phenomenon. In studies of abortion among primitive peoples, Murdock (1934), Sumner (1906), and particularly Devereux (1955), in his analysis of more than 300 primitive societies, point out factors which have motivated the women of these cultures to purposefully interrupt their pregnancies. Devereux has classified these motivating factors into the somewhat overlapping categories of: (a) economic, (b) medical-biological, (c) political, (d) social structure, and (e) family dynamics. Economic want, specifically defined within each culture, but most frequently linked to an insufficient food supply, is described as a common reason for a woman's aborting. Nomadic tribes who would have their way of living made more difficult with additional

children often resorted to abortion. The pregnant, nomadic wife sometimes feared being left behind by her husband.

Abortion for medical and biological reasons covers a rather broad area ranging from the feared shame of a torn perineum to concern for the possible death of the mother. Abortions were permitted when the woman was considered by her society to be either too young or too old to give birth. Similarly, children were often aborted because of an old or sick father. Fearing a defective child--the birth of a "monster" or the child's death in infancy--was another cause for terminating pregnancy.

Political considerations have also played a role in the motivation of abortion. In several societies, the threat or fear of her children's enslavement is described as a woman's motive for aborting. As another form of political causation, Devereux cites attempts to acculturate several tribes which resulted in increased abortion. The repression of infanticide has been known to raise abortion rates. Also, missionary efforts toward Christianization have resulted in abortion with a woman's fearing expulsion from the Church if she were known to have conceived an illegitimate child.

Social structure covers a broad spectrum of motivations also included in the category of family dynamics. Children conceived of incestuous or adulterous relationships were sometimes aborted. Unwed mothers frequently

terminated their pregnancy and married women were known to abort with the death of their husband.

Devereux included within the category of family dynamics, a woman's aborting an illegitimate child from fear of penalties to her, to her kin, or to her child. Husbands might also force adultrous wives to abort. Widowed women, fearing destitution within a tribe which destroys a dead man's property, may abort a post-humous child. Other factors motivating women to terminate their pregnancies were anger felt toward the husband, vanity, taboos during pregnancy, rejection of the parental role, and a fear of the child's death as other children of the family had died after birth.

Modern Society

Although civilized man prefers to avoid thinking of himself in terms of primitive man, the similarity of the reasons for aborting among primitive women and modern women is striking. Present day authors in the United States present an abundant number of case studies in which women seek an abortion for many of the same reasons as those categorized by Devereux for women of primitive cultures. Based on case studies, dramatic scenes of women seeking an abortion because of: (a) rape, (b) fear of a defective child, (c) illegitimacy, (d) poverty, and (e) pregnancy in later life, were presented before the participants of the International Conference on Abortion

(Cooke, Hellegers, Hoyt, & Richardson, 1968). Lowe (1966) offers the additional reasons of infidelity, fear of becoming a mother, and a woman's "possibly well-grounded fears" of her physical or mental impairment. Edwin Gold (in Lowe, 1966, pp. 8-9) asserts some women will seek an abortion when they feel unable to cope with and provide the needed care for an additional child; the mother believes she should give her attention to her husband and the children she has previously born.

Hamilton (1929) asked 81 married women participating in a marital adjustment study if they had ever had an abortion, and, if they had, their reasons for having the operation. Among the 23 women who admitted experiencing at least one abortion, the reasons most frequently given for having the operation were: maternal health, illegitimate pregnancy, economic difficulties, and desire not to have children or more children. Reasons mentioned less frequently concerned: the pregnancy's interference with vocational pursuits, its occurrence during war-time, desires to terminate the marriage, and fears that a husband's organic pathology would foster defects in the child. Among these womens' replies, one again notices the similarity of modern and primitive reasons for aborting.

Bates and Zawadzki (1964) found that aborted women during pre-trial examinations, prior to their testifying

before a Grand Jury, gave similar reasons for wanting to terminate their pregnancies.

Time and again the married witnesses brought out their desire to have "no more children" or the idea that they "couldn't have another one so soon." One woman said her husband "had just lost his job"; another said her husband "had just been drafted"; while a third claimed she was "too weak to care for a fifth child" (Bates & Zawadzki, 1964, p. 47).

The Causation of Induced Abortion

Bates and Zawadzki (1964) suggest that the reasons women give for seeking an abortion may be rationalizations. Rosen (1967a) explicitly asserts that in legal and illegal abortions the verbalized reasons are often rationalizations for "usually socio-economic" concerns. This awareness that a woman's stated reasons for terminating pregnancy may rationalize feelings of not wanting the child, enhances, rather than eliminates, the need to explore her underlying feelings. Such explorations of feminine emotions must take into account the effect of society's institutionalized values upon the woman. Segments of society proclaim and attempt to instill feelings of the sacredness of life from the moment of conception and the divinity of motherhood. Often it is suggested that a woman's universal desired purpose is to be a loving mother. However, values which appear inconsistent with, or even contradictory to, those of motherhood are also common. Conditions of living which sharply differ from those ideally supposed and imputed into the "sacrament of motherhood" value structure abound.

Also, this philosophy has been hotly disputed in recent years (Friedan, 1963). Other segments consider life sacred at points other than conception and offer a woman broader purposes than only that of motherhood. Society's conflicting values and/or impoverished but realistic living conditions often create strong subjective stresses for the pregnant woman which she desperately seeks to resolve. This "dilemma" is often resolved through abortion.

For unwed mothers living in the United States today, anxiety is created by the presence of a child symbolizing and enhancing the guilt and shame of a relationship which violates strong family and society stressed sexual taboos. More than sufficient to produce severe psychological stress for an unmarried woman are: her fear of societal condemnation and her impaired self-esteem as an unwed mother; her concern of society's condemnation of her bastard; her wanting, yet not wanting, the child and fearing its being taken from her; her doubts of her ability to alone mother the child if she were to keep it, and; her strong doubts of the success of a forced marriage. Although abortion may violate instilled societal values, for the unwed mother the feelings created from norms violated through abortion are often perceived as less psychologically threatening than the shame and fear which may accompany her giving birth.

Parents confronted with the possibility of a defective child face more than increased time and financial demands. They fear seeing one of their flesh struggle against elements of society. Many of these "elements" which will foster discriminatory social, economic, and occupational hardships upon the defective individual will be the actions of persons who actually demand the defective's birth. While some naively hope that people will be humanitarian, the realist knows the cruel and relentless harassment imposed upon a defective child by other children; she foresees a life of discrimination in which the defective person is made to feel inadequate, insecure, worthless, and often--at best--pitied. An empathic parent may anticipate the child's suffering as her own and seek to avoid these feelings as well as avoid her anticipated frustration of feeling inadequate to deal with, and helpless to alter, the child's life situation.

For a large poverty-stricken family, it is not difficult to see why another child is often feared. The demands of another baby to care for, another mouth to feed from an inadequate supply of food for the presently existing family members, creates a feeling of being overburdened, inadequate, and helpless in coping with life in general. To avoid this family anxiety the wife may resort to abortion.

For the older woman, whose children have married and formed families of their own, confrontation with

another pregnancy implies another long period of re-experiencing the many stresses of child bearing and rearing, the sacrifice of some of her aspirations and desires to play the less demanding role of "grandmother," and the loss of what may be felt as a well deserved and needed rest from the role of a mother.

Although abortion may be seen and criticized as expressing a woman's self-interest, society's "double bind" emphasis upon the contradictory ideals of upward striving and fun-seeking encourages and actually requires self-interest for its development. Boundaries between "good" and "not good" self-interests inevitably blur. However, the predominant form of self-interest shown by the woman seeking abortion is that of maintaining her self-integrity. The reasons that a woman gives for wanting to interrupt her pregnancy may be stated insightfully or rationalized into a form more understood by society. Words, sympathy, or sermons rarely resolve the stress and anxiety felt by a pregnant woman nor do they eliminate the stress with which society threatens her if she does give birth. Although it may contradict someone else's moral code, concealed abortion frequently becomes a woman's only resolution to this "double pronged" stress. It seems clear that the essential motivation for abortion is to preserve and maintain the woman's psychological well-being.

CHAPTER III

LEGAL ABORTION

Among the women who desire to interrupt their pregnancy, only a very small percentage are granted a legal (or therapeutic) abortion. In each of the 50 states, if a woman's reasons for wanting to terminate her pregnancy are in accord with those provided as acceptable by state statute, she may legally procure an abortion. This chapter presents data concerning both the number of legal abortions and the requisite conditions. Demographic characteristics of women obtaining a legal abortion are also reviewed. In addition, the medical procedures of inducing an abortion, and the woman's physical and psychological well-being after a therapeutic abortion are fully discussed.

Although much information exists, the inaccessibility of other vital data makes difficult the study of legal abortion. Cooke et al. (1968) point out that the absence of an authoritative agency to record and coordinate case records results in much valuable information being "buried in hospital charts of individual patients."

Researchers have, however, attempted to "unearth" these data. Comparing, contrasting, and analyzing their works makes possible valuable insight into the phenomenon of legal abortion.

Incidence

The number of legal abortions performed in the United States is consistently estimated to range from 8,000 to 10,000 (report of the American Public Health Association summarized by Hall, 1966; Lader, 1966a; Lowe, 1966; New grounds for abortion, 1967; Cooke et al., 1968). Although the records of several hospitals indicate an upward trend in the number of therapeutic abortions (Mount Sinai Hospital: Rovinsky & Gusberg, 1967; two Buffalo teachings hospitals: Niswander, Klein, & Randall, 1966), the general trend in hospitals throughout the country is a decreasing incidence of therapeutic abortion (Niswander, Klein, & Randall, 1966; Doctor's fears, 1954). Lader (1966a) reports that the number of hospital abortions performed annually has decreased by 20,000 in contrast to the number performed 25 years ago.

Reviewing the records of all hospitals in New York City during the period 1943-1962, Gold, Erhardt, Jacobziner, and Nelson (1965) found a consistent downward trend of legal abortions. The downward trend was "in the nature of" a 65 percent decline, from a ratio of 5.1 to 1.8 therapeutic abortions per 1,000 live births. This

decreasing frequency, in addition to being shared by each county within the city, was also consistent over maternal age group, parity grouping, ethnic group, type of hospital service, and specific indication for the termination of pregnancy. Similarly, studies investigating the number of therapeutic abortions performed over time periods, reveal a decreasing incidence in the University of Virginia Hospital (Doctor's fears, 1954), University of Iowa hospitals (Kretzschmar & Norris, 1967), and the Los Angeles County Hospital (Russell, 1953).

Indications

The declining number of therapeutic abortions can be understood, in part, when considering the indications for the operation. Advanced medical knowledge has greatly reduced the necessity of abortion for life-saving reasons. Concomitant with this reduction of abortions for physical reasons, there has been an increase in the number of abortions performed for psychiatric and fetal reasons. However, the decrease in abortions for physical indications has greatly exceeded the rate of increase for psychological and fetal circumstances. Consequently, there has been an overall downward trend in the total number of therapeutic abortions.

Hospitals which have shown an increase in the number of abortions are relatively more liberal in their granting the operation for psychological and fetal

considerations. When investigating the indications for therapeutic abortion, it is important to note that the circumstances considered appropriate for the interruption of a woman's pregnancy vary widely among physicians and hospital staffs. This variability has been frequently discussed and criticized (Statement by the committee, 1965; Rossi, 1966; Rosen, 1967b; Hall, 1968). The variability of hospitals in their performing therapeutic abortions is dramatically illustrated in the findings of Hall (1965a) who found Woman's Hospital in New York City to grant one abortion per 20 deliveries among private patients (1960-1962) in contrast to Cincinnati's General Hospital which performed no abortion per 24,417 deliveries (1957-1962).

Many hospitals have established abortion committees to review the woman's reasons for wanting to interrupt her pregnancy. After hearing the circumstances the committee approves or refuses the operation. The Committee on Public Health of the New York Academy of Science (Statement by the committee, 1965) asserts that hospitals with such committees are often sensitive to their reputation and often limit the number of abortions they grant regardless of the indications for interruption. Edmund Overstreet, M.D., a professor of obstetrics-gynecology, University of California in San Francisco (Abortion 'quota' system described, 1969) asserted that some large urban California hospitals, fearing than an increasing abortion rate would bring criticism from

the Joint Commission on the Accreditation of Hospitals, have established quota systems. Rossi (1966) further asserts that hospitals which have established an abortion committee have lower therapeutic abortion rates than hospitals without a committee. Hall (1965a) illustrates Rossi's assertion in finding the number of abortions granted during a five-year period after the establishment of an abortion committee at Sloane Hospital in New York were one-third of the number permitted during the five years previous to the committee's formation. Rosen (1967a) claims some physicians use the red tape delay of having a committee evaluate a woman's request to abort as a method to get the woman past the twelfth week of pregnancy, after which she is told the abortion cannot be performed as the "physiologic time limit [p. 31]" has been passed.

Physical Indications

The advances in general medicine and surgery have practically eliminated conditions which threaten a woman's life during pregnancy. Hall (1965a) asserts, "the life of the mother is almost never jeopardized by pregnancy [p. 522]." Rosen (1967a) states that present medical indications for abortion "are virtually, if not actually, non-existent [p. 302]." With the development of thoracic surgery, hormone therapy and antibiotic medication, pregnancy need now seldom aggravate organic disease [p. 302]." Decker (1967), reviewing the indications for therapeutic

abortion in the past decade at the Mayo Clinic, also asserted, "There are few, if any, absolute medical indications for therapeutic abortion in the present state of medicine. Almost all of the indications are relative [pp. 31-32]." Similarly, Gold et al. (1965), referring to New York City hospitals, stated that pregnancies interrupted for physical reasons could "almost be termed rare [p. 971]."

Pulmonary disease and cardiovascular conditions, once common reasons for therapeutic abortion, are today practically nonexistent as causes for the interruption of pregnancy (Niswander, Klein, & Randell, 1966; Southermer, 1956; Hall, 1965a). During the period from 1951-1953 to 1960-1962 in which the total number of therapeutic abortions in New York City decreased by 50 percent, Gold et al. (1965) report a similar or greater drop in abortions per 1,000 live births for the following physical indications: rheumatic heart disease; other circulatory diseases; tuberculosis; benign neoplasms; hypertension and toxemia; nephritis, pyelitis, and other genito-urinary (diseases); diabetes; other allergic, endocrine, metabolic, and nutritional diseases; and, diseases of the nervous system. The number of therapeutic abortions performed for malignant neoplasms remained relatively constant (10 percent decline). However, malignant neoplasms resulted in approximately only one abortion per 1,000 live births.

Psychiatric Indications

The majority of therapeutic abortions are performed for psychiatric indications (psychological well-being of the mother). Rossi (1966) has attributed the majority of abortions being performed on psychiatric grounds to both the advanced knowledge of medicine in treating physical complications during pregnancy and medicine's acceptance of psychoanalytic theory.

Niswander, Klein, and Randall (1966), reporting the statistics for two Buffalo, New York teaching hospitals, revealed the percentage of abortions performed for psychiatric indications increased almost linearly from 13 percent in 1943 to 87.5 percent in 1963. Rovinsky and Gusberg (1967) report the number of psychiatric, therapeutic abortions performed at Mount Sinai Hospital in New York during 1953-1964 rose during the latter half of this 12-year period to more than double the number of therapeutic abortions performed for all other indications. Simon (1964) reported psychiatric indications account for 80 percent of the therapeutic abortions.

Studying New York City hospitals, Tietze (1950) reported a steady increase from 1943-1947 in the number of abortions performed for psychiatric indications. The percentage of pregnancies terminated for psychological reasons rose from 8.2 percent in 1943 to 19.1 percent in 1947. Accompanied by the linear rising percentage was a

corresponding increase in the absolute number of psychiatric, therapeutic abortions. Gold et al. (1965), in contrast to Tietze's (1950) earlier study, report that New York City hospitals reveal a decline in the absolute number of therapeutic abortions for "mental disorders" from 1943-1962. However, relative to other indications, Gold et al. assert "mental disorders" presently represent the major indication for therapeutic abortion, accounting for about two-thirds of the abortions in propriety hospitals; more than one-half in the private service of voluntary hospitals; and, about one-third in the private service of voluntary hospitals and municipal hospitals. Hall's (1965a) 10-year review of therapeutic abortion in Sloane Hospital reveals the percentage of pregnancies terminated for psychiatric indications was approximately equal for the period 1951-1955 (42 percent) and 1956-1960 (44 percent). The total number of abortions permitted in the latter period, however, was only one-third of the number granted in the earlier period.

Such variability in the number of abortions performed in hospitals partly reflects the controversy as to what constitute appropriate psychiatric indications for the interruption of pregnancy. Fear of public disapproval, police interference, criticism from accreditation boards, and "biased" abortion committees are additional reasons. The primary psychiatric criterion for granting a therapeutic abortion is the probability that a woman would

commit suicide if she were to carry her child to term (Barno, 1967; Lowe, 1966; Rosenberg & Silver, 1965). Some physicians would prefer to interpret psychological well-being on a broader basis and be more liberal in their granting abortions (Rovinsky & Gusberg, 1967; Rosenberg & Silver, 1965). Rosen (1967b, pp. 83, 84) asserts the psychiatrist may recommend abortion when: (a) patients have had previous pregnancies which "repeatedly precipitated post-partum psychotic reactions"; (b) "possible homicidal drives are becoming intensified"; (c) specific patients manifesting manic-depressive or schizophrenic psychosis are "not amenable to therapy"; (d) a woman has had a lobotomy; (e) it appears the pregnancy or stress of early motherhood would precipitate a psychotic reaction; (f) a woman is of "pronounced emotional immaturity," must be babied, cannot be trusted with adult responsibilities, and cannot function as a mother is expected in American culture.

Contrary to this broad application of psychiatric reasons to terminate pregnancy, other physicians (Sim, in *Grounds for abortion*, 1963) assert there are no valid psychiatric indications for the termination of pregnancy; or that valid psychiatric circumstances are rare (Bolter, 1962; Arkle, in *Ethics of abortion*, 1957).

Fetal Indications

A substantial percentage of therapeutic abortions are performed for fetal indications. The most common of these indicators have been: (a) Rh incompatibility; (b) hereditary disease; (c) radiotherapy; (d) ingestion of harmful drugs during pregnancy, such as thalidomide; and (e) the contraction of viral infections during pregnancy, such as rubella (Hall, 1965a; Barno, 1967; Loth & Hasseltine, 1956; Niswander, 1967; Kretzschmar & Norris, 1967). The most prevalent indicator has been rubella, particularly during the epidemic years of the early 1960's.

The percentage of therapeutic abortions granted for fetal indications, as for psychiatric indications, varies greatly depending upon the hospital. In Sloane Hospital (Hall, 1965a), 4 percent of the total number of therapeutic abortions were for fetal indications. In sharp contrast, the Committee on Public Health of the New York Academy of Science (Statement by the committee, 1965) reports 30 percent of the abortions performed at Mount Sinai Hospital in the same city (New York) were based on fetal considerations. Kretzschmar and Norris (1967) report that of 32 therapeutic abortions performed at University of Iowa hospitals from 1960-1965, 12 (38 percent) were performed for fetal indications (nine rubella, two Rh incompatibility, and one hereditary disease).

Recipients

This section concerns the: (a) age, (b) marital status, (c) parity, (d) socio-economic status, (e) race, and (f) religious affiliation of women who receive therapeutic abortions.

Age

Studies reveal that proportionately more therapeutic abortions are granted to women ranging in age from 25-39 years. More recently, however, there have been an increasing number of therapeutic abortions performed on women under 20 years of age.

Among 3,592 women who received a therapeutic abortion in New York City hospitals from 1943-1957, Tietze (1950) found 71 (2 percent)* were under 20 years of age; 374 (10 percent), 20-24; 742 (21 percent), 25-29; 968 (27 percent), 30-34; 938 (26 percent), 35-39; 431 (12 percent), 40-44; and 54 (2 percent), 45 or more years of age (14 did not state their age). The mean age was 33 years. About one-eighth of the women were younger than 25 and about one-eighth were older than 40. Approximately three-fourths (2,684) of these women ranged from 25-39 years of age.

Tietze's general findings are supported by those of a later study investigating therapeutic abortion at

*Percentages are based on 3,578 women who stated their age.

Sloane Hospital during 1951-1960 (Hall, 1965a). Of 366 women granted abortions, 15 (4 percent) were under the age of 20; 61 (17 percent), 20-24; 92 (25 percent), 25-29; 84 (23 percent), 30-34; 73 (20 percent), 35-39; and 41 (11 percent), 39 or older. Sixty-eight percent of the abortions were performed on women 25-39 years of age.

Extending Tietze's (1950) study, Gold et al. (1965) reviewed cases of therapeutic abortion in New York City from 1943-1962. Looking for possible trends in the number of abortions among age groups, it was found that, except for a recent shift toward increased abortion for teenagers, therapeutic abortion became uniformly more frequent with advancing age over this 20-year span. The incidence of therapeutic abortion remained highest for women 30 or more years of age, although teenagers were recently receiving more abortions than women in their 20's.

Niswander, Klein, and Randall (1966), investigating abortion in two relatively liberal Buffalo teaching hospitals, found an increase in the incidence of therapeutic abortion in all age groups--with the exception of women over 39. Similar to the findings of Gold et al. (1965); Niswander, Klein, and Randall found the rate of therapeutic abortion progressively increasing for women under 20 years of age. Comparing incidence rates of therapeutic abortion between 1940 and 1960, the number of abortions among women under 20 years was found to have increased

significantly ($p < .005$) more than the number among women 20 to 39 years of age. The decrease in the incidence of abortion among women older than 39 years was also significant ($p < .005$) when compared to the incidence of therapeutic abortion among women 20 to 39 years of age.

Marital Status

The findings of several studies suggest that more therapeutic abortions are performed for married women than for unmarried women. However, the number of abortions granted to unwed women appears to be increasing and at a more rapid rate than the number granted to married women.

Hall (1965a) reports that among 366 women receiving therapeutic abortions at the Sloane Hospital for Women (1951-1960), 276 (75 percent) were married and 90 (25 percent) were unmarried.

Similar findings are reported by Kretzschmar and Norris (1967). Of 32 abortions performed from 1960-1965 at University of Iowa hospitals; 21 (66 percent) were performed for married women, 9 (28 percent) for single women, 1 (3 percent) for a woman separated from her husband, and 1 (3 percent) for a divorcee.

Niswander, Klein, and Randall (1966) found a marked increase in the number of therapeutic abortions obtained by unmarried women (single, separated, divorced, widowed) from 1940-1964. During the period 1943-1949, abortions were performed for six unmarried women (4.5 abortions per 1,000

births, and; from 1960-1964, 90 therapeutic abortions were performed for unmarried women (22.2 abortions per 1,000 births). The number of therapeutic abortions granted to unmarried women increased more rapidly than the number granted to married women ($p < .005$)--even though the number of married women aborted from 1940-1960 also increased and the absolute number of therapeutic abortions granted to marrieds was greater than that granted to unmarrieds in 1960-1964 (marrieds, 129 therapeutic abortions--5.9 abortions per 1,000 births; unmarrieds, 90 therapeutic abortions--2.2 abortions per 1,000 births).

Parity

Research findings support the statements that:

(1) presently the largest number of therapeutic abortions are performed on those women having few children, and (2) the ratio of therapeutic abortions to live births does not appreciatively differ among parity groups.

For the period 1943-1947, Tietze (1950) found the largest percentage of abortions (31 percent) to occur among women who were pregnant for the first time. The general trend was a decrease in the percentage of abortions performed on women as their number of previous children increased. Women with one previous child accounted for 23 percent of the therapeutic abortions; two children, 24 percent; three children, 11 percent; four children, 6 percent; five children, 3 percent; six children, 2 percent;

seven children, 1 percent; eight children, 1 percent; nine or more children, 1 percent. However, the highest ratios of abortions per live births were found among women having two (8.3), three (9.4), four (9.5), five (8.5), and six (9.0) previous children.

Gold et al. (1965) discovered that Tietze's finding of a greater ratio of abortion to live births in the third (two previous children) and higher birth orders during 1943-1947 did not hold in the later years of the 1943-1962 period. From 1960-1962, the ratio of abortions per 1,000 live births ranged from 0.8 to 2.7 from the first (woman with no children) through the ninth birth order. Consequently, Gold et al. conclude that the rising frequency of therapeutic abortion is not evident with advancing parity. Throughout the 1943-1962 interval, however, the lowest ratio of abortions to live births occurred for women having one previous child.

For the period 1960-1965, Kretzschmar and Norris (1967) also report that generally the percentage of therapeutic abortions was inversely related to parity. Among 32 women, abortions were granted to 10 women (31 percent) who had no previous children, 5 (16 percent) to women with one child, 8 (25 percent) to women with two children, 6 (19 percent) to women with three children, 2 (6 percent) to women with four children, and 1 (3 percent) to a woman with five children.

Socio-economic Status

Therapeutic abortions have repeatedly been found more frequent among persons of higher socio-economic status than among the lower socio-economic strata. Although various explanations of this finding have been offered, it is a common opinion that a stricter policy of therapeutic intervention exists for the poor woman in contrast to the more liberal policy applied to her wealthier counterpart (Tietze, 1950; Hall, 1965a). Hall (1965a) found that a greater number of abortions were granted for psychiatric reasons among private patients but that psychotherapy was known to have been given to only 69 of 118 (57 percent) private patients in contrast to 19 of 22 (86 percent) ward patients who had abortions for psychiatric reasons. These results led Hall to formulate the explanation that "private patients with unwanted pregnancies are more often referred for primary psychiatric evaluation and/or that psychiatric justification for abortion is more easily obtained for private patients [pp. 519, 522]." Substantial financial resources are normally necessary for a woman to make contact with a number of psychiatrists and to gain their recommendation for a therapeutic abortion. Obviously the wealthier private patient can more readily make contact with psychiatrists.

Hall (1965a) also felt that a ward patient's tendency to register for antepartum care later in her

pregnancy, and for her to be less aware of the advantages and possibilities of abortion, may be a "dual" cause for the difference in the number of abortions performed among private and ward patients. Rovinsky and Gusberg (1967) share Hall's reasoning, stating that ward patients do not have the advice of physicians until "too late." They attributed the ward patient's seeking prenatal care later in gestation as due to her being "less sophisticated."

Tietze (1950) attributed his finding that a higher percentage of abortions were performed in later gestation among ward patients than private patients to: (1) stricter standards of intervention for the less wealthy, and (2) the possible explanation that ward patients may actually demand and receive less adequate prenatal care.

Socio-economic Status and Abortion Incidence

Surveying 60 hospitals, Hall (1965a) found a ratio of 3.6 abortions granted to private patients to every one abortion granted to ward patients. Among 45 hospitals having both ward and private services, 36 performed more abortions on the private services than on the ward services; 5 hospitals performed no abortions on either the ward or private services. The four remaining hospitals, which collectively performed only a total of eight abortions, reported a higher incidence of abortion for ward rather than private patients.

Adding 10 hospitals having only ward services to the 45 with both ward and private services, it was determined that 23 of the 55 wards performed no therapeutic abortion. With the addition of 5 hospitals having private services but no ward services, only 9 of the 50 private services performed no abortion.*

Although all hospital categories of New York City hospitals displayed an overall downward trend in therapeutic abortions, Gold et al. (1965) reported that this decline was sharpest in municipal hospitals. Data in which the incidence of therapeutic abortions were granted in the various types of New York hospitals from 1960-1962 reveal the following ratios of abortions per 1,000 live births: proprietary (profit), 3.9; voluntary (nonprofit)-private service, 2.4; voluntary (nonprofit)-general service, 0.7; municipal, 0.1.

Further suggesting that economic factors are important determinants of who is granted a therapeutic abortion were the differing ratios of therapeutic abortions to live births in five New York boroughs as based on the residence of the woman (Tietze, 1950; Gold et al., 1965). The ratio was highest in Manhattan; near the average in the Bronx, Queens, and Brooklyn; and lowest in Richmond.

*The period of time over which each of the 60 hospitals reported statistics ranged from less than one year to 12 years.

For the period 1950-1964, Niswander, Klein, and Randall (1966) found a downward trend of therapeutic abortions for clinic patients but an upward trend for private patients. Clinic patients had 11 therapeutic abortions, or 2.6 abortions per 1,000 live births from 1950-1959, and only one abortion, or 0.3 abortions per 1,000 live births, from 1960-1964. To the contrary, private patients had 185 therapeutic abortions, or 4.4 abortions per 1,000 live births, from 1950-1959, and 218 abortions, or 9.6 abortions per 1,000 live births from 1960-1964.

Among 32 women receiving therapeutic abortions in University of Iowa hospitals; 22 were private patients, 5 were clinic patients, and 5 were indigents (Kretzschmar & Norris, 1967).

Socio-economic Status and Abortion Indications

Gold et al. (1965) found that for most indications to terminate pregnancy, the ratio of therapeutic abortions is higher in the proprietary hospitals than on the private service of voluntary hospitals. Within the general hospitals, there was a higher frequency of abortions for private patients than for general service patients.

Referring to the therapeutic abortion practices of Sloane Hospital for Women, Hall (1965a) asserts that:

abortions were more common among the private patients at Sloane Hospital for virtually all of the more debatable indications, such as arthritis, inactive tuberculosis, and rubella, and more common among the ward patients for most of the less debatable indications, such as rheumatic heart disease and hypertensive cardiovascular disease (p. 519).

Hall further emphasized that a higher incidence of abortions were performed for psychiatric indications among private patients than among ward patients. On the private service, one therapeutic abortion was performed for psychological reasons per 104 deliveries and on the ward service the ratio was one abortion per 1,149 deliveries.

Race

Although few studies have been concerned with the race of the woman receiving a therapeutic abortion, those which have show that therapeutic abortions are performed in disproportionately greater numbers among whites. While cultural attitudes may play a part in this disparity, the economic well-being of the various racial groups appears to be the major determinant.

Of the 3,592 women granted permission to terminate their pregnancies in New York City from 1943-1947, 3,445 (96 percent) were white and 147 (4 percent) were members of other races, mostly Negro (Tietze, 1950). The ratio of therapeutic abortions per 1,000 known pregnancies was 5.0 for the white and 2.0 for the "colored" populations. However, Tietze noted that "pregnant colored women" in New York City were on the average 3.4 years younger than

white women. Taking this fact into account, he attempted to "partially explain" the racial discrepancy in therapeutic abortions by determining ratios of therapeutic abortions per 1,000 known pregnancies standardized for age. The standardized ratios were 4.9 for "white" and 2.9 for "colored"--ratios which still reveal a disproportionate number of therapeutic abortions among whites.

Reviewing the statistics of New York City hospitals for the period 1951-1962, Gold et al. (1965) found that of 4,703 therapeutic abortions, 4,361 (92.7 percent) were performed on whites, 263 (5.6 percent) on nonwhites, and 79 (1.7 percent) on Puerto Ricans. During this 12-year period, there was a downward trend in the number of therapeutic abortions per live births for all three ethnic groups. This trend was greatest (90 percent), however, among Puerto Ricans, least (40 percent) among whites, and intermediate (65 percent) among nonwhites.

From 1960-1962, 811 (92.7 percent) therapeutic abortions were granted to whites, 56 (6.4 percent) to nonwhites, and 8 (0.9 percent) to Puerto Ricans. For this three-year interval, the ratio of therapeutic abortions per 1,000 live births among whites (2.6) was more than 5 times greater than that among nonwhites (0.5), and 26 times greater than that among Puerto Ricans (0.1).

Among the 366 women terminating their pregnancies at Sloane Hospital for Women (1951-1960), 316 (86 percent) were Caucasian, 47 (13 percent) were Negro, and 3 (1

percent) were Oriental (Hall, 1965a). Further analysis of these data reveals the apparent economic influence involved in granting therapeutic abortions to ethnic groups. Of the 366 women, 118 were ward patients among which were 69 Caucasians (22 percent of the aborting Caucasian women), 47 Negroes (100 percent of the aborting Negro women), and 2 Orientals (67 percent of the aborting Oriental women). Among the remaining 248 private patients were 247 Caucasians (78 percent of the aborting Caucasian women), no Negroes (0.0 percent of the aborting Negro women), and 1 Oriental (33 percent of the aborting Oriental women).

Religion

Among white and nonwhite women 14 years of age or older surveyed in the United States (excluding Alaska and Hawaii) as of March, 1957, 67.5 percent reported they were Protestant; 25.7 percent, Catholic; 3.2 percent, Jewish, 1.4 percent, no religion; 1.2 percent, a religion other than Protestant, Catholic, or Jewish; and, 0.9 percent, not reported (United States Bureau of the Census, 1968, p. 41). Conclusions relating incidence of legal abortion to religious preference are made difficult, if not impossible, because of the limited number of studies and the difficulty of generalizing the findings of a specific study to the total general population. The percentage of persons expressing a particular religious preference often varies substantially between the locale of a specific

study and national statistics. Frequently, the specific religious composition of the localities studied is not reported. Also, the extent of religious devotion tends to vary in unknown ways among the locations in which the studies have been conducted and to influence the findings of the studies. Consequently, a comparison of the "general" findings of the few studies which report the legally aborting woman's religious preference with the national census data tentatively suggests: (1) the percentage of Protestant women legally terminating their pregnancies appears lower than the percentage of Protestant women in the general population, (2) the percentage of Catholic women legally terminating their pregnancies tends to approximate the percentage of Catholic women in the general population, (3) the percentage of Jewish women legally terminating their pregnancies appears to greatly exceed the percentage of Jewish women in the general population, and (4) the percentage of women of "another, no, or an unknown" religious preference tends to slightly exceed the percentage of such women composing the general public.

Hall (1965a) found that among 366 women receiving a therapeutic abortion at Sloane Hospital for Women (1951-1960), 199 (54.4 percent) were Protestant; 69 (18.9 percent), Catholic; and 80 (21.9 percent), Jewish. The remaining 18 women (4.9 percent) were not discussed with reference to a religious preference.

Laidlaw (in Calderone, 1958, p. 106) reported that 25 percent of the women aborted at Roosevelt Hospital (New York) during the period 1952-1954 were Catholic. The remaining persons (75 percent) were not categorized by their religious affiliation but were classified as "other." The number of women from which the percentages were determined also was not reported.

Kretzschmar and Norris (1967) found the percentage of Catholics interrupting their pregnancies to be lower than that determined by Hall or Laidlaw. Of 32 women who received therapeutic abortions at University of Iowa hospitals from 1960-1965, 3 (9.4 percent) were Catholics and 29 (90.6 percent) were "non-Catholics."

Niswander, Klein, and Randall (1966) conducted a more extensive analysis, examining trends in the incidence of therapeutic abortion among religious groups over time periods and investigating the relationship between the aborting woman's religious preference and her marital status. From 1943-1964, of the 504 women aborted in two Buffalo teaching hospitals, 266 (52.8 percent) professed to be Protestant; 137 (27.2 percent), Catholic; 74 (14.7 percent), Jewish; 1 (0.2 percent), Buddhist; and 26 (5.2 percent) did not state a preference at the time the admission history was obtained.

Restricting the analysis to the 477 Protestant, Catholic, and Jewish women, the number of therapeutic abortions per 1,000 births had increased, in general, for

each of these three religious groups over this 22-year period. The increase is greatest among Jewish women, least among Catholic women, and intermediate among Protestant women. For the periods 1943-1949, 1950-1959, 1960-1964; the respective number of abortions per 1,000 deliveries and the actual number of abortions in brackets were: Jews--20.7 (11), 18.6 (33), 56.4 (30); Catholics--2.9 (32), 3.0 (56), 4.2 (49); Protestants--3.8 (41), 3.9 (99), 9.4 (126).

An examination of the percentage of abortions performed among the three major religious groups and a group classified as of "other or unknown" religious preference during each of the three time intervals (1943-1949, 1950-1959, 1960-1964) reveals an increasing percentage for Protestants, a decreasing percentage for Catholics, and a relatively constant percentage for Jews as well as for women categorized as of "other or unknown" religious preference. For the progressive time intervals, the respective percentages for Protestants were 46.1, 50.5, 57.5; Catholics, 36.0, 28.6, 22.4; Jews, 12.4, 16.8, 13.7; "others or unknowns," 5.6, 4.1, 6.4.

Again restricted to the three major religions, an analysis of religious preference and marital status over this 22-year period revealed that 359 of the 477 therapeutic abortions were performed for married women. Of these, 207 (57.7 percent) were for Protestants, 97 (27.0 percent) were for Catholics, and 55 (15.3 percent) were

for Jews. Single women were granted 118 abortions of which 59 (50.0 percent) were performed for Protestants, 40 (33.9 percent) for Catholics, and 19 (16.1 percent) for Jews. Among aborting Protestant women, 207 (77.8 percent) were married and 59 (22.2 percent) were single; among Catholic women, 97 (70.8 percent) were married and 40 (29.2 percent) were single; and among Jewish women, 55 (74.3 percent) were married and 19 (25.7 percent) were single.

That single women faced with motherhood often feel shame and fear of parental and societal response is reflected in the finding that 93.7 percent of the single women, in contrast to 47.7 percent of the married women, were aborted for psychiatric indications. Related were the findings that: (1) within marital classifications, the percentage of single Catholics who legally aborted was greater than that of married Catholics; and (2) Catholic women constitute the largest percentage of aborting single women within religious groups. These latter findings also suggest that the pregnant, single Catholic woman is especially fearful of the response of persons in her cultural subgroup.

Medical Procedures

The operative techniques used in therapeutic abortion depend primarily on the period of gestation,

the health of the woman, and the physician's knowledge of abortion techniques. Although an abortion may be performed during any period of gestation prior to birth, the operation is safer the sooner it is performed after conception.

Prominent among the techniques currently employed for abortion in the United States are the methods of dilatation and curettage (D & C); vacuum extraction; hysterotomy (vaginal and abdominal); hysterectomy; intravenous, concentrated, oxytocin solution; and injection of hypertonic solutions into the uterus. Dilatation and curettage has been the most frequently used method. This procedure of dilating the cervical canal and scraping the products of conception out of the uterus is used primarily through the first 12 weeks of pregnancy. The more recently developed and increasingly preferred technique of vacuum extraction may also be employed during this period. The cervix is dilated and a tube inserted into the uterus to dislodge the fetus from the uterine wall; the fetus is then drawn out of the uterus through a lateral opening in the tube by means of a vacuum pump attached to the tube.

From 12 to 17 weeks after conception, the methods of dilatation and curettage and vacuum extraction may together be employed--the suction tube extracts the products of conception after they have been broken up by dilatation and curettage (Women flock to London, 1969).

Hysterotomy, an incision of the uterus through the vagina or abdomen, frequently is used after the twelfth week of pregnancy. Intravenous, concentrated oxytocin solutions, first employed in 1964, are also used during later periods of gestation. However, this technique, being questioned as hazardous to specified cardiovascular patients, has sometimes been replaced by the use of intra-amniotic hypertonic solutions (Guttmacher, 1964). The solution (glucose or saline) injected into the uterus "ends the development of the fetus and causes it to be expelled within a few days [Tietze & Lewit, 1969, p. 22]." Presently, hypertonic and oxytocin solutions account for only a small percentage of therapeutic abortions (Niswander, 1967).

Hysterectomy, frequently used in the 1940's, is reportedly employed less extensively today as it is considered "too radical" and is mainly limited to situations involving abnormalities of the uterus (Niswander, 1967).

Consequences

Many persons (Davis, 1944; More abortions, 1965; Little reason for, 1955) have asserted the physical and psychological consequences of therapeutic abortion are largely negative. However, research studies of post-abortion sequale generally fail to support these assertions.

Physical Consequences

To accurately assess the physical effects of a therapeutic abortion, one must take into account the critical and overlapping variables of: (1) the woman's health prior to the operation as it may affect her health after the abortion, (2) the period of gestation, and (3) the medical procedure used to produce the abortion. Researchers often do not document these variables and, consequently, facilitate misinterpretation of the data.

Mortality

Few studies investigating mortality attributed to legal abortion have been conducted in the United States. One study which did take mortality associated with therapeutic abortion into account was that of Tietze (1950). Reviewing 3,592 legal abortions in New York City from 1943-1947, Tietze found seven deaths ascribed to the operation. Tietze and Lehfeldt (1961) attributed this large mortality rate of 195 deaths per 100,000 legal abortions to these operations being legal abortions performed many years ago when techniques were poorer and also to the restrictive interpretation of the medical indications for the termination of pregnancy. Tietze and Lehfeldt argue that restrictive interpretation would result in granting abortions to women in a poor state of health and for whom the stress of the operation would be difficult. A closer examination of the 1943-1947 data

reveals that no deaths occurred among 2,703 women upon which dilatation and curettage was performed. The seven deaths occurred with the more complicated techniques-- among 534 hysterectomy patients, 6 deaths; among 294 hysterotomy patients, 1 death. Five of the seven occurred for women suffering from fibroids.

In a later study, Loth and Hasseltine (1956) reported no immediate postoperative deaths among 301 women receiving a therapeutic abortion at the Chicago Lying-in Hospital from 1939-1954. Follow-up of 256 of the 301 women revealed three deaths but none of these fatalities were attributed to the abortion. The medical procedures of hysterectomy (114 cases), hysterotomy and sterilization (89 cases), dilatation and curettage (79 cases), and hysterotomy (13 cases) were employed for the following indications: cardiac (77 cases), renovascular (77 cases), psychiatric and neurological (46 cases), pulmonary (40 cases), maternal-fetal (22 cases), and miscellaneous (39 cases).

Because of the limited number of legal abortions performed in the United States and the relatively few hospital follow-up studies of aborted women, an examination of therapeutic abortion in countries with more liberal attitudes and, consequently, a greater incidence of legal abortion affords a better understanding of the outcome of therapeutic abortion.

For the Eastern European countries, maternal mortality associated with the legal termination of pregnancy has been extremely low. The mortality rate in Hungary has been low and rather consistently declining. For the period 1957-1958, the mortality rate was 5.6 deaths per 100,000 operations* (Hirschler, 1961a); 1960-1961, 2.7 per 100,000 (Szabady, 1962); 1963-1964, 0.6 per 100,000 (Cernock, 1965); 1964-1967, 1.2 per 100,000 (Tietze, in Legal abortion mortality, 1969).

In Czechoslovakia the mortality rate was 3.1 deaths per 100,000 legal abortions for the period 1958-1962, and 2.5 per 100,000 during 1963-1967 (Tietze in Legal abortion mortality, 1969). No death was reported in 1961 (Vojta, 1963), and; from 1963-1964, among 140,000 legal abortions, there was no death reported (Cernock, 1965).

In Yugoslavia there were 8 deaths reported among 177,000 legal abortions performed from 1960-1961--a mortality rate of 4.5 deaths per 100,000 operations (Mojic, 1962). For 1961-1967, the mortality rate was 5.7 per 100,000 (Tietze in Legal abortion mortality, 1969).

*As three of the 15 deaths did not appear to be caused by the abortion (Hirschler, 1961b), 4.5 deaths per 100,000 operations may be a more accurate estimate.

In comparison to the abortion death rates of Eastern Europe, those of Northern Europe are much higher. Mortality rates between 64 and 68 deaths per 100,000 legal operations during 1953-1957, have been reported for Sweden (Medicinalstyrelsen, 1957), Finland (Olki, 1960), and Denmark (Berthelsen & Ostergaard, 1958). The lower death rates of the eastern countries have been attributed to their restricting the operation to the first three months of pregnancy, with possible exceptions for medical indications (Tietze & Lehfeldt, 1961). Only 1 percent of the abortions performed in Hungary during 1957 were granted to women pregnant longer than three months (Tietze & Lehfeldt, 1961). On the other hand, 35 percent of the abortions granted in Sweden during 1949 (Inrikesdepartementet, 1953) and 25 percent of those approved in Denmark during 1955 and 1957 (Frandsen, Mosbech, & Molgaard, 1959) were performed after the third month of pregnancy.

That abortions performed late in gestation contribute heavily to the total number of deaths may account for the discrepancy between the mortality rates of Eastern and Northern Europe is revealed in the 1957-1958 abortion statistics for Hungary. Hirschler (1961b) reported that of the 15 deaths following legal abortion, "about one-half" involved pregnancies of more than three months gestation. "The mortality rate of these late abortions

was, therefore, on the order of 300 per 100,000 [Tietze & Lehfeldt, 1961, p. 118]."*

As a further explanation for the disparity of European abortion mortality rates, Tietze (Legal abortion mortality, 1969) asserts that the abortion-seeking women of Northern Europe are in poorer health than those of Eastern Europe.

The relative safety of an abortion performed during the first three months of pregnancy is illustrated in a comparison of Hungary's death rates from abortion to the mortality rates associated with pregnancy and childbirth in the United States. The abortion mortality rates ranging from 5.6† per 100,000 operations in 1957-1958 to 0.6 per 100,000 operations in 1963-1964 are much lower than the mortality rate of 22 deaths from complications of pregnancy, birth, and the puerperium (excluding abortion) per 100,000 live births among white women in the United States during 1959 (Greep, 1963).

*Kolstad (1957) found the percentage of serious complications to be 10 times greater among women having an abortion performed after 12 weeks of pregnancy in contrast to women having the operation prior to the twelfth week of pregnancy.

†Of the 15 deaths among 269,000 operations, about half of the deaths occurred in roughly 2,690 operations performed after three months of pregnancy. Consequently, a mortality rate of 3.0 per 100,000 operations (performed during the first three months of pregnancy) would be more appropriate for comparison.

The abortion mortality rates of Hungary are also much lower than the mortality rates from tonsillectomy and adenoidectomy (tonsillectomy and adenoidectomy are usually performed at the same time) in the United States. There were 17 deaths per 100,000 tonsillectomy and adenoidectomy operations during 1957-1958 (Tietze & Lehfeldt, 1961).

Impairment

Although mortality rates are primary evidence of the safety of legal abortion, less extreme physiological impairments must also be examined to evaluate the overall safety of the operation.

Sterility. Sterility has been infrequently associated with therapeutic abortions, although studies of this outcome have been inconsistent in their findings. In view of the many uncontrolled variables which have confounded the interpretation of previous research in this area, conclusions regarding the relationship of sterility and abortion must be considered tentative and subject to further study.

Before a relationship between abortion and sterility can be established, the number of women who would become sterile regardless of a therapeutic abortion must be known. Kinsey (in Calderone, 1958, p. 62) asserts that many women would become sterile whether or not they had become pregnant or had an abortion. Holtz (1939, cited by Kolstad, 1957, p. 58) reports that up to 7

percent of women may become sterile after a first pregnancy.

Also, the period of gestation, the woman's health prior to the operation, and the medical technique for inducing abortion are often unreported, although these may be critical factors affecting postoperative health.

Furthermore, sterility may be misidentified and assumed to be permanent when the "disorder" may actually be "temporary infertility." Consequently, periodic and thorough medical follow-up over appreciable time periods seems required to make an adequate evaluation of sterility. Some of the reported cases of sterility also appear subject to alleviation with proper medical treatment. A study illustrating the above points is that of Bass (1927; Stamer, 1946, p. 269). Bass found 20 cases of partial cervical atresia (partial closing of the uterine cavity and cervical canal due to the destruction of the endometrium) among 1,500 Russian women who had experienced abortion. Bass's figure of 1.3 percent seems dubious as the 20 women returned to the clinic where the operation was performed; others may have gone elsewhere with the onset of symptoms. However, each of the 20 women recovered from this condition of "sterility." Several women recovered spontaneously. For others, medical treatment was successfully applied. Stamer (1946) asserts that partial atresia has been treated successfully

up to six years after its onset and that biological functions return to normal independent of the duration of the condition.

Having further implications for other studies bearing upon the association between sterility and abortion is Stamer's assertion that this condition is often misdiagnosed and that the consequent treatment is inappropriate and unsuccessful. Probably some cases of "permanent sterility" reportedly resulting from abortion, are misdiagnosed cases of atresia which could be successfully treated and removed from sterility statistics.

Cervical atresia may be caused by excessive pressure of the curette near the internal orifice ultimately removing endometrial tissue which then fuses and obstructs the uterine cavity. Stamer (1946) has demonstrated that the cause of this condition (as well as other possible impairment) may, in part, lie in the skill of the physician rather than abortion per se.

An attempt to investigate the possibility of sterility resulting from therapeutic abortion again necessitates, for the most part, turning attention to the findings (as confounded as they may be) of other countries. Bovin (1934) and Shajaa (1936) contend that injuries following abortion are infrequent among Russian women and that the sterility rate approximates only 1 percent. Mehlan (1965) examined 2,000 Soviet women five years after

they had had an abortion and found a sterility rate of 2 percent.

Following 119 Norwegian women who were not practicing contraception and who wanted to have children four-seven years after their abortion, Kolstad (1957) found four were sterile--a sterility rate of 3.4 percent.

In an investigation of 65 American women receiving an abortion at The Jewish Hospital of St. Louis from 1955 to 1965, Rothman (in Kretzschmar & Norris, 1967, p. 371) reports no evidence of involuntary sterility. The operations were performed for psychiatric (24), medical (18), and fetal (23) indications.

Of the many Swedish studies, Feniger and Wetterdal (1947) found 3.5 percent of the women aborted in a Stockholm hospital to be sterile. Among 79 of 229 Swedish women who received hospital abortions, Svanberg (1949) found 4 (5.1 percent) to be sterile. Kolonja and Ulm (1952) found no case of sterility among 756 women upon which a vaginal hysterotomy had been performed to induce abortion; 339 of the 756 women participated in a follow-up study. Ekblad (1955) reported that 4 of 479 (0.8 percent) women who had received a therapeutic abortion stated they were involuntarily sterile during a follow-up examination. However, the duration of sterility for each of these four women leaves undetermined the possibility of temporary infertility. One woman reported being sterile for one

and one-half years; another one year; and the remaining two, six months.

Following 1,013 Swedish women with complete medical examinations over a period of one to five years after abortion, Lindahl (1959) found only one (0.1 percent) woman with impaired fertility, and concluded that abortion presented "Little risk of persistent impairment of fertility [Lader, 1966a, p. 20]." Lindahl further asserted that the operation "had not demonstrably resulted in any increased disposition [Lader, 1966a, p. 19]" to spontaneous abortion or premature delivery.

Concerned with women pregnant after an earlier abortion, Arén (1958) found that among 235 pregnancies in which the fetus became viable, 9 percent (22) of the children were premature as compared to 5 percent for the department of obstetrics and gynecology during 1950-1954. However, further analysis revealed that 134 of these 235 women had abortions induced by vaginal hysterotomy. Among this group of 134 women, there were 17 premature births (13 percent). The percentage of premature deliveries occurring in women operated on by other abortion-inducing procedures was 5 percent--the same as for non-abortion linked deliveries in that department. The findings of this study indicate that the operative technique of vaginal hysterotomy and/or the woman's health prior to the abortion and/or the period of gestation may be the critical factors, rather than abortion per se, influencing

the possibility of premature delivery subsequent to an abortion.

"Minor problems". Studies concerned with "minor problems," such as menstrual disorders, and their relationship to abortion are subject to the uncontrolled variables which confound research findings of possible associations between sterility and abortion. Additionally, these data are much more subject to the researcher's personal attitudes toward abortion influencing his under-or-over acute elicitation, examination, and interpretation of such problems.

Kolstad (1957) found 19 of 136 Norwegian women (13.6 percent) reported hypogastric complaints following abortion. Nine women complained of menorrhagia and four women were distressed by dysmenorrhea. The remaining six women were "inconvenienced" by such symptoms as hypogastric pains, vaginal discharge, dyspareunia, or frigidity. Assessing these findings based on the womens' written responses to questionnaires, Kolstad states, "As for the question of the connection between the above mentioned symptoms and the operation itself, it is impossible to form any reliable opinion based merely on the answers written on the question forms [pp. 58-59]." But since his results supported the earlier findings of (Mayer, 1953; Holtz, 1950; Svanberg, 1940), Kolstad further states that his findings "may, at any rate, be said to

point in the direction of a possibility that the patients may develop menstrual disorders as a consequence of induced abortion [p. 59]."

Contrary evidence is provided by the findings of Kretzschmar and Norris (1967). In a one- to five-year follow-up study of 24 women who had received a therapeutic abortion in the United States, none of these 24 women indicated poor health after the operation. Although two of the 24 women reported an altered menstrual cycle, all 24 stated their health was as good or better than before the operation. The discrepancy between the findings of the earlier studies and those of Kretzschmar and Norris may be attributed, in part, to the advances in drug therapy.

In summary, because of many uncontrolled variables, conclusions regarding the overall safety of therapeutic abortion must be considered tentative, warranting further research of improved sophistication. However, from the review of previous research, the following tentative statements are offered:

1. An abortion properly performed by dilatation and curettage during the first 12 weeks of pregnancy on a woman of reasonably good health is a safe operation with little risk of mortality or physiological impairment.

2. The procedure of hysterectomy, often performed in later gestation and among less healthy women, increases the risk of mortality, but rarely to the extent that the operation would be termed dangerous. The risk could be described as ranging from little to a mortality rate of 1.1 percent.*
3. Hysterotomy, most often performed in later stages of pregnancy, does not appear to run the risk of death as high as does hysterectomy but is less safe than dilatation and curettage --less safe from the standpoint of mortality, sterility, and menstrual disorder. The increased risk of sterility or menstrual disturbance for women having a hysterotomy rather than dilatation and curettage appears to range from no increased risk to a maximum increased risk of 8 percent.†
4. The woman's physical health is a variable which interacts with those of medical procedure

*The figure of 1.1 percent is derived from Tietze's (1950) finding 6 deaths among 534 women upon which abortion was performed by hysterectomy.

†The figure of 8 percent is derived from Arén's (1958) finding that women having a vaginal hysterotomy had 8 percent more premature deliveries than the number of premature deliveries among women for which abortion was induced by another medical procedure.

and period of gestation. Obviously, the healthier the woman, the less the risk of mortality or physiological impairment from therapeutic abortion.

Psychological Consequences

Although many unknown variables characterize the investigation of physical aftereffects of therapeutic abortion, an even greater number of uncontrolled factors confound the interpretation of studies which attempt to report psychological consequences. To relate a woman's psychological well-being to abortion, an evaluation of the woman's psychological adjustment is required prior to and following the operation. Psychological disturbance after the abortion cannot be attributed to the operation if the same degree of disturbance existed prior to the abortion. Ideally, psychological evaluations would be made periodically before and after the abortion. Post-operative evaluations should be extended over a sufficient length of time to determine if earlier latent or suppressed aftereffects may become manifest. Among the studies investigating psychological consequences, only Kretzschmar and Norris (1967) performed pre and post-abortion psychiatric evaluations.

Researchers have consistently avoided considering whether the women wanted, did not want, or felt ambivalent toward abortion when dealing with psychological outcome.

Relatedly, the indications for which the abortion was granted are not categorized with respect to psychological consequences. Difference might reasonably be anticipated in reactions to abortion among: (1) women not wanting the child, (2) women wanting the child but physically unable to give birth, and (3) women who were ambivalent, such as those fearing fetal abnormality.

Sterilization accompanying abortion frequently appears as a confounding variable. Sterilization may be a factor, apart from that of abortion, which may alone influence a woman's psychological health. However, researchers rarely distinguish between simple abortion and abortion plus sterilization. A woman who has experienced hysterectomy will no longer be able to bear children. The impact of sterilization and its relationship to her perceived role of herself as a woman, cannot be considered equivalent to the experience of a woman who has been aborted by a medical procedure which will permit her to have children.

Among the many other variables which have received little attention are lack of support from significant others, marital disharmony, other's persuasions and their line of arguing for her to continue her pregnancy, and the general acceptability of abortion within the society.

Dubious methods of evaluating a woman's psychological well-being becloud many research findings. Women's self-reports may be inaccurate (among many

reasons) because of her distortion of her feelings or her inability to adequately express feelings in words. Inaccuracy may also result from the researcher's attitudes toward abortion biasing his interpretation and classification of the women's self-reports. A psychiatric evaluation conducted and/or interpreted by an individual knowing the research purpose of the interview may also be biased.

Until the effects of these variables are known, an accurate assessment of postabortion psychological sequelae is difficult, if not impossible. However, a critical evaluation of previous research allows the general and tentative statement that a woman who herself desires the operation, is psychologically healthy prior to the abortion, and who receives some support from significant others will experience minimal psychological disturbance as a result of the therapeutic abortion.

Kretzschmar and Norris (1967) found that women receiving therapeutic abortions at University of Iowa hospitals were "uniformly positive" in their reaction to the operation. Pre and Postabortion psychiatric evaluations were conducted among two-thirds of 32 women granted an abortion from 1960-1965. None of these evaluated women had previously received "extended treatment." However, prior to the operation, all of the women displayed anxiety and depression--two women admitted depressive episodes and eight women were

considered suicidal. After the abortion, 12 women experienced depression and 3 of these women sought psychiatric care during the immediate postabortion period. Seven women felt emotionally well and stable.

Following 24 of these 32 women, one to five years after the operation, Kretzschmar and Norris asserted the women were "uniformly positive" in their impression that the operation was beneficial. Only two patients stated they had occasional regrets or were sorry that abortion had been medically necessary. In response to a question concerning subsequent marital adjustment, two women reported improvement and the remaining women reported no change. From their findings Kretzschmar and Norris concluded "there had been no permanent psychiatric sequelae noted during the one- to five-year follow-up period" and "that the emotional adjustment of the patient remains consistent in spite of the acute anxiety producing situation [p. 370]."

By not relating psychological consequences to the indications for the operation, Kretzschmar and Norris left unknown the possibility that women granted an abortion for differing indications may react differently to the therapeutic abortion. Also, one-third of these 32 women had also been sterilized but their individual reactions to this additional medical procedure were not reported.

A study reported by Rothman (in Kretzschmar & Norris, 1967, p. 371) reveals some information as to how women with specific indications for the operation will react psychologically to the abortion. Among women aborted at The Jewish Hospital of St. Louis, Rothman found that "serious psychiatric illness after abortion was related to pre-existing psychiatric illness and was not related to or precipitated by the abortion [p. 371]." For 46 of the 65 women aborted during 1955-1965, information was obtained from a psychiatric interview; a questionnaire; hospital charts; and psychological tests (MMPI and Loevinger Family Problems Scale). Although 24 of the 65 abortions were granted for psychiatric reasons, 23 for fetal indications, and 18 for medical reasons; 30 of the 46 women examined psychiatrically were diagnosed with "psychiatric illness" prior to the abortion. The evaluations revealed rather uniform and selected expressions of psychopathology: sado-masochism, 40 percent; rejection of the feminine biologic role, 40 percent; and depression, 29 percent.

While 65 percent of the women expressed little or no conscious guilt after the operation, 22 percent experienced moderate guilt, and 13 percent revealed marked conscious guilt. Women granted the abortion for psychiatric reasons, more than women with medical or fetal indications, experienced moderate to marked conscious guilt.

With respect to postabortion depression, 60 percent of the women expressed no depression; 27 percent, mild depression; and 13 percent, moderate to severe depression. Mild and transient depression were more characteristic of women who had the therapeutic abortion fearing a deformed child. Rothman stated that the women having the abortion for fetal indications (rubella) were psychologically the healthiest and described their reaction to the operation as "a normal response to suffering a loss [p. 371]."

Investigating the possible effects of sterilization by comparing the psychological reactions of aborted women to the reactions of women aborted and sterilized, Rothman presents evidence which reveals that sterilization, rather than abortion per se, resulted in the most severe guilt reaction. In contrast to 9 of 20 sterilized women who experienced a marked guilt reaction, marked guilt was noted in only one of eight women who were aborted but not sterilized.

Kummer (1963) took a somewhat different approach in studying the psychological consequences of abortion in a preliminary study. Inquiries among 32 psychiatrists, 28 of whom were associated with the University of California at Los Angeles School of Medicine, revealed that 75 percent of the psychiatrists had never encountered moderate to severe psychological reactions to abortion. (Abortion in this preliminary study referred to both legal and illegal abortion and, consequently, makes impossible the

application of these findings specifically to legal abortion.) Of the remaining psychiatrists, 25 percent encountered such sequelae "only rarely"; the highest figure reported was six women in 15 years of practice. The average length of practice for the 32 psychiatrists was 12 years.

One may reason that a survey of psychiatrists would be an accurate method to determine the incidence of severe psychological disturbance from an abortion because the outcome of the operation eventually required the woman to seek a psychiatrist's aid. However, no preabortion psychiatric evaluation was available to provide a sound perspective on the judgment that these women would not have needed a psychiatrist's aid regardless of the abortion. Also, because psychiatry is more available to the wealthy than to the poor, in addition to the present fear and taboo of seeing a psychiatrist, many people--including some who are severely psychologically disturbed--would never approach a psychiatrist. These criticisms imply that the findings of a survey conducted among psychiatrists to determine psychological consequences of abortion are of questionable worth. Thus, Kummer's findings cannot be generalized to the public as a whole but must be restricted to an unknown sample of more wealthy persons.

Again confronted by the lack of studies conducted in the United States, further understanding of abortion and possible psychological consequences must be sought in the studies of other countries with a more liberal abortion policy. Attempts to investigate the psychological effects of therapeutic abortion performed in other countries range from broad general statements: "In Eastern Europe psychological disturbances after abortion have not been any more common than after childbirth [Darby, 1964, p. 18]"; through inquiries with individual authorities: Dr. Henrik Hoffmeyer, Chief Psychiatrist, Mothers' Aid Society in Copenhagen, reports no moderate to severe psychiatric after-effects from abortion among approximately 30,000 legal abortions performed over the past 15 years (Kummer, 1963, p. 981); to efforts of empirical research. However, the research of these countries appears even more susceptible to the criticism of uncontrolled variables than does much of the research in the United States.

Brekke (Calderone, 1958, p. 135) reports a Norwegian follow-up study in which 34 women, considered statistically representative of 187 women granted a legal abortion, were personally interviewed in their homes by a social worker. Among the 34 women, only two were described as having a psychological reaction to the operation--a reaction considered "very slight, just a feeling of distress and embarrassment that lasted for a few weeks, and then disappeared [p. 135]."

Lending support to the contention of more adverse effects from sterilization than from abortion was the finding that one of the women who had been sterilized in connection with abortion (but was not in the group of 34) displayed a severe reaction after the operation. Brekke attributed this reaction to the sterilization.

The findings of another Norwegian study, however, conflict with Brekke's findings. Arén (1958) found that of 100 women who had a prior legal abortion, but who had just given birth to another child at the time of his study, 35 stated the abortion was a "good help" and were classified as "content"; 17 found the operation "helpful in that situation but preferred not to be reminded of it" and were classified as "content but bad conscience"; 25 were classified as having "mild guilt feelings"; and 23 were classified as having "severe guilt feelings." As evidence of "severe guilt reactions," Arén considered nervous disorders, insomnia, and decreased working capacity. Many of these women were described as "troubled by the sight of small children" and "some complained of a strange feeling of emptiness and longed for the child they had not borne [p. 34]."

Supporting the findings of Arén, and contrary to Brekke's findings, are the results of a study conducted by Malmfors (Calderone, 1958, p. 133) in Stockholm during 1951. Among 84 aborted women, 39 (46.4 percent) declared that they were "perfectly happy and satisfied at having

had the abortion" whereas 45 (53.6 percent) were described as "not completely happy" about the abortion. Among the 45 women less than completely satisfied with the operation, 4 were "embarrassed and distressed" and did not like to talk about the abortion, 9 were considered "consciously repressing" guilt feelings, 22 were classified as having "open feelings of guilt," and 10 were characterized as having suffered impaired mental health after the abortion.

However, Arén pointed out that in most cases the guilt feelings became "less poignant" and the memory of the abortion began to "fade" with the subsequent birth of a child, regardless of whether or not the later child was planned.

Concerning sterility, of 9 women sterilized among the 84 women aborted, no case of psychological impairment was reported and all 9 were considered "well satisfied and grateful about their situation." This finding contradicts that reported by Rothman (in Kretzschmar & Norris, 1967) in the United States and Brekke (Calderone, 1958, p. 135) in Norway.

Each of the three above studies (Brekke, in Calderone, 1958; Arén, 1958; Malmfors, in Calderone, 1958) can be criticized because of many uncontrolled variables confounding the findings. Not one of these studies reports preabortion psychiatric evaluations. As earlier stated, the lack of such evaluations renders attempts to

relate psychological aftereffects to the abortion, at best, inconclusive, tentative, and questionable. For example, Brekke (Calderone, 1958, p. 134), discussing the 10 women Malmfors (Calderone, 1958) described as suffering from impaired mental health, claimed there were assertions that the 10 women "had shown various neurotic complaints before the abortion, and the abortion became an additional psychic trauma that contributed to a fixation or accentuation of the symptoms [p. 134]."

Other factors make it difficult to meaningfully generalize about, or to even compare, findings. In the study by Malmfors, abortions for eugenic indications were not included. Considering the studies of Kretzschmar and Norris (1967) and Rothman (in Kretzschmar & Norris, 1967), which found indications for the operation to be associated with psychological consequences, the credibility of comparing the general findings of the Malmfors study with those of other studies must be strongly questioned.

The generalizability of Arén's (1958) findings are restricted because all of his subjects had given birth to another child subsequent to the abortion and just prior to the study.

Furthermore, the 84 women included in the Malmfors study were from an original group of 200 women requesting an abortion. Sixty of the 200 women were "persuaded" to carry the child to term. This may imply that efforts of persuasion were also made on the 84 women who did receive

a therapeutic abortion. Such persuasion efforts would introduce a variable of unknown consequences. Hardin (Kerby, 1967) states that a physician who "tries to argue his patient out of a desperately wanted abortion by predicting psychological consequences is not so much predicting as creating grief [p. 756]."

Each of these three studies may also be criticized for the possible unreliable and invalid descriptions of the psychological consequences. The criteria for the categorization of reactions does not appear consistent across studies. Descriptions of consequences easily may be influenced by the researcher's method of questioning and his personal bias toward abortion. A statement suggesting such a bias, possibly affecting the definition, description, and evaluation of consequences is that of Arén who describes a woman's "first" experiencing self-reproach three years after the abortion but "not until after the woman had been delivered of her first child, when she realized what she had missed by having a legal abortion [p. 34]."

Two additional Swedish studies concerned with therapeutic abortion and psychological consequences are those of Kolstad (1957) and Ekblad (1955). Kolstad classified the reactions of 135 women after having received a legal abortion as "glad, without reserve," 112 (82.8 percent); "satisfied but doubtful," 13 (9.8

percent); "not happy but know the abortion was necessary," 5 (3.7 percent); and "repentant," 5 (3.7 percent).

Limitations of the Kolstad study include the non-specification of abortion indications, the lack of follow-up data, and the absence of preabortion psychiatric evaluations. His usage of terms such as "repentant" is elusive with respect to psychological meaning and intensity of affect.

Ekblad's (1955) study was more extensive and rigorous. He interviewed and examined 479 Swedish women immediately after and between 22 and 30 months after their therapeutic abortion. In general, adverse psychological reactions were infrequently found. When a severe reaction did occur, it was influenced by the woman's psychological well-being prior to the abortion and/or others' influencing a woman to have the abortion, particularly when the woman herself was doubtful of having the operation.

Of interest is the comparison of the womens' attitudes toward the abortion shortly after the operation as opposed to two to three years afterwards. Immediately after the abortion the majority of women felt "relieved and glad," although some women demonstrated depression and self-reproach. Of these 479 women, the attitude of 423 (88 percent) was classified as "satisfied, no self-reproaches"; 15 (3 percent), "considered the abortion unpleasant but no self-reproaches"; 30 (6 percent), "mild

self-reproaches"; and 11 (2 percent), "serious self-reproaches."

Two to three years later there was a tendency for the women to be less satisfied with the abortion. Among the 479 women, 312 (65 percent) were "satisfied, no self-reproaches"; 47 (10 percent), "considered abortion unpleasant, but no self-reproaches"; 66 (14 percent), "mild self-reproaches"; and 54 (11 percent), "serious self-reproaches." Ekblad attributed this less favorable tendency over the follow-up period to publicized negative environmental and community attitudes toward abortion.

Discussing these 54 women who experienced a severe reaction from the standpoint of a more rigorous psychiatric evaluation of their condition, Ekblad observed:

Fifty-four (11%) of the women had felt serious self-reproaches or regretted the abortion. A closer study of the case-histories of these women with serious self-reproaches shows that even if their subjective sufferings due to the abortion were severe, their depression must from the psychiatric viewpoint be designated as in general mild. The women seldom needed to consult a doctor on account of these mental troubles (p. 212).

Further data analyses revealed that among these 54 women, only 5 (1 percent) suffered a definite impairment in their working capacity. Discussing these 5 women with regard to their male relationships and their psychological health prior to the abortion, Ekblad concludes:

In four of these cases it was probably the break with the male partner and the disappointment connected herewith, and not the abortion, that constituted the most essential cause of the subsequent depression, and

in the fifth case a protracted conflict with an alcoholic and violent husband. In the light of their symptoms and their situation at the time of the abortion it is probable that they would have developed equally severe symptoms of insufficiency even if they had not been granted legal abortion. All of these 5 women had had severe manifest neurotic symptoms even before the abortion (p. 212).

Commenting on the relationship of self-reproach and psychological health, Ekblad found that 16 percent of the women diagnosed as normal personality in contrast to 31 percent diagnosed as abnormal personality felt self-reproaches for the operation. Serious self-reproaches were experienced by 6 percent of the women considered having normal personalities as opposed to 15 percent of the women diagnosed as abnormal personality. Both of these differences were presented as being statistically significant. The findings were interpreted by Ekblad as implying "that the greater the psychiatric indications for a legal abortion are, the greater is also the risk of unfavorable psychic sequelae after the operation [p. 213]."

Svanberg (1949) similarly found the incidence of psychological disturbance considerably larger among women who had been mentally disturbed prior to the abortion. Ekblad further found that women who were influenced and persuaded to apply for the abortion, particularly among women who themselves were uncertain of wanting the operation, experienced self-reproaches to a greater extent than women who had not been persuaded to apply for the abortion.

No relationship was established between psychological consequences and the variables of the woman's intelligence, age, subsequent pregnancy, previous pregnancy, childhood environment, or occupation outside the home.

Further confusing any conclusion which may be made with regard to sterilization as opposed to abortion per se influencing psychological reactions, Ekblad found that a woman who was sterilized displayed "a tendency to feel self-reproaches for the abortion to a lesser extent than the woman who had not been sterilized [p. 217]." However, Ekblad stated that "the women who had been sterilized had as a rule felt a very intensive desire not to have any more children" and concluded that women themselves who desire sterilization are not subject to "increased risk of self-reproaches [p. 217]." Consequently, for sterilization, as for abortion, the woman's desiring or not desiring the sterilization influences her reaction to it. It would seem that to adequately assess the relationship between abortion per se and psychological consequences, women who have been sterilized should be segregated from the analysis.

In summary, these available studies, although limited in number and often poor in quality, suggest that a distinct majority of the women who experience therapeutic abortion suffer no adverse psychological consequences.

Some women do experience guilt and/or depression but cases of severe mental disturbance caused by the abortion per se are relatively infrequent. The woman who possesses reasonably good psychological health prior to the abortion, herself desires the operation, and receives the support of significant others will generally experience little, if any, psychological disturbance following therapeutic abortion. However, the woman who is of poor psychological health, is influenced by others to have the abortion although she herself is uncertain of wanting it, and receives little support from others may experience an adverse psychological reaction to the operation. For the woman of questionable psychological stability, speculation about her adjustment if granted the abortion as compared to her adjustment if not granted the operation, must guide the decision of permitting or refusing the abortion. A second consideration for the decision may ultimately be the condition of a psychologically disturbed woman without a child or the consequences for the child of being reared and influenced by a disturbed woman.

CHAPTER IV

ILLEGAL ABORTION

Unable to meet the exacting requirements for a legal abortion, many women have chosen to illegally terminate their pregnancy. Because these abortions are illegal, all persons involved are subject to criminal sanctions. Consequently, an accurate understanding of illegal abortion is partially concealed in the minds of those who seek and perform this operation. Available factual knowledge of this phenomenon is necessarily limited and of questionable validity. However, supplementing the available data with the statements of authoritative sources fosters a meaningful discussion of the incidence, recipients (their demographic characteristics), performers, and consequences (physical and mental) of illegal abortion.

Incidence

Many estimates have been given for the number of illegal abortions performed each year in the United States. The smallest recent estimate encountered is 71,000 (Cooke et al., 1968, p. 42) and the largest has been 2,000,000

(Rongy, in Tolnai, 1939). The most frequently quoted estimate is that of 1,000,000 annual illegal abortions (Lowe, 1966; Hall, 1966; Calderone, in Gains for birth control, 1965). Rosen (1967c) asserts that there are "a million or more" yearly extralegal abortions. The Planned Parenthood conference held in 1964 determined that 1,123,611 illegal abortions were performed each year (Lader, 1966a).

The "classic" source for an estimate of the annual abortion rate was that of Taussig (1936). His estimate of 681,600 annual abortions in the United States was based upon the findings of Plass (1931) who asked 81 rural Iowa physicians to estimate the number of abortions per live births and Kopp (1934) who studied the case histories of 10,000 women voluntarily seeking birth control advice at the Margaret Sanger clinic in New York City. This figure of 681,600 would correspond to 1,200,000 abortions in 1968 (Cooke et al., 1968). Some of these estimated abortions were thought to be natural, others were believed to be therapeutic, but the great majority were considered to be illegal. The reliability of Taussig's estimate has been questioned by Bates and Zawadzki (1964) for its being based upon the possibly biased samples used by Plass and Kopp. Also, the statistical formulae from which the estimate was derived has been questioned by Guttmacher (Calderone, 1958, p. 50).

Rather than stating a specific number, several sources have taken a more "safe" and perhaps a more realistic approach in giving an estimated range of the number of annual, illegal abortions. An often quoted source is the Statistical Committee appointed at the 1955 conference of the Planned Parenthood Federation of America. The committee estimated that 200,000 to 1,200,000 illegal abortions occur each year. This estimated range was based upon the findings of several studies (Whelpton & Kiser, 1948; Wiehl & Barry, 1937; Tietze & Martin, 1957), each criticized for sample bias making impossible a precise estimate of illegal abortions among the total population of the United States.

Cooke et al. (1968), who described the proceedings of the International Conference on Abortions held in 1967, cited studies whose findings resulted in estimates ranging from 71,000 to 1,200,000 annual, illegal abortions. An Indianapolis study done in the early 1940's cites 71,000; an undated study by Cooke et al. drawing upon the five boroughs of New York City suggests 160,000; Kinsey's data reported in Calderone (1958) imply 600,000; and Kopp's data from the women attending the Margaret Sanger clinic in the late 1920's suggest 1,200,000. Cooke et al. strongly emphasized that the samples of women in these studies were also not representative of the nation. Concluding that no additional knowledge of the number of

illegal abortions had been obtained since the report of the Statistical Committee of the Planned Parenthood conference (in Calderone, 1958), the panel at the International Conference on Abortion made no revision of the Statistical Committee's 1957 estimate of 200,000 to 1,200,000 illegal abortions per year.

Recipients

Few studies have investigated the demographic characteristics of the women obtaining illegal abortions and those studies which have examined these variables often have been biased in their sample selection. Nevertheless, these data provide the only available knowledge of the women who obtain an illegal abortion. In this section women who illegally terminate their pregnancy are discussed with regard to their age, marital status, parity, socio-economic status, educational attainment, race, and religious preference.

Age

Mindful of biased samples in previous studies, the largest percentage of women who obtain an illegal abortion appear to range in age from 20-29. Women who range from 30-34 years of age also account for a large percentage of the illegal abortions.

Of four studies which pertain to the aborting woman's age, three (Tietze, 1949; Timanus, in Calderone,

1958; Lader, 1969) use samples of women who appear to come from higher socio-economic strata and/or possess a higher level of education than the general population. The fourth study (Hellman, in Calderone, 1958) appears biased in having an overabundant number of women from the lower economic strata in its sample. Consequently, caution is required in the evaluation and generalization of the findings from these studies.

Tietze (1949) reviewed the records of two "abortion specialists" in a large Eastern city who had performed abortions for 363 women. The number and percentage of these women, categorized by five-year age intervals, were as follows: 3, 0.8 percent, 10-14; 34, 9.4 percent, 15-19; 88, 24.2 percent, 20-24; 91, 25.1 percent, 25-29; 80, 22.0 percent, 30-34; 35, 9.6 percent, 35-39; and 32, 8.8 percent, 40 and over. Their payment of between 300 and 500 dollars for this operation before 1949, establishes that these women must have come from relatively high income brackets.

An M.D. who made abortion his specialty, Timanus reported to a conference sponsored by the Planned Parenthood Federation of America (Calderone, 1958) that of 5,210 women he had aborted 17, 0.3 percent, ranged in age from 12-15; 688, 13.2 percent, 16-20; 1,834, 35.2 percent, 21-25; 1,268, 24.2 percent, 26-30; 1,312, 25.2 percent, 31-40; and 91, 1.8 percent, 41-50. These women, as was

true for the women included in Tietze's sample, possessed more education and were more affluent than the general population.

Among 500 women writing to Lader (1969) requesting medical help, Lader followed by questionnaire 282 of the women who had obtained an abortion from East Coast gynecologists. Among the 282 women, 62, 22 percent, were of age 20 or under; 144, 51 percent, 21-30; 59, 21 percent, 31-39; and 17, 6 percent, 40 or over. The women included in this study were also from a relatively high socioeconomic strata.

A study reporting the ages of women primarily from the lower economic strata of society who had obtained an illegal abortion is that of Hellman (in Calderone, 1958). Of 65 women who had entered Kings County Hospital in New York City after having a "bungled" illegal abortion, 5 women, 7.7 percent, had ages ranging from 15-19; 23, 35.4 percent, 20-24; 18, 27.7 percent, 25-29; 14, 21.5 percent, 30-34; 4, 6.2 percent, 35-39; 1, 1.5 percent, 40 or older. Hellman's study, contrary to the others previously reported, is limited in terms of its generalizability because the sample of women had come predominantly from the lower economic sectors of society and had required medical attention after the abortion. However, all of these studies, regardless of the direction of their high or low economic status bias in their sample of women,

concur that the majority of illegal abortions occur among women aged 20-29.

Marital Status

The studies reviewed for this subsection concerning the marital status of the woman who seeks an illegal abortion generally have found that the majority of abortions are performed on women who "claim" they are married. However, one study (Lader, 1969) indicates that the proportion of abortion seekers is higher among pregnant single women than among pregnant married women. There are also indications that the number of illegal abortions performed for single women may be increasing.

Taussig (1936) in his analysis of Kopp's (1934) data on abortion among 10,000 women attending the Margaret Sanger clinic in New York City, found that 90 percent of the abortions occurred among married women. Among the relatively upper income and highly educated patients of Timanus (in Calderone, 1958), 2,773 (53.2 percent) were married; 1,830 (35.1 percent) were single; and 607 (11.7 percent) were widowed, separated, or divorced. Tietze (1949) in his review of 363 upper income women found that 180 (49.6 percent) were married; 102 (28.1 percent), single; and 81 (22.3 percent), previously married. In a study which examined the marital status of women who had been aborted in New York during 1925-1950 by persons later convicted of that "crime," 75 (67.6 percent) were

married and 36 (32.4 percent) were single (Bates & Zadadzki, 1964). Simons (1939) found that three-fourths of the women admitted to charity hospitals with post-abortion complications in Minneapolis were married.

Kinsey (Wed and unwed, 1958) found married women to account for the largest number of illegal abortions among 5,293 educated, white, urban, relatively high income women. However, of all pregnancies among married women, 66 percent were carried to term while the remaining 34 percent ended in an equal proportion of miscarriages and induced abortions. Among single women, Kinsey (in Calderone, 1958) reported that the proportion of pre-marital conceptions resolved by induced abortion ranges from 88 to 95 percent.

Lader (1969) found single women to have procured the majority of illegal abortions. Of the 282 women who returned Lader's questionnaire after they had had an abortion, 52.8 percent had never been married; 37.6 percent were married; and 9.6 percent were widowed, separated, or divorced. Hellman (in Calderone, 1958) found that among the 65 women admitted to Kings County Hospital in New York City with postabortion complications, 30 (46.2 percent) of the women were married. Hellman did not categorize single women apart from those widowed or divorced. However, the combined classification of single, widowed, or divorced women accounted for the remaining 35 (53.8 percent) of the abortions.

Parity

The greatest number of illegal abortions occur among women with relatively few children. Taussig (1936), analyzing Kopp's (1934) data, found that most married women who obtained an abortion had two or three children. Kummer and Leavy (1966) present Kopp's data to indicate a positive linear relationship between the order of pregnancy and the percentage of induced abortions. This implies that although the absolute number of women who abort with two or three previous children may be greater than for women with, for example, 14 previous children, the percentage of women who have 14 children and abort their fifteenth pregnancy is greater than the percentage of women who have two or three children and abort their next pregnancy.

Timanus (in Calderone, 1958) found an inverse relationship between parity and absolute number of abortions. A larger number of abortions was found to occur among women with progressively fewer children. Among 5,210 women Timanus had aborted, 3,149 had no children, 960 had one child, 699 had two children, 254 had three children, 90 had four children, 32 had five children, 15 had six children, 6 had seven children, and 5 had eight children. If one were to assume that the 1,830 single women in this study had no children, 1,319 abortions--still the largest number--were performed for women who

were married, or previously had been married, and had no children.

Tietze (1949) in his analysis of parity and the number of induced abortions, reports findings similar to those of Timanus. Of the total number of 363 women who had illegally terminated their pregnancy, 170 had no children, 72 had one child, 68 had two children, 35 had three children, and 18 had four or more children. Categorizing the aborted women as single, married, and previously married, Tietze found that 100 single women with no children and 2 with one child had aborted. The number of married women who had zero, one, two, three, four, or more children and had an abortion were respectively 45, 39, 52, 27, 17. Among previously married women having zero, one, two, three, four or more children; 25, 31, 16, 8, 1 women respectively had had an induced abortion.

Of the 65 women with postabortion complications reported in the study by Hellman (in Calderone, 1958), 13 had no previous children, 37 had been pregnant one-three times, and 15 women had been pregnant four or more times prior to the illegal abortion.

Socio-economic Status, Education, and Race

Bates and Zawadzki (1964) assert that the New York Court records "clearly illustrate that the abortionist is patronized by women of all social classes and economic

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

levels [p. 43]." However, two general categories of studies--women illegally aborted by physicians and women admitted to hospitals with postabortion complications--reveal that although people of all economic levels may procur abortions, the wealthy, educated woman finds the skilled abortionist while the poor, less educated woman seeks the solution to her situation through self-induced abortion or an abortion performed by someone less skilled than a physician.

Kinsey (in Calderone, 1958) reported that among his sample of women, 87 percent of the abortions were performed by physicians and that a "somewhat smaller percentage" of the abortions were performed among unwed girls who had not received education beyond high school in comparison to college-educated women.

Lader (1969) found that among 282 women who had an abortion performed by East Coast gynecologists he had recommended, 67 percent of the women had at least one year of college and 9 percent had at least one year of graduate school. Lader also reported that 23 percent of the women had family incomes of less than 5,000 dollars, 43 percent had incomes of 5,000-10,000 dollars, and 32 percent reported family incomes of over 10,000 dollars.

Timanus (in Calderone, 1958) stated of the 5,210 people upon whom he had performed an abortion, "these people were all in a fairly substantial economic group [p. 66]." Similarly the 363 women discussed by Tietze

(1949) were aborted by two "abortion specialists" in a large Eastern city and paid 300 to 500 dollars for the operation.

In addition to Kinsey's (in Calderone, 1958) assertion of abortion being more prevalent among the educated, he states that the Negro obtains abortion less often than the white female. Kinsey claims the birth of a child prior to marriage is not the social disgrace and handicap in subsequent marriage among "socially lower-level Negroes" that it is among the college educated. Kinsey further asserts that over demographic variation, such as education and age, Negroes obtain fewer abortions than whites.

The preceding studies have been dominated by samples of more educated and wealthy women having illegal abortions from physicians. In contrast, studies of hospitalized women with postabortion complications dramatically illustrate that indigents go unnoticed in abortion studies with higher economic biased samples and that it is these lower income persons who most frequently incur unfortunate physical impairments due to faulty illegal abortions.

Simons' (1939) sample of women consists of patients from an underprivileged urban area who patronized the less skilled abortionists and subsequently found themselves in a charity hospital. Charles Stevenson

(in Barno, 1967) reports that 138 deaths due to septic abortion during 1950-1956 in Michigan occurred "primarily in the greater metropolitan Detroit area and nearly all of these were in the medically indigent group of women living in the poorest and most rundown areas in our city [p. 364]."

Among these indigents experiencing postabortion problems, an excessive proportion are Negro. Of the 65 women admitted to Kings County Hospital in New York City with a known induced abortion, Hellman (in Calderone, 1958) found 20 (30.8 percent) were white, 42 (64.6 percent) were Negro, and 3 (4.6 percent) were "mostly" Puerto Rican. Similarly, Helpern (in Calderone, 1958) reports that of the deaths in New York City for the years 1921, 1931, 1936, and 1940, more deaths occurred among Negro women than white women--both single and married--although Negroes comprise only about 18 percent of the total population of New York City.

Concurring with Helpern's "guess" that the Negro women, as compared to the white women, had less access to a skilled abortionist, the International Conference on Abortion (Cooke et al., 1968) asserted that the "wealthy are more likely to find a physician who, for a fee, will perform an illegal abortion, and who will do so competently [p. 45]." The conference pointed to the abortion death statistics of New York City from 1960 to 1962 to illustrate the relationship between quality of abortion,

race, and poverty. Between 1960 and 1962 among every 10,000 live births, 8.0 Negro women, 4.7 Puerto Rican women, and 1.0 white women died from abortion (Gold et al., 1965). The conference further added that, although there are many times more white than nonwhite women in the United States, of the 235 known deaths due to abortion in the United States in 1965, 129 deaths occurred among nonwhite women as compared to 106 deaths among white women.

Religion

As earlier reported (Chapter III, p. 39), among white and nonwhite women 14 years of age or older surveyed in the United States (excluding Alaska and Hawaii) as of March, 1957, 67.5 percent reported they were Protestant; 25.7 percent, Catholic; 3.2 percent, Jewish; 1.4 percent, no religion; 1.2 percent, a religion other than Protestant, Catholic, or Jewish; 0.9 percent, not reported (United States Bureau of the Census, 1968, p. 41). Comparing research examining the religious preference of women illegally interrupting their pregnancies with the census data, it tentatively appears: (1) the percentage of Protestant women obtaining an illegal abortion is lower than the percentage of Protestant women in the United States; (2) for women included within each of the classifications, Catholic and Jewish, the percentage of women who illegally interrupt their pregnancies appears to

slightly exceed the percentage of women similarly categorized among the general public; (3) the percentage of women with "another, no, or unreported" religious preference who illegally terminate their pregnancies approximates the percentage of such women in the general population. However, due to the limited number of studies, biased samples, and the need for updated, unbiased studies which can be generalized to the total population, it is emphasized that these are tentative and suggestive statements--not definitive conclusions.

Lader (1969) found that among 282 women who had obtained abortions from practitioners who he had recommended, 51 percent "were raised as" Protestants; 28 percent, Catholics; and 16 percent, Jews. A religious preference was not reported for 5 percent of the women.

Brunner and Newton (1939) found an equal percentage of Protestants, Catholics, and Jews to have had induced abortions. Brunner and Newton examined the case histories of 4,500 consecutive patients attending the New York University College Clinic, Department of Obstetrics and Gynecology. These women were seen at the clinic between 1930 and 1938, and were primarily of low educational and economic status. Among Protestants, 14 percent of 631 women had had induced abortions; Catholics, 12 percent of 1,732; and, Jews, 13 percent of 650.

Investigating abortion among women of higher socio-economic status than that of the women in the study by Brunner and Newton, Brunner (1941) obtained findings similar to those of Brunner and Newton. Brunner found the percentage of conceptions terminated by induced abortion to be essentially equivalent among Protestants, Catholics, and Jews. He had examined 979 clinical case histories taken between 1929 and 1938 from ambulatory patients seen in the course of obstetrical or gynecologic consultation. Among 221 Protestant women there were 356 conceptions of which 82 (23.0 percent) were terminated by induced abortion. Of 628 conceptions among 304 Catholic women, (27.1 percent) were interrupted by induced abortion. There were 103 (26.0 percent) induced abortions among 396 conceptions for 202 Jewish women.

Of the 65 women admitted to Kings County Hospital in New York with postabortion complications, 40 (61.5 percent) were Protestant; 21 (32.3 percent), Catholic; 3 (4.6 percent), Jewish; and 1 (1.5 percent), unknown religious affiliation (Hellman, in Calderone, 1958).

Although Kinsey (in Calderone, 1958) asserted that the number of Catholics in his sample was too small for a comparison of abortion incidence among persons of different religious affiliation, he did report a relationship between religious devoutness and illegal abortion. Among both Protestant and Jewish groups, the highest frequency of abortion occurred among the least religiously devout

members. Devoutness for Protestants was based upon the frequency of church attendance and the frequency of engagement in other church activities. For Jews, devoutness depended primarily upon the extent to which they observed orthodox Jewish custom and less on the frequency of attendance at the synagogue,

Abortionists

People from many diverse walks of life have been known to perform illegal abortions. Bates and Zawadzki (1964) provide an interesting breakdown by principal occupation of 111 persons convicted for abortion in New York County, New York from 1925-1950. Classified by occupations, these persons included: physicians (31) 27.9 percent; midwives (25) 22.5 percent; housewives (8) 7.2 percent; "quacks" (6) 5.4 percent; practical nurses (5) 4.5 percent; unskilled laborers (5) 4.5 percent; skilled laborers (5) 4.5 percent; "amateurs" (4) 3.6 percent; public assistants (3) 2.7 percent; clerks (3) 2.7 percent; petty criminals (3) 2.7 percent; chiropractors (3) 2.7 percent; registered nurses (2) 1.8 percent; salesmen (2) 1.8 percent; barber (1) 0.9 percent; chemist (1) 0.9 percent; lawyer (1) 0.9 percent; prostitute (1) 0.9 percent; upholsterer (1) 0.9 percent; physiotherapist (1) 0.9 percent.

Bates and Zawadzki further classify these persons by sex, race, religion, and education. Among the

abortionists, 56.8 percent were females and 43.2 percent were males; 79.3 percent were white and 20.7 percent were Negro; 44.1 percent were Catholic, 32.4 percent were Protestant, and 23.4 percent were Jewish. Twenty-three people did not complete grade school, 28 graduated from grade school, 10 had one to three years of high school, 9 graduated from high school, 2 had one to three years of college, 31 had gone to medical school, and 4 attended professional school.

To simplify a general discussion of the abortionists, Bates and Zawadzki have placed these persons into five major categories:

1. Physicians who possess a medical degree and are licensed practitioners.
2. People with some medical training, such as nurses, dentists, midwives, chiropractors, physiotherapists.
3. "Quack" doctors who possess little, if any, medical training and are not licensed physicians but who pose as licensed medical doctors.
4. "Amateur types" are skilled or unskilled laborers who have no medical training, such as barbers, salesmen, prostitutes, elevator operators.
5. Women who abort themselves (self-induced abortion).

Physicians

Rongy (in Tolnai, 1939) asserted that 2 percent of all physicians were involved in the "abortion traffic." Of the 1,900,000 illegal abortions Rongy claimed were performed annually, 1,700,000 were attributed to physicians. Among 5,293 predominantly urban women whose educational level and socio-economic status were far above average (making them more able to seek and pay a physician for an abortion), Kinsey (in Calderone, 1958) reports that of these women who had had an illegal abortion, 87 percent had their pregnancies terminated by a physician. Offering a lower estimate, Taussig (in Bates & Zawadzki, 1964) suggests that 50 percent of the illegal abortions are the work of physicians.

In contrast to the more global estimates of physicians' involvement in illegal abortion, there are specific reports of the individual abortion practices of several doctors. Probably the most well-known physician who has performed illegal abortions is Timanus (in Calderone, 1958). Over a period of 20 years, he performed 5,210 abortions. Many of his clients were referred by one of 353 doctors, most of which were general practitioners in Maryland. Timanus (in Calderone, 1958) describes another physician who over 50 years had performed an estimated 40,000 illegal abortions. When known by Timanus, this doctor was averaging "about 25 cases a week," or "over a thousand a year [p. 66]." "Dr. S." (Lader, 1966a)

reportedly had terminated 28,658 pregnancies. A physician named Knapp had performed 200 to 300 abortions a year over a span of 22 years (One doctor's choice, 1956).

Often physicians do not work alone in private practices but participate in abortion organizations known as "mills" and "rings." A mill may consist of an abortionist or abortionists, a secretary-receptionist, business manager, nurse, and "runners." The abortionists work "steadily in a fairly permanent location" and may abort "a dozen or so women daily [Bates & Zawadzki, 1964, p. 51]."

Abortion rings are relatively rare and few in number in contrast to the number of mills. Bates and Zawadzki (1964) emphasize that a ring is structurally and functionally different from the mill in that the ring:

1. Has two or more operating abortionists with cooperating interacting staffs.
2. A shifting physical location.
3. Aborts a relatively large number of women daily.
4. Operates seven days per week.
5. Has specialists on staff to handle difficult cases, or cases beyond first trimester of pregnancy (induction cases).
6. Frequently has relatively distant sources of client referral, sometimes on an interstate basis.
7. The "floating" portion of the ring uses portable equipment (p. 71).

Connolly (1944) reported that between 1941 and 1944, five Manhattan abortion mills averaging 30 to 40 abortions a week were closed. A Time magazine article (Sin no more, 1941) describes an abortion mill headed by Dr. Nathaniel Collins who had run an "illegal hospital" for five years. He had 20 sets of abortion instruments--

"as many as in the best equipped hospital"--with which he performed five abortions a day. Three beds upon which women could rest for an hour after the operation were provided in a "drab ward." The women were referred by any one of over 100 physicians and druggists who received about one-half of Collin's fee.

Bordering between a mill and a ring was an organization operated by Leopold W. A. Brandenburg (\$500,000 mill, 1947). Brandenburg himself was located in the Bronx of New York City and he had two assistants working in other states. The organization reportedly performed 8 to 14 abortions a day.

An early and well-known abortion ring was that headed by Reginald L. Rankin who with a staff of 12 physicians had a chain of mills extending from Seattle to San Diego (Abortaria, 1936). Rankin had even organized The Medical Acceptance Corporation to finance installment payments for the abortion.

Persons with Limited Medical Training

Little research has been conducted to foster an accurate estimate of the number of abortions performed by persons with some, but not extensive, medical knowledge. Of 1,900,000 illegal abortions estimated by Rongy (in Tolnai, 1939) in 1939, he assumed 200,000 were the work of midwives. Taussig (in Bates & Zawadzki, 1964) estimated that midwives performed roughly 20 percent of

the illegal abortions. Among the convicted abortionists in the earlier reported study by Bates and Zawadzki (1964), 36 persons (32.4 percent) possessed some medical training.* Specifically, of the 111 convicted abortionists, 25 (22.5 percent) were midwives; 5 (4.5 percent), practical nurses; 3 (2.7 percent), chiropractors; 2 (1.8 percent), registered nurses; and, 1 (0.9 percent), physiotherapist.

"Quacks," "Amateurs," and Self-
abortionists

Information regarding the number of abortions performed by "quacks" and "amateurs" (skilled and unskilled laborers with no medical training) is even more meager than that available for abortionists with limited medical training. Again referring to the study of 111 convicted abortionists (Bates & Zawadzki, 1964), 6 (5.4 percent) were considered "quacks" and 38 (34.2 percent) were "amateurs" or persons with no apparent medical training.*

Although more data have been collected on the incidence of self-induced abortion, sampling bias warrants caution in interpreting these findings. Stix (1935) found among 991 married women attending a Bronx birth control clinic, there had been 686 illegal abortions of which 42 (6 percent) were admitted to be self-induced.

*Among the 111 persons, there were no convictions for self-induced abortion. Consequently, these percentages of persons with some medical knowledge, "quacks," and "amateurs" who perform abortions would be lowered an unknown amount if one considers that some illegal abortions are self-induced.

Kinsey (in Calderone, 1958) found about 8 percent of the abortions occurring among his sample of educated and higher income women were self-induced. Lader (1966a) feels Kinsey's finding of 8 percent is a "minimum estimate" because the study was limited to women of high socio-economic status. He thinks "far closer to the true figure is the Kinsey study of Negro women, and white and Negro prison women, where about 30 percent of the abortions were self-induced [p. 73]." Taussig (1936) similarly estimated that roughly 30 percent of the illegal abortions were self-induced. Of the abortions reported by women attending the Margaret Sanger clinic in New York, 24 percent were self-induced (Kopp, 1934). Bates and Zawadzki (1964) after criticizing the inadequate sampling techniques, rarely dealing with such variables as race, religion, and social class, "offer, for what it is worth, an 'educated guess' that about 20 percent of all induced abortions are self-induced [p. 85]."

Legal and hospital authorities are other sources which have offered estimates of the incidence of self-induced abortion. Of 247 abortions investigated over a 10-month period by the Los Angeles police, 42 (17 percent) were "dropped" as self-induced (Martin, 1961b). Bates and Zawadzki (1964) reported that they had found no record of a woman convicted for a self-induced abortion. Of 70 suspected illegal abortions reported to New York

authorities, Hellman (in Calderone, 1958) reported that "three quarters or more" were self-induced.

An investigation of 41 deaths following abortion in New York over a period of 6 years, revealed that 25 (61 percent) of the abortions had been self-induced. Similarly, Nelson (in Calderone, 1958) states that of the abortion deaths occurring in the District of Columbia from 1940-1943, the Health Department reported that the majority followed self-induced abortion.

In summary, most illegal abortions appear to be performed by physicians. Persons possessing limited or no medical training also perform a significant number of operations. A minority of the illegal abortions are self-induced. However, in addition to biased samples making difficult accurate, conclusive estimates of who performs how many illegal abortions, there exists the possibility that women try to abort themselves without fatal consequences and later seek the aid of another individual. Kinsey (in Calderone, 1958) stated that the records of an experienced abortionist "indicated that about 80 percent of the women who came to him for consummation of an abortion had previously attempted some sort of self-induction [p. 57]." Consequently, the above "conclusions" must be considered most tentative. One finding which appears clear among these generally blurred findings is that the majority of women fatally

injured or admitted to hospitals following illegal abortion have attempted a self-induced abortion. Consequently, although most abortions may not be self-induced, self-attempts to terminate pregnancy result in the most physical damage to the woman.

Techniques

The techniques of inducing an illegal abortion vary over the categories of persons classified as abortionists. The physician-abortionist commonly uses the technique of dilatation and curettage--earlier reported as a procedure used to induce a legal abortion (Chapter III, p. 43). Bates and Zawadzki (1964) assert that midwives and others with some medical training generally lack the equipment and level of training required to perform dilatation and curettage. Consequently, they frequently insert a sterilized rubber catheter into the uterus. The woman's subsequent movements result in the catheter irritating the womb, mild hemorrhage, and the expulsion of the fetus. Another technique is packing the uterus with sterile gauze which stimulates uterine contractions and the expulsion of the fetus.

There appears to be a great deal of overlap in the wide variety of procedures used by "quacks," "amateurs," and self-abortionists. Bates and Zawadzki (1964) report attempts at self-abortion with hot baths, exercises, drugs, and homemade instruments. An umbrella rib or a

knitting needle is often inserted into the uterus. Slippery elm has also been used. After its insertion into the cervical canal, the dehydrated stick is supposed to swell and dilate the cervix. A variety of noxious solutions have also been injected into the uterus. Organic drugs, such as ergot, and inorganic drugs of metallic salts, such as lead, have also been used in attempts to induce abortion. Guttmacher (1959) reports a woman who attempted her twenty-ninth abortion by using a goose feather dipped in kerosene. Mumford (1963) reports a woman attempted self-induced abortion with potassium permanganate and a wire hanger. Charles Stevenson (in Barno, 1967) found the most common instrument used upon women entering Detroit General Hospital from 1958-1965 was the rubber male catheter (which is inserted into the woman's uterus). Hutcherson (in Barno, 1967) found women admitted to Baroness Erlanger Hospital in Chattanooga to have taken large doses of quinine, turpentine, and used hot douches. Although any of these techniques may result in death, additional procedures which have produced fatal consequences are reported in a subsequent section of the present chapter, Causes of death and the techniques used to induce abortion resulting in death, p. 115.

Monetary Cost

In 1937 Rongy (1937) estimated that the "abortion racket" grossed 100,000,000 dollars. More recently, Lowe (1966) estimated that the abortion racket, the third largest in the United States, annually grossed 350,000,000 dollars. Today one would expect this figure to be even greater.

The monetary intake of individual rings, mills, and private physicians indicate why the total estimated cost of illegal abortion is so great. During 1936 the abortion ring headed by Rankin which operated from Seattle to San Diego was said to annually take in 1,000,000 dollars (Abortaria, 1936). Leopold W. A. Brandenburg's organization in the Bronx and his two assistants in other states netted 500,000 dollars a year (\$500,000 mill, 1947). Individual physicians have charged a woman as much as 2,000 dollars (Rongy, 1937; Martin, 1961a) or even 3,000 dollars (Timanus, in Calderone, 1958).

Prices paid by women may vary with the abortionist's personal rates, the duration of the pregnancy, the category of abortionists to which the particular abortionist belongs, and the area of the country. Rongy (1937) asserted that abortions ran from 50 to 250 dollars before 1937 but even prior to the depression one abortionist had charged a minimum fee of 2,000 dollars. Knapp (One doctor's choice, 1956) who annually performed 200 to 300

abortions for 22 years, charged 200 dollars for the operation. Nathaniel Collins, running his "illegal hospital" charged prices ranging from 60 to 500 dollars (Sin no more, 1941). Initially during his 20-year practice, Timanus (in Calderone, 1958) charged fees of 25, 50, 75, or 100 dollars depending "somewhat" on the period of gestation and the woman's "ability to pay." Later, "to make the thing more or less prohibitive," he charged 400 dollars a "treatment [p. 63]." The largest fee Timanus received was 3,000 dollars. Rankin's ring, similar to Timanus' early practice, had prices dependent, in part, on the duration of the pregnancy (Abortaria, 1936). The cost ranged from 35 dollars for a pregnancy of 6 weeks or less to 300 dollars for a pregnancy of 7 months duration.

As is typical for many abortionists, Rankin's organization paid fees to persons soliciting business. A soliciter was paid 10 dollars for a 35 dollar operation, 15 dollars for a 50 dollar operation, and larger commissions for higher priced abortions. Similarly, for the mill headed by Leopold W. A. Brandenburg, a large portion of the 500,000 dollars the mill grossed annually was paid to "steerers" and "lookouts" (\$500,000 mill, 1947). Nathaniel Collins in running his "illegal hospital" paid approximately one-half the fee he charged the woman to any one of over 100 physicians and druggists who had referred the woman to him (Sin no more, 1941).

Pointing out the differences in cost over geographical area and over the categories of abortionists, Martin (1961a) asserted the average cost of an illegal abortion in Chicago was 400 or 500 dollars but was more expensive in New York or Los Angeles. Midwives reportedly charged 25 dollars; a male nurse, 100 dollars; a chiropractor, 150 to 200 dollars; and, a medical doctor or osteopath, at least 500 dollars.

Consequences

Physical Consequences

In addition to dealing with the incidence of mortality and physiological impairment caused by illegal abortion, this section presents information concerning the trend from the early 1930's to the present in the number of fatalities and the demographic characteristics of the women who have become abortion fatalities. The causes of death and the techniques used to induce abortions resulting in death are also discussed.

Mortality

Cooke et al. (1968), reporting on the proceedings of the International Conference on Abortion, state that the number of deaths caused by illegal abortion can be estimated more easily than the actual number of abortions. However, the wide discrepancy among the estimates of abortion deaths proposed by various "authorities" does

not lend much support to this statement. Taussig (1936) and Tolnai (1939) estimated 10,000 women die each year after illegal abortion. A study conducted by the University of California's School of Public Health led to the estimate of 5,000 to 10,000 annual abortion deaths (Roemer, 1964). Lowe (1966) attributed more than 5,000 deaths each year to abortion and Fisher (1967a) asserted 5,000 to 6,000 women had died in 1953 because of illegal abortion. Tietze and Martin (1957) consider 1,000 to be a more accurate figure of the number of deaths. The physicians attending the International Conference on Abortion "reached a consensus that a total of 500 abortion deaths per year would be a reasonable figure--based on the current data [p. 43]." It should be noted, however, that physicians might be strongly motivated to underestimate the number of abortion deaths to minimize their personal and collective feelings of guilt. More recently, an article appearing in Life magazine (Abortion comes out of the shadows, 1970) reports that of 350,000 women admitted to hospitals in 1969 following "botched abortion attempts [p. 208]," more than 8,000 died.

Statistics, in the form of death certificates reporting abortion as the cause of death, are available for the estimates of abortion deaths. In 1957 there were officially reported to be 260 deaths from legal, illegal, and spontaneous abortion (Calderone, 1960); in 1964, 247 deaths, and; in 1965, 235 deaths (Cooke et al., 1968).

Although the deaths recorded for 1964 and 1965 also resulted from all forms of terminated pregnancies, Cooke et al. felt the "vast majority" of deaths were due to illegal abortion. However, these data appear extremely unreliable due to "mislabelling." Illustrations of "mislabelling" are provided by (Bates & Zawadzki, 1964; Taussig, 1936; Barno, 1967; Sheriff, in Calderone, 1958; Helpren, in Calderone, 1958; Martin, 1961a). Bates and Zawadzki (1964) assert, "Court records reveal that the practice of filing false death certificates is usual among abortionists [p. 78]." Although any physician may falsify such records, the greatest source of false certificates was said to be small private sanitariums and nursing homes supported by abortions. Taussig (1936) describes a study conducted in New York and Philadelphia which found "that in 25 to 30 per cent of abortion deaths a false diagnosis was put upon the death certificate [p. 3]." Similarly, Barno (1967) reports that for Minnesota from 1950-1965, a personal investigation revealed that "in 25 per cent of the instances, there was no correlation between the cause of death on the death certificate and what actually happened [p. 367]." Sheriff (in Calderone, 1958) also asserts that in South Carolina a "true picture" of the deaths resulting from abortion is not obtained because "many of the death certificates give as the cause of death some condition associated with septicemia, but they do

not state what the septicemia was due to [p. 67]." Helpren (in Calderone, 1958) further adds, "The history given in many cases is that the abortion began spontaneously, yet the clinical and autopsy evidence indicate that the process was anything but spontaneous in origin [p. 67]." Martin (1961a) asserts many hospitals do not report abortions or suspected abortions because they "don't want to get involved [p. 21]." Consequently, as evidenced by the above illustrations, death certificates as a sole source for the estimation of abortion deaths would result in a considerable underestimate and could only serve as a minimum figure.

Although abortion deaths reported as such on death certificates generally underestimate the actual number of abortion deaths, such information is helpful in providing suggestions as to trends in the number of abortion deaths and the characteristics of the fatality victim of illegal abortion.

Trends in incidence of abortion mortality. Tietze (1948) stated, "The actual level of mortality from abortion cannot be accurately determined but the downward trend is certainly real [p. 1441]." Tietze used deaths from septic abortion as an index of deaths from illegal abortion "because of the close association known to exist between illegal induction and fatal infection [p. 1434]." From 1927 to 1945 the mortality ratio of deaths from septic abortion per million women of child bearing age (15-44 years) decreased over 15 states from 109 to 18. The

actual number of deaths due to septic abortion decreased linearly from 1934 to 1945 with the largest number of deaths (2,204) occurring in 1934 and the smallest number (587) in 1945. Tietze attributed the steady accelerating decrease in deaths from abortion to: (1) improvements in and the greater use of contraceptives resulting in fewer women resorting to abortion, (2) abortionists being more able to skillfully avoid infection, and (3) the saving of lives by improved medical treatment, particularly with the use of penicillin and sulfa drugs.

At the conference of the Planned Parenthood Federation of America, Helpren (in Calderone, 1958) similarly reported a progressive decline in abortion deaths in New York City. The randomly selected years and the number of deaths (in brackets) were: 1921 (144), 1931 (140), 1936 (92), 1940 (70), 1941 (48), 1944 (25), 1945 (21), 1951 (15). Helpren asserted he felt that just as many abortions were being performed but the operations were being done under better conditions. He also attributed the advent of chemotherapy followed by the use of antibiotics as largely responsible for the reduction of abortion deaths. Fisher (1967a), speaking of abortions prior to 1954, also credits antibiotics for the decreased death rates from induced abortions.

However, contrary to the research of Tietze (1948) and Helpren (in Calderone, 1958), more recent studies indicate there may now be an upward trend in mortality

due to abortion. Examining puerperal mortality in New York City, Gold et al. (1965) found the number of deaths caused by illegal abortion to have increased linearly from 1951-1962. For the period 1951-1953, there were 80 deaths attributed to abortion; 1954-1956, 105 deaths; 1957-1959, 137 deaths; and, 1960-1962, 154 deaths. This increase in mortality was found among all racial classifications--white, nonwhite, and Puerto Rican.

A review of 677 Michigan maternal mortality case studies accumulated during 1955-1964 revealed that abortion was responsible for an increased number and an increased percentage of maternal deaths in that state (Stevenson, L., 1967b). During the first five-year period (1955-1959) abortion accounted for 21 percent of the total maternal deaths; in the second five-year period (1961-1964), 37 percent of the deaths were attributed to abortion. The number of abortion deaths and their percentage of the total number of maternal deaths for the years 1955-1964 were: 1955, 13 (21 percent); 1956, 19 (23 percent); 1957, 12 (16 percent); 1958, 17 (24 percent); 1959, 13 (20 percent); 1960, 22 (33 percent); 1961, 26 (37 percent); 1962, 16 (28 percent); 1963, 31 (49 percent); 1964, 25 (40 percent).

During 1963, about one-third of Pennsylvania's maternal deaths followed induced abortion (Stevenson, L., 1967b). Janovski, Weiner, and Ober (1963) report that for New York City the percentage of abortion deaths among

all maternal deaths rose from about 20 percent in the period from 1945 to 1952 to a level of almost 45 percent during the years 1957-1961. For the year 1962, the New York Department of Health determined that over 50 percent of all maternal deaths resulted from illegal abortion (Stevenson, L., 1967b). The Committee on Public Health of the New York Academy of Science (Statement by the Committee, 1965) reported that a steady increase in illegal abortion with the corresponding rise in the number of abortion deaths was due to the current state-law barriers which have led to a decline in the number of legal abortions in recent years. With regard to the United States as a whole, Guttmacher (Need new abortion laws, 1964) asserted that abortion is the second leading cause of maternal death.

In general, it appears that improved medical treatment, particularly drug therapy, has reduced the general incidence of maternal mortality from the figures of the 1930's. However, illegal abortion still accounts for a significant percentage of the maternal deaths. The absolute number of abortion deaths appears to have steadily decreased during the 1930's and 1940's. However, there are indications that after reaching a low in the 1940's, the incidence of abortion fatalities has risen through the 1950's to the present.

Characteristics of the fatality victim. Classifying abortion deaths by region and size of community, but

stating the "total number of cases are small and our estimate of population is less than one would like to make it [p. 1439]," Tietze (1948) found that "mortality from septic abortion appears to be on the same level in larger and smaller cities and only slightly lower in rural areas [p. 1439]." However, an analysis of the 235 abortion fatalities occurring in 1965, does not support Tietze's statement. The death statistics reported for 1965 broken down by state indicate that many more deaths from abortion occur in the highly urbanized than in the rural areas (Cooke et al., 1968). New York, California, Michigan, and Texas reporting 49, 39, 15, and 14 abortion deaths respectively accounted for one-half of the total number of abortion deaths for the United States. Twenty-three "less urban" states were stated to account for only 10 deaths and 18 states reported no deaths.

The analysis of the 1965 statistics, finding illegal abortion more prevalent among the urban rather than the rural woman, has implications for deriving abortion estimates. The number of abortions and abortion deaths determined in a large urban area possibly should not be projected and generalized to the total population which would include rural residents. It is uncertain how many rural residents come to urban areas to have the operation. Also, the cause of death may more easily be disguised in rural areas which have less adequate medical and autopsy facilities.

Relating abortion mortality with race and economic standing, Tietze (1948) in analyzing abortion fatalities among 15 states found the mortality ratio of septic abortion deaths per million women 15-44 years of age to be approximately three times greater for "colored" women as compared to "white" women. Again looking at the 1965 death statistics for the entire United States (Cooke et al., 1968), there were 129 abortion deaths among non-white women as compared to 106 among white women. Considering the 1:7 ratio of nonwhite to white women living in the United States greatly magnifies these racial differences which are reported in absolute numbers.

Statistics for more localized areas also reveal a greater rate of mortality among nonwhites. In New York City during 1960-1962, for every 10,000 live births within respective ethnic groups; 1.0 white woman, 4.7 Puerto Rican women, and 8.0 Negal women died from abortion (Gold et al., 1965). The discrepancy in mortality between ethnic groups, although easily apparent, does not appear as great for Michigan as New York--based on the assumption of similar racial compositions for the New York and Michigan statistics. Support for this assumption is obtained in Charles Stevenson's (in Barno, 1967) assertion that the greatest problem of septic abortion is concentrated in the greater Detroit area. During the period 1955-1959, 48 white women as contrasted to 26 nonwhite

women died in Michigan from abortion. During 1960-1964, abortion deaths occurred among 67 white women and 53 non-white women.

In terms of percentage of racial composition of the United States, abortion proportionally takes a much greater death toll among nonwhite women as compared to white women. This assertion is supported by: Charles Stevenson's (in Barno, 1967) finding the Michigan women who died from abortion to reside primarily in the poorest and most rundown area of Detroit; the large number of women admitted to charity hospitals with postabortion complications (Hutcherson, in Barno, 1967; Lader, 1966b), and; a study conducted by the Milbank Memorial Fund, reported by Ward (1941), which found the greatest percentage of abortion among New York women occurring for women on relief.

Among the nation's economic strata, the impoverished woman unable to secure adequate funds for a skilled abortionist is most likely the woman who dies from the "operation."

The limited number of studies examining the marital status of the abortion fatality have generally found her to be married. Only Barno (1967) whose investigation included 21 abortion deaths in Minnesota from 1950-1965, found a majority of unmarried fatalities. Among these 21 women, 12 (60 percent) were illegitimately pregnant and 9 (40 percent) were married. To the contrary (Smith, 1934;

Helpren, in Calderone, 1958; Stevenson, L., in Barno, 1967a), reviewing case histories of abortion fatalities, found a majority of the women to be married. A study conducted by the Children's Bureau found that of roughly 1,875 deaths (one-fourth of 7,500 maternal fatalities) due to "some form of abortion" but for which accidental abortion was not considered a prominent cause of death, 90 percent were among married women (Smith, 1934). Helpren (in Calderone, 1958) reported that "most" of the 555 abortion deaths occurring in eight selected years were among married women. Similarly, among 57 women whose deaths were attributed to illegal abortion, Lee Stevenson (in Barno, 1967a) found 42 women were married, separated, or common-law wives; 15 women were single, divorced, or widowed.

The age and parity of the abortion death victim are relatively unknown. Whereas Smith (1934) reports that most of the roughly estimated 1,875 abortion deaths occurred among women aged 35 to 39, Helpren (in Calderone, 1958), while reporting a great variation in the women's ages, asserted most deaths occurred among women between the ages of 21 and 30.

Concerned with the number of the woman's previous children, Smith (1934) reports that the majority of the 1,875 abortion deaths occurred for women in their sixth, seventh, and eighth pregnancies. Lee Stevenson (in Barno, 1967a), investigated Michigan abortion deaths from 1955-1964, found 26 women had had no previous children; 45

women, one or two children; 80 women, three or more children. The number of previous children was unknown for 43 women.

Causes of death and the techniques used to induce abortion resulting in death. Hemorrhage, infection, and vascular accidents appear to be the primary causes of death among abortion fatalities. Perforation of the uterus by an inserted instrument often results in laceration and hemorrhaging. Lowe (1966) asserts that even though the woman may obtain a blood transfusion, she is still subject to death from shock and renal shutdown. Several of the many instruments used in the perforation of the uterus have been a nut pick, catheter, ear syringe, slippery elm tent, clothes pin, rectal irrigation tube, knitting needle, pencil, and glass straw (Barno, 1964; Schoeneck, 1964; Stevenson, L., 1967b).

Death is very frequently caused by bacteria entering the blood stream and affecting various organs. Although limited and restricted infection may successfully result in an abortion, Lowe (1966) points out that such infections may produce death if they should spread to the peritoneum and the encased organs. Bates and Zawadzki (1964) assert that gas gangrene is a common form of fatal infection. The implanted bacteria grow rapidly in the dead tissue destroying blood cells and ultimately causing death. Lowe (1966) also discusses jaundice as a cause of death among women who use tablets composed of an ergot

drug and a parsley substance poisoning the liver and kidneys.

Other deaths caused by infection may be induced by the local application or injection of irritating or corrosive substances into the cervix. Helpren (in Calderone, 1958) asserts that such substances result in a possible combination of chemical corrosion and complicating infection. Methods of abortion resulting in death from this cause have been the injection of a soap solution, the injection of a detergent solution, the injection of a soap and bleach solution by syringe, the injection of a solution of soap and turpentine by syringe, and a douche of green soap and glycerine. Lader (1966a) asserts that the soap in these solutions goes directly to the uterine veins and brings collapse and death. Fatalities can also be caused by Lysol, vinegar, silver salts, lye, and other chemicals injected under pressure. Bates and Zawadzki (1964) state that metal salts, such as arsenic, mercury, copper, and lead have been used with frequent fatal results. Phosphorous producing acute yellow atrophy of the liver is frequently fatal as an abortion technique (Taussig, 1936).

Uterine pastes, generally made of soft soap, with soap again causing death, have been sold on the market and have been persistently attacked by the Food and Drug Administration (Lochridge, 1947; Bates and Zawadzki, 1964; Lader, 1966a).

In addition to hemorrhage, infection, and vascular accidents as causes of death, Bates and Zawadzki (1964) assert that electrical attempts to produce uterine contractions and an abortion have on occasion resulted in electrocution. Helpren (in Calderone, 1958) claims that women have died from the anesthetic during or even prior to the abortion. Bates and Zawadzki (1964) report an uncommon cause of death due to a reflex cardiac arrest when a catheter, stiffened with wire, entered the cervical os.

Physiological Impairment

One of the least studied areas of abortion is the incidence and form of physiological impairment caused by illegal abortion. Although estimates of the incidence of impairment have been made, there appears to be little, if any, factual data available from which accurate estimates could be derived. Rongy (1937) asserted that for each fatality due to an illegal abortion there were "five or six cases which become so invalid that sooner or later the patients must undergo major operation [p. 146]."

Tolnai (1939) estimated that each year 90,000 to 100,000 women become "chronic invalids" as the result of illegal abortion. Ward (1941) estimated that illegal abortion causes sterility in 50,000 women annually.

Rather than giving specific statistical estimates of the incidence of physiological impairment, some

authorities have made general statements to describe the extent of physical injury caused by illegal abortion.

Bates and Zawadzki (1964) assert that "the amount of pain, suffering, and subsequent invalidism at the hands of bungling abortionists staggers the imagination [p. 4]."

Lader (1966a) states that "no study could begin to measure the physical and psychological injury inflicted on women by quack abortionists nor the damage done by women attempting a self-induced abortion [p. 3]." However, Lader did comment that 10,000 women were admitted to New York City municipal hospitals in 1964 with "incomplete abortions" and "postoperative complications." On a national scale (previously reported on p. 105), 350,000 women were admitted to hospitals in 1969 after unsuccessful abortion attempts (Abortion comes out of the shadows, 1970).

Summarily, most authorities assert that countless women are inflicted with physiological impairment caused from illegal abortion. However, there has been little, if any, factual data collected from which the incidence or form of illegal abortion injuries could be accurately derived.

Psychological Consequences

A woman's psychological well-being following an illegal abortion undoubtedly depends upon many of the same critical variables which would affect a woman's psychological health after a legal abortion. Variables

affecting the woman's psychological integrity after a legal abortion were discussed on pages 59-61 of Chapter III. Included among these variables might be: (1) the woman's psychological health prior to the operation; (2) her actual desire, ambivalence, or not wanting the operation; (3) the support given her by significant others prior to and following the abortion; (4) others' attempts to influence her decision to have or not to have the operation but in a direction contrary to her true feelings; (5) her physical well-being after the abortion.

However, procuring an illegal abortion may have additional variables affecting the psychological outcome which may not be encountered when acquiring a legal abortion. Possible feelings of being a criminal who is violating state laws may affect a woman's reaction to the operation and to herself. Other variables interacting in unknown ways to affect the woman's psychological well-being following illegal abortion are the process of finding an abortionist, concerns over obtaining sufficient funds for the operation, and the woman's fear of the abortionist.

Only two studies dealing with the woman's psychological health after illegal abortion were found. In addition to their not controlling for many of the variables discussed above, these studies are biased in that the women appear to come from higher than average socioeconomic conditions. Physicians had aborted roughly 90

percent of the women composing one study and all of the women participating in the second study. Consequently, the conclusions which can be drawn from these two studies are more or less limited to women from relatively high socio-economic levels who have been aborted by physicians. Even such restricted conclusions must also be made with caution because of the many uncontrolled variables, particularly the absence of prepregnancy or preabortion measures of psychological status.

Kinsey found that three-fourths of the women he interviewed who had procured an abortion reported no unfavorable results. Most of the women did not regret having the operation (Martin, 1961a). Of these women approximately 90 percent had been aborted by a physician and 8 percent had attempted a self-induced abortion (in Calderone, 1958).

Lader (1969) surveying 282 of 500 women all of whom he had referred to East Coast gynecologists for an abortion found that only 11 percent reported any "emotional damage." Lader asserted that generally the emotional damage was assessed on vague comments such as "at times feel depressed," which Lader claims would "hardly rank as medical criteria [p. 64]." Asked their feelings about the abortion, 55 percent reported they were "glad without reservation"; 8 percent, "satisfied but doubtful"; 33 percent, "not happy, but knew the abortion was necessary"; and, 0.5 percent, "regret the abortion."

Taking into account that 52.8 percent of the women had never married; 9.6 percent were widowed, separated, or divorced; and 37.6 percent were married, Lader found the following classified comments as to the effect of the abortion on the woman's marital and sexual relations: 59 percent "felt the abortion had no effect on marital or sexual relationship"; 30 percent "reported some effect"; 9 percent "cited an improved relationship"; 9 percent "broke up with their partners"; and 10 percent "reported increased caution, fear, or reduction of sexual activity." Although Lader asserts that mainly single women reported being more cautious and in some cases inhibited in their sexual relationships; and that more single women reported a broken rather than an improved relationship with their sexual partner, these findings would have been more meaningful and clear had the women been grouped according to marital status.

In summary, with caution and mindful of the restrictions implied by biased sampling and many variables left uncontrolled, the limited research of the two studies suggests that illegal abortion performed by physicians among women from the relatively high socioeconomic strata infrequently results in severe adverse psychological affects.

CHAPTER V

A HISTORICAL PERSPECTIVE OF ABORTION

LAW-MORTALITY

Contemporary United States laws generally require that women carry unwanted children to term. Many women, unable to satisfy the law's rigid standards for a legal abortion, resort to illegal abortion and its hazards to their health to evade these restrictive legal requirements. Consequently, the opposition displayed by these women to current abortion laws results in the public health problems of illegal abortion, as well as the maintenance of an enormous financial racket to meet these women's deeply felt needs. This implies that abortion laws, being a critical factor forcing women to the abortionist, are a pivot point from which a solution to the abortion problem could be derived. To gain a better understanding of the abortion laws, a discussion tracing their development, their relationship to morality, and the practice of abortion is provided in this chapter. Although of historical interest, the primary function of this discussion is to clarify the purpose of our abortion laws

as they were originally proposed, enabling a later reevaluation of this purpose as it does or does not apply to the attitudes and culture of today.

Hebrews

Noonan (1965) asserts that the Hebrew text of Exodus made "no effort to deal with intentional abortion [p. 86]." Exodus 21:22-23 was only concerned with accidental abortion for which the man responsible was to pay a fine or to receive an injury identical to the woman's injury. On the other hand, Sumner (1906) claims the Jews considered abortion as a "heathen abomination." Bates and Zawadzki (1964) similarly state that no "positive reference [p. 15]" to abortion can be found among the religious writings of the Hebrews prior to their flight into Egypt. The primary basis of the Hebrew disapproval of abortion appears to be tribal survival rather than religious morality. The demand for increased strength in numbers and warriors was prominent throughout the history of the Hebrew nation as it constantly was threatened with annihilation by stronger, surrounding nations. The threat of national destruction does not immunize a woman to the stresses generated by unwanted children. However, the Jewish culture provided an alternative to abortion to alleviate the plight of the woman while still maintaining national strength. When a pregnant Hebrew woman was troubled with great social hardship at the same time

when national survival seemed contingent upon the production of more potential warriors, Jews were permitted to sell their children to other Jews (Exodus 21:2).

The following account of history reveals the Hebrew struggle for survival, their dependence upon numbers, and also their growing awareness of the practice of abortion. Prior to 1550 B.C. famine had driven the Hebrews out of Palestine into Egypt where they were to be enslaved by an Egyptian Pharaoh. In Egypt the Hebrews would have been made aware of the intentional practice of abortion, for the Ebers Papyrus (1550 B.C.) described the Egyptian technique of producing abortion (Bates and Zawadzki, 1964). Trained as warriors, the people of Israel, led by Joshua, were later able to return and conquer the inhabitants of Palestine. However, the duration of this newly unified kingdom of Israel and Judah formed in 1000 B.C. was only a generation in length and the kingdom's split led Israel into needed alliances with stronger neighbors. These alliances failed to protect Israel, for the Assyrians conquered Israel's neighbors and, in 721 B.C., captured Samaria, the capital of Israel. The Israelites were scattered and replaced by aliens brought into the country by the Assyrians.

Judah, to the south of Israel, remained the Hebrew religious center while paying tribute to the Assyrians. But the Hebrew existence was made more

difficult with the fall of the Assyrians to the Babylonians. Puppet kings of Judah were established and the constant rebellions which ensued caused the Babylonians to take the leaders of Judah captive to Babylon and to destroy the temple in an effort to crush the Hebrew identity.

Persia later conquered the Babylonians and the remaining Hebrews, under conditions of limited self-government, returned to Palestine and rebuilt the temple. However, this independence was confronted by the expanding Greek civilization in 333-331 B.C. and Alexander the Great's conquest of the Near East. A successful revolt against one of "the conqueror's" successors again gave the Hebrews a period of independence. Nevertheless, the Jews had become exposed to the Greek civilization and its practice of abortion. This period appears to afford a demarcation where the spreading Hebrew culture began to "relax (its) stringent attitude toward abortion [Bates & Zawadzki, 1964, p. 16]."

Greeks

The Greek philosophers Plato (427-347 B.C.) and Aristotle (384-322 B.C.) each professed there were circumstances in which abortion was appropriate. Plato advocated abortion when the father was over 55 years of age or the mother over 40 (Adam, 1938). Stressing

population control, Aristotle stated that the number of persons should be limited. If a couple exceeded the prescribed number of children, pregnancies should be terminated (Sumner, 1906). Sumner (1906) further asserts that "these two philosophers evidently constructed their ideals on the mores already established amongst the Greeks, and their ethical doctrines are only expressions of approval of the mores in which they lived [p. 315]."

That abortion was common among the Greeks is revealed by Moissides (1922) who reports numerous drugs used by the Greeks to induce abortion. Finding that these drugs frequently failed to terminate pregnancy, the Greeks then experimented with intrauterine injections and with instruments to induce abortion (Bates & Zawadzki, 1964).

Romans

A changing Hebrew attitude toward abortion, if initiated by the Greeks, could only have been enhanced by the Roman Civilization. The Jews "were conquered by the Romans who created the province of Judaea in 6 A.D." A Jewish "revolt in the seventh decade of the century led to the final destruction of the temple and the scattering of the people [Easton, 1966, p. 45]." Scattered within the Roman Empire, the Jews found abortion flourishing. "Plautus, the Latin playwright, described it (abortion) as a natural step in the life of a Roman woman [Rongy, 1933,

in Bates & Zawadzki, 1964, p. 17].\" Abortion had become a profession for midwives who were frequently visited by women of all classes. Many abortionists were also Greek slaves who brought into captivity their art including curettement, drugs, and douches.

No law in the Roman Republic (500-44 B.C.) or during the greater part of the Roman Empire (44 B.C.-476 A.D.) condemned the practice of abortion (Lecky, 1929). The legal principle which applied to abortion was that an unborn child was not a human being; \"it was a spes animantis, not an infans [Westermarck, 1924, p. 415].\" The fetus was considered \"merely a part of the mother as the fruit is a part of the tree till it becomes ripe and falls down [Westermarck, 1924, p. 415].\" Consequently, abortion in early Rome was of no concern to the State but only of importance to the family. The Roman husband's absolute and unlimited power over all family members permitted him to order an abortion, or, should his wife procure an abortion without his consent, he could punish her.

By 200 B.C. Roman women, demanding emancipation, were using abortion not only as it concerned family limitation and poverty, \"but also for personal vanity and social ambition [Lader, 1966a, pp. 76-77].\" The prevalence of abortion was to increase and peak during Caesar's reign, 102-44 B.C. (Lader, 1966a). However, a high incidence of abortion was maintained in the first century as revealed by the classical writer Seneca

(3 B.C.-65 A.D.) who praised his mother for not following custom and resorting to abortion to maintain her shapeliness (Rongy, 1933).

The first attempt to restrict abortion was not by prohibitory decree, but rather by offering the father political gain with each additional child. The power of the husband had declined and during the reign of Emperor Augustus, the Senate passed laws governing marriage, divorce, property rights, and inheritance (Guttmacher, 1967). Concerned with the falling birth rate in the upper class, the State legislated two enactments, the Lex Julia de maritandis ordinibus of 18 B.C. and the Lex Papia Poppaea of 9 A.D. (Noonan, 1965). The Lex Julia et Papia, as these two enactments were jointly called, sought to restrict the increasing incidence of abortion and to stimulate births by granting the father tax benefits and more rapid political advancement with each additional child (Lader, 1966a; Guttmacher, 1967). The Lex Julia et Papia also sought to "punish" childless persons. Persons without children were not allowed to hold certain high offices; inheritance rights were denied to single males over 25 and single females over 20 years of age; and, if married but childless, a person could only inherit one-half of what he had been willed (Noonan, 1965). However, as evidenced in the writings of the second century Latin writer-lawyer Gellius (Rongy, 1933), the practice of abortion appeared to remain in vogue. Tacitus, a well

informed Roman official writing about 116 A.D., also reports that Augustus' laws had failed to increase the incidence of marriage or the rearing of children (Noonan, 1965).

Amendments to the Lex Julia et Papia providing increased inheritance benefits and exemptions from proscribed duties were extended to additional classes in the second and early third centuries. For while the decreasing birth rate of the aristocracy was the governmental concern in the first century, "serious plagues [p. 23]" and a "variety of wars which adversely affected the population [p. 24]" became the government's concern in the second century (Noonan, 1965).

Not until a period during the second and third centuries did the State actually forbid the practice of abortion. Septimius Severus (146-211) prohibited abortion and "even attempted to exile wives [p. 77]" for aborting their children (Lader, 1966a). However, this penalty appears to have been applied only to married women and rarely enforced, "probably only when the father had refused consent to the operation [Lader, 1966a, p. 77]." In such instances, abortion deprived the husband of his legal right to children (Bates & Zawadzki, 1964; Westermarck, 1924; Lader, 1966a). After this period of "prohibited" abortion, even though the population of the Roman Empire continued to decline throughout the third century and into the fourth century, the State did not

further interfere in family life by forbidding abortion. The Lex Julia et Papia continued to be the State's main recourse to increase its population. The government's view was that the destruction of the fetus with parental consent was not of legal concern because the fetus was not a man.

Christianity

Although abortion was never legally condemned during the Roman Empire (Noonan, 1965; Lader, 1966a), it was viewed with abhorrence and severely condemned during this period by the Christian moralists. To understand the early Christian attitude toward abortion, one must begin with a revision of the Hebrew text of Exodus 21: 22-23. As described earlier (p. 123), this passage dealt with abortion accidentally caused for which the person responsible was to pay a fine--unless the woman was injured as a result of the abortion in which case a similar injury would be inflicted upon the individual who caused her to abort. The fetus was not discussed as a human being and no penalty was levied for its death per se. The penalty of a fine or injury was decreed to satisfy parental loss. However, this passage was modified in the Septuagint, a Greek translation of the Old Testament. The translation was made between 250 B.C. and 100 B.C. supposedly by 72 translators over a period of 72 days (The Columbia-Viking, 1964). The revised passage implied the fetus when "formed"

was to be treated as a human being. A person who caused a woman to abort a "formed" fetus was to pay for the life of the fetus with his life. Nevertheless, this passage still did not deal with intentional abortion performed or requested by the parents.

Intentional abortion by parents was incorporated into the context of the Septuagint passage through the imprecations of Philo (B.C.-A.D.), an Alexandrian Jewish philosopher (Noonan, 1965). In the mind of Philo, abortion was confusingly linked with his hatred of both infanticide and pleasurable intercourse. To Philo parents were "self-condemned" as "pleasure lovers" because the purpose of their mating was "not to procreate children and perpetuate the race, but like pigs and goats in quest of the enjoyment which such intercourse gives [Noonan, 1965, p. 87]."

Philo's condemning philosophy of abortion, intricately confused with infanticide and sexual intercourse, was to be incorporated into the morality of the early Christians and maintained by later Christian theologians.

For the Christian theologian, the acceptance of a "formed" fetus as a human being, in addition to the significance of taking a transient life, had serious implications regarding the fate of an immortal soul. If a fetus was aborted after it had "formed" and was not baptized, its soul would be eternally damned. Consequently, it became of great importance to precisely define when a fetus becomes "formed" and/or ensouled. Philo, influenced

by the teachings of Aristotle (History of Animals, 7.3) considered a male to be formed and ensouled 40 days after conception; a female, 90 days after conception. The time of ensoulment as expressed by Philo, was not accepted by Tertullian (150-230) who argued that although a fetus became a man when it attained its final form, it had a soul immediately after conception (Noonan, 1965). However, the dominant and most accepted position was that formation as a human being and ensoulment occurred 40 days after conception for a male and 80 days for a female. This position may, in part, incorporate the teaching of Aristotle, but primarily it is that of (Leviticus 12:1-5). While Aristotle spoke of formation occurring 40 and 90 days after conception for a male and female respectively; Leviticus 12:1-5 concerned the time required for a woman's purification after having given birth, 40 days for a male and 80 days for a female. This philosophical specification of different time periods required for the formation of the sexes would have posed problems if an abortion occurred prior to the eighth week of pregnancy. Today it is known that not until the end of the seventh week of fetal development can an embryo's sex be determined from the appearance of its external genitalia (McCary, 1967). Even at the end of the seventh week of pregnancy and for roughly three more weeks errors can be made in distinguishing a male from a female on the basis of external genital appearance. Internal sexual differentiation cannot be

observed until roughly six weeks after conception. Consequently, if a fetus were aborted after it had developed 40 days but before it had developed 49 to 70 days--or before 42 days provided skilled, advanced surgery could have been performed--its sex would be unknown and the need for baptism would be uncertain. However, because the fetus could be a male, baptism would be required.

Acceptance of the Septuagint's version of Exodus 21:22-23, adherence to Philo's condemnation and incorporation of intentional abortion into the revised passage, and concern for the damnation of the soul of an unbaptized fetus as well as the taking of a transient life, sequentially combined to enhance Christian condemnation of abortion. The first known Christian writings--the Didache or The Teaching of the Twelve Apostles (A.D. 65-80) condemned abortion as the killing of children (Noonan, 1965; Lader, 1966a). The Letter of Barnabus, estimated to be an early second century document, commands, "thou shalt not kill the fetus by an abortion or commit infanticide [Noonan, 1965, p. 87]." Similarly the practice of abortion and the abortifacient were attacked directly and vigorously by the Christian theologians of the late second and third centuries. Tertullian (150-230) asserted, "Prevention of birth is a precipitation of murder; nor does it matter whether one take away a life when formed, or drive it away while forming. He also is a man who is about to be

one. Even every fruit already exists in its seed [Wester-marck, 1924, p. 416]."

The Roman's official tolerance of Christianity in 313, and its becoming the official religion of the Roman empire in 392, facilitated the open condemnation of abortion in the Church law of the fourth century. Meeting in 314, the Council of Ancyra decreed that a woman who had aborted would be excluded from the Sacrament until the hour of her death. This penalty was soon reduced to ten and later seven years' penitence. However, "the offense still ranked amongst the gravest in the legislation of the Church [Lecky, 1929, p. 22]."

Although the Council of Ancyra prescribed Church legislation for the Eastern provinces of Syria and Asia Minor, its canons were cited in later Church legislation in the West as well as the East. "In the West, St. Jerome (347-419) described the mother who commits an abortion as a parricide"; in the East, "climactically and sweepingly, the canons of St. Basil (330-379) which were to be the basic legislation of the Eastern church, condemned without qualification all women who commit abortion, whatever the state of development of the fetus [Noonan, 1965, p. 88]."

The strength of Christianity continued to grow both within and outside of the Roman Empire. In 320, Christianity, with its stress on premarital virginity, its unwillingness to relate procreation to the good of the social order, and its consequent insensitivity to

the underpopulation problem which was endangering the Empire, led to a legislative modification of the Lex Julia et Papia in which one's tax benefits and higher governmental positions were no longer dependent upon the number of his children. However, the inheritance of a childless couple continued to be restricted; but, a Church-influenced decree in 410 ended even this penalty.

The Church's influence outside of the Roman Empire was demonstrated by Pope Leo I who helped to avert the destruction of Rome in 452. With the Empire's fall in 476, Rome decreased in importance. Under zealous Christian leadership, however, Rome was seen to reassert itself as the capital of the Papal States and the center of Christianity. Christianity with its teachings was to spread throughout the known world.

Caesarius, bishop of Arles from 503-543, who denounced abortion as murder, had a strong influence in Gaul, Spain, and Italy. Augustine, as the missionary of Pope Gregory I (590-604), converted South Britain, but in northern Britain he found prevalent Irish Christianity which had adopted a form of ecclesiastical usage different from that of the Roman Church. However, in 664 the Synod of Whitby enabled the Roman Church rather than the Irish Church to establish the new English Church which became patterned in the Roman tradition. Similarly, Christianity continued its missionary conversion and became the accepted and universal religion of the West.

From 500-1100 the vigorous condemnation of abortion was continued in the teachings of the Penitentials such as Theodore, Bede, Egbert, Regine, and Burchard. The eighth century writings of Bede display the relationship between the Penitential attitude toward sexual activity and the attitude toward abortion. However, Bede did acknowledge a relationship between a woman's economic status and abortion which he felt should modify the penalty for abortion. Bede wrote, "It makes a big difference if a poor little woman does it on account of the difficulty of feeding or whether a fornicator does it to conceal her crime [Noonan, 1965, p. 160]." In the writings of Egbert, it was advocated that the penalty be "approximately halved [p. 160]" for a poverty stricken married woman who aborts a child (Noonan, 1965).

The theologians of the twelfth and thirteenth centuries did not discuss qualifications to the penalty for abortion, but condemned the act in written works which had an enduring influence in the law and theology of the Church. Ivo, bishop of Chartres from 1091 to 1116, influenced by earlier Augustinian texts, denounced abortion in canon law. The two influential canonists Gratian in Decretum (1140), and Lombard in Sentences (1157), also condemned abortion. Gratian's Decretum was "treated as part of the basic law of the Western Church until the enactment of the Code of Canon Law in 1917 [Noonan, 1965, pp. 173-174]." Lombard's Sentences was "of about equal

influence in theology" as it was "the text book of theology commonly used in the universities until about 1550 [Noonan, 1965, p. 174]." Under the direction of Pope Gregory IX, Raymond of Pennaforte collected and organized all authoritative decrees into the Decretals. This work which condemned abortion became (with occasional modifications) "the law of the Catholic Church for the next 685 years [Noonan, 1965, p. 178]."

English Common Law

Shortly after the completion of Decretals, a significant intertwining of Church law and English common law was to occur. Henry de Bracton in The Laws and Customs of England (1256) "for the first time places abortion under civil law [Lader, 1966a, p. 78]." As English common law was to become the foundation of early American law, this event has direct relevance to present abortion laws in the United States. Abortion caused by poison or by a blow was considered as homicide if the fetus was formed. Bracton's statement of law was elaborated upon in the following generation by the anonymous royal official who wrote the law book Fleta. This work describes as homicide the self-administration of an abortificant which destroys an ensouled child in the womb. Although abortion had become an offense in English common law as well as in ecclesiastical law, there was a difference in the

vehemence of the Church's as opposed to the State's reaction to the practice of abortion.

Catholicism

After the rejection of papal control and the creation of the English Church (Act of Supremacy, 1534), and after several theologians had defended the idea of pleasure during sexual intercourse, the Catholic Church toward the close of the Renaissance was to condemn abortion, as well as sexuality, with renewed zeal. The Roman Catechism of the middle 1500's, not canon law but a statement of Catholic doctrine, considered abortion and contraception as homicide and sins against the Fifth Commandment, Thou shalt not kill (Noonan, 1965). A second act, the bull Effraenatam (1588) of Sixtus V was even more stringent. The 40 and 80 day rule of ensoulment was abandoned and abortion at any moment of fetal development was considered murder. Both canon and secular penalties for murder were to be applied to one guilty of abortion. Excommunication, the severest ecclesiastical penalty, was invoked and unless the "murderer" was about to die, this penalty could be released only by the Pope. Even ecclesiastics who had produced an abortion "were to be treated as laymen, and were handed over to the secular power [Noonan, 1965, p. 362]."

Noonan (1965) asserts that the personality of Sixtus V "almost wholly" accounts for the severity of this papal bull.

This Franciscan Pope set about to reform Rome and the Church in a draconian way. Men who had committed crimes twenty years before his accession were now brought to trial. An extremist in the pursuit of virtue, he displayed toward sins connected with sexual intercourse a severity which would have done credit to a New England Puritan. In Renaissance Rome he made adultery a hanging matter, and he actually had carried out the execution of a woman who had been a procurer for her daughter (p. 362).

However, Effraenatam was not applied literally, did not become criminal law, and was the rule of the Church for only two and one-half years. The decree was not looked upon with favor by the theologians nor the canonists. Pope Gregory XIV, who became the papal head following the death of Sixtus V in 1590, asserted that the bull had not produced "the hoped-for fruits" but instead resulted in sacrilege as persons affected by the bull simply ignored their excommunication (Noonan, 1965). Consequently, Gregory XIV in Sedes Apostolica repealed and annulled the penalties of Effraenatam. Although it provided penalties for aborting a formed fetus, Sedes Apostolica, redefined the time of formation during fetal development. Rather than applying the 40-80 day ruling of ensoulment or defending ensoulment immediately following conception, the Pope decreed that a person who produced an abortion after "quickening" (the first interuterine movement of

the fetus which the Pope designated to occur 116 days after conception) would be excommunicated (Kinsolving, 1964).

The Church's determination of quickening as the period of ensoulment adheres to the principal of quickening by English jurists used earlier in applying English common law shortly after Bracton's treatise. However, quickening as applied in common law was not specifically defined as occurring 116 days after conception as in ecclesiastic law, but was defined as the moment at which the individual mother first felt and reported fetal movement (Lader, 1966a). The common law usage of quickening to define the beginning of fetal life, rather than the prevalent 40-80 day theological theory of animation, appears to have been adopted from the teachings of Thomas Aquinas who was a contemporary of Bracton (Lader, 1966a). Aquinas modified Aristotle's three stages of life (vegetable, animal, human) with the principal of motion, and asserted that the life of the fetus, separate from the life of the mother, came into existence only at quickening.

Although quickening provided a more lenient approach because only the mother could testify as to when she felt the first interuterine movement, Lader (1966a) asserts that there is doubt if even this more lenient sanction was enforced by common law from the early 1500's to 1800. He states:

Some legal scholars doubt that, after England's break with the Catholic Church, abortion was even prosecuted under common law. And English

ecclesiastical courts seem to have lost all interest in the problem after 1527: the preamble to the first British legislation on abortion in 1803 states that "no adequate means have hitherto provided for the prevention and punishment of such offenses" (p. 79).

The tolerant view of abortion during this period is further reflected by the eminent jurist, Sir Edward Coke (1552-1634). In his summation of English law, the Third Institute, Coke asserts that punishment for abortion after quickening was a "great misprison [Lader, 1966a, p. 78]."

British Legislation

The relatively tolerant approach displayed during the latter sixteenth through eighteenth centuries by both common and ecclesiastical law, with their adoption of quickening as the time of formation, was to be altered in the nineteenth century. Common law as well as the law of the Roman Catholic Church were to legislate penalties for abortion from the moment of conception. In 1803, the rarely applied common law was replaced by the first British legislation on abortion (Lader, 1966a). The Ellenborough Act provided punishment for abortion at any time of fetal development, but abortion produced before quickening was subject to a lesser penalty than abortion after quickening. The act concerned "abortion by poisoning or other noxious substances" but made no mention of "abortion by surgery or other methods [Lader, 1966a, p. 82]."

The British legislation of 1803 appears to have been instigated by both social movements and biological discovery. Lader (1966a) asserts that England as a growing industrial nation strongly needed to increase its population. A high mortality rate characterized England during an era when disease uncontrolled by medicine ran rampant and decimated the supply of workers. Consequently, in industrial England of the 1800's, the number of required workers exceeded the birth rate.

The stress for population growth was also enhanced by the earlier poor harvests and the economic crisis of 1799. The soon to ensue Napoleonic wars would also provide a strong demand for increased manpower.

Lader (1966a) further claims that the Ellenborough Act of 1803 was:

a catch-all piece of legislation inspired by a fanatical chief justice who seemed determined to excoriate the British for a raft of sins that had long been overlooked or ignored. . . . The fact that Ellenborough produced thirteen children may also provide a clue toward his attitude on British population (p. 82).

Layden's discovery of spermatozoa in 1677 may have been another influence in the passage of the Ellenborough Act and an influence to subsequent legislation. A British statute in 1828 prohibited abortion by surgical instruments and medical agents; and, an 1837 amendment eliminated a distinction between punishment given prior to quickening and that given following quickening. The punishment was identical for abortion produced any moment after conception.

Layden's discovery also appears to have influenced the thought of Catholic theologians of the eighteenth century. There grew a trend for abortion performed prior to ensoulment to be considered a form of homicide preventing ensoulment still not "true homicide." This stance is similar to the distinction of penalties for abortion prior to and after quickening as provided in the Ellenborough Act. Following attempts to differentiate "homicide" before and after ensoulment, there followed the position that the soul was infused at the moment of conception. Thomas Roncaglia in 1736 was the first theologian to accept instant animation (Noonan, 1965). Ensoulment at the moment of conception also became commonly accepted by eighteenth century medical men.

The eighteenth century changes in English law, Layden's discovery, the growing acceptance of animation at conception, and Ferdinand Keber's discovery in 1853 of insemination caused by the male sperm's penetration of the female ovum, appear to have brought about the first noted Church legislation since Sedes Apostolica. In 1869 Pope Pius IX eliminated quickening as the demarcation for ensoulment. Abortion at any period of fetal development was considered murder and punished by excommunication.

United States Legislation

It was also in the 1800's that laws in the United States began to prohibit abortion from the moment of conception; but the change from the states' usage of English common law (prohibiting abortion only after quickening) to the prohibition of individual state legislation was very gradual. Lader (1966a) states that "many states retained all or part of the old quickening rule well past the Civil War and even into the twentieth century [p. 86]." Abortion prior to quickening was not punished in Arkansas until 1947 and not until 1956 in Mississippi (Lader, 1966a). Although each state of the union gradually came to outlaw abortion from the moment of conception; New York, providing an example for almost every other state's eventual legislation, in 1828 legislated that an abortion could be legally performed if it was necessary to save the life of the mother. Today, a distinct majority of the states still permit abortion only if the operation is necessary to preserve the woman's life (see Chapter VI, pages 218-220).

Basing his discussion on various court decisions in the United States, Lader (1966a) offers several reasons to account for the gradual change of replacing common law with prohibitive state legislation. One factor was considered to be the "humanitarian movement of the mid-nineteenth century [p. 87]" during which there was strong

concern for the life and health of the mother. During this period, the procedure of producing an abortion was considered a dangerous operation.

A second concern was to prevent fetal destruction, not because of ensoulment, but because abortion was a "violation of the 'mysteries of nature [p. 88]'" and denied the country a needed population expansion. As a growing industrial nation, the United States needed factory workers and as an expanding agricultural nation, persons were also needed to develop the new Western frontiers.

"The Puritanical obsession with sin [p. 89]" was discussed as the third factor influencing state legislation. Laws prohibiting abortion were to punish the unmarried pregnant girl for her sin, causing her to be shamed by revealing the "visual product of immorality." The Puritan concern was to eliminate sin through legislation and to enforce morality with the fear of punishment if the law were violated.

Cooke et al. (1968) state another reason offered by legal scholars to account for the more restrictive state legislation--the recognition that the use of quickening was "artificial." "It was arbitrary to say that life did not begin until then [p. 48]."

While state laws gradually came to prohibit abortion from the moment of conception, the Catholic Church maintained and restated in the twentieth century its present condemnation of abortion. The encyclical

Casti connubii of Pope Pius XI in 1930 asserted that life begins at conception and abortion at any moment following conception is homicide. Abortion in this decree again appears to be intertwined with concern for an "absolutely perverse morality" endangering marriage, the sins of contraception, and procreation as the "primary good" of marriage which would "daily increase" the number of Christians (Noonan, 1965, p. 426).

In summary, there is no specific statement concerning abortion in the New Testament of the Bible (Noonan, 1965). The Biblical passage which does concern abortion, as originally stated, only concerned abortion accidentally produced and dealt with parental loss rather than the death of the fetus. However, the Greek Septuagint (250 B.C.-100 B.C.) drastically changed this passage to imply that a fetus was to be treated as a human being if "formed"; but the Septuagint still did not deal with abortion intentionally produced or requested by the parents. The early theologians were to assert that whoever produced an abortion was guilty of murder if the fetus had been formed (or ensouled). With ensoulment now defined as occurring at conception, the Catholic Church presently maintains this attitude.

The Church's consideration of abortion as homicide appears to have been consistently confused in an intertwined mesh of abhorrence and condemnation of sexuality contraception. Confusion is also demonstrated in centuries

of disagreement among theologians, canonists, and popes as to the actual time when a fetus becomes an ensouled human being. This controversy among the Church's leaders over such a "boundary line" certainly suggests any such line is "man made," clearly dependent upon human needs, knowledge, and attitudes rather than being "God given."

As human knowledge, needs, and beliefs have plainly shaped theological thought, so did they influence the content of laws. Legal scholars theorize that the abortion laws of the United States were created from: (1) concern for the pregnant woman's life and health which were jeopardized from, at that time, a dangerous operation, (2) the young nation's need for population growth, (3) Puritan attempts to legislate and enforce their morality, and (4) the realization that quickening was an artificial and arbitrary determination of a human's beginning.

Because the abortion laws which developed from the attitudes and needs of 100 years ago are presently applied with little, if any, modification in their content, it is essential to determine if these laws meet the needs and attitudes of today. Examining the determinants of these abortion laws with regard to their relevance today, it seems clear that the United States does not need an increased population. Medical techniques of producing abortion no longer threaten the life or health of the woman. The majority of the population no longer

adheres to early Puritan morality, and furthermore, few religious groups today believe that morals can be legislated. Also, any decision as to the "moment of becoming human" is arbitrary and subject to individual attitudes and interpretations of life. Most Catholics believe a human being is created at conception; most Jews, when the head of the fetus emerges from the mother. There are no mutually acceptable criteria by which it can be determined whether the Catholic or Jewish attitude is the more "right."

Because the needs and attitudes which shaped the form of our present applied abortion laws cannot be considered relevant today, the attitudes and needs of today must be accurately determined and incorporated into new abortion laws. In a democracy such as the United States, the laws are presumed to represent the will and needs of a majority of the people. The following chapter undertakes the first task, examining today's attitudes toward abortion. Chapter X deals with the second task, examining the nation's public health needs.

CHAPTER VI

ATTITUDE TOWARD ABORTION

With abortion having become a controversial issue, considerable effort has been made to assess attitude toward abortion. There has evolved the question of under what circumstances would the public approve or not approve of legalized abortion. This chapter reviews the findings of accessible attitude surveys which have attempted to determine the general public's answer to this question. These surveys are further discussed so as to establish the demographic characteristics and traits of persons who express diverse opinions. Apparent trends of change in attitudes will also be considered.

In addition, the attitudes of several influential professional bodies will be described. The law's position toward abortion will be traced through a review of state legislative statutes, court decisions, and the stance of specific law bodies. Similarly, the medical profession's views toward abortion are examined in the findings of attitude surveys conducted among physicians and in the recommendations of specific medical organizations. The

clergy is the third category of professionals whose attitudes toward abortion are the subject of discussion. Where they have been stated, the positions of religious bodies making up the three major faiths are presented and discussed.

General Public

Attitudes Determined from National Surveys

Four recent national surveys have shown that the general public favors the legalization of abortion when: (1) the life of the mother is threatened, (2) the health of the mother is in danger, (3) there is risk that the child may be defective, and (4) the pregnancy was the result of rape or incest (Public favors abortion, 1966; Rossi, 1967; Westoff, Moore & Ryder, 1969; Kantner & Allingham, 1968). However, these surveys reveal that general opinion does not favor legalized abortion when: (1) the married woman's family has a very low income and cannot afford more children, (2) the woman is unmarried, and (3) the woman is married but does not want more children. For each of the four surveys, the circumstances which were presented and the percentage of persons who responded favorably or unfavorably to legalized abortion in those circumstances are given in Table 1.

TABLE 1
ATTITUDE TOWARD ABORTION IN SPECIFIC CIRCUMSTANCES AMONG RESPONDENTS IN NATIONAL SURVEYS

Public favors abortion (1966) ^a Year of Survey: 1965	Don't know		
Circumstance	Yes	No	Know
Where the health of the mother is in danger	77	16	7
Where the child may be born deformed	54	32	14
Where the family cannot support additional children	18	72	10

Rossi (1967) ^b Year of Survey: 1965	Don't know		
Circumstance	Yes	No	Know
If the woman's own health is seriously endangered by pregnancy	71	26	3
If she became pregnant as a result of rape	56	38	6
If there is a strong chance of serious defect in the baby	55	41	4
If she is not married and she does not want to marry the man	18	80	2
If the family has a very low income and cannot afford any more children	21	77	2
If she is married and does not want any more children	15	83	2

Westoff, Moore, & Ryder (1969) ^c Year of Survey: 1965	Don't know		
Circumstance	Yes	No	Other
If the pregnancy seriously endangered the woman's health	87	11	2
If the woman had been raped	52	42	6
If the woman had good reason to believe the child might be deformed	50	46	4
If the woman was not married	13	84	3
If the couple could not afford another child	11	87	2
If they didn't want any more children	8	91	1

Kantner & Allingham (1968) ^d Year of Survey: 1967	Don't know		
Circumstance	Yes	No	Other
Endangered woman's health	86	10	4
Rape	72	20	8
Child deformed	62	31	7
Not married	28	63	9
Can't afford child	25	70	5
Don't want child	21	74	5
Incest	69	19	12

^aSource: American Institute of Public Opinion, Public favors abortion operation where health is at stake, Gallup Poll Reports, January 21, 1966.

^bSource: A. S. Rossi, Public views on abortion, in A. F. Guttmacher (Ed.), The case for legalized abortion now. Berkeley: Diablo Press, 1967, pp. 26-53. The original paper by A. S. Rossi, "Public views on abortion," was issued by the National Opinion Research Center in February, 1966.

^cSource: C. P. Westoff, E. C. Moore, & W. B. Ryder, The structure of attitudes toward abortion, Milbank Memorial Fund Quarterly, January, 1969, XLVII, No. 1, Part 1, 11-37.

^dSource: J. P. Kantner, & J. D. Allingham, American attitudes on population policy: Recent trends, Studies in Family Planning, The Population Council, May, 1968, No. 30, 1-7.

Attitudes Determined from a State Survey

A representative cross-section of New York State residents was sampled by Oliver Quayle and Company at the request of the Association for the Study of Abortion Incorporated (ASA survey of public opinion, 1968). Persons were asked if they would prefer New York's present abortion law (abortion permitted only if necessary to save the life of the mother or child) revised to permit abortions when: (1) the woman's health is jeopardized, (2) fetal deformity may exist, and (3) the pregnancy is the result of rape or incest. Among the total sample, 75 percent favored such a revision, 17 percent were opposed, and 8 percent were undecided. Of those persons expressing an opinion, 81.5 percent favored this revision.

Attitudes Determined from "Local" Surveys

Chicago, Illinois

A Chicago station televised the videotape of a symposium concerning the medical implications of therapeutic abortion (Hartman, 1967; Therapeutic abortion--a very timely topic, 1967). The symposium was sponsored by the Illinois State Medical Association and was viewed during prime time as a public affairs program. The panelists were eight persons from the specialties of obstetrics, pediatrics, psychiatry, and public health. Among the panelists, four members were "pro-abortion" and four were "anti-abortion."

To build an audience, ads were published in both the Sun Times and Daily News. The station also included a questionnaire ballot to assess feed-back response. Circumstances in which the viewers were to indicate their favorableness toward legal abortion were presented only once and this occurred at the close of the telecast. The responses were scored as "yes," "no," "depends," or "gave no answer."

Among 1,119 questionnaires returned by mail to the station, 1,013 were scorable. Of these 1,013 persons, 86.5 specifically said "yes" to permitting abortion if "the mother's life is in danger"; 77.4 percent stated "yes" if "the pregnancy resulted from rape"; 73.1 percent said "yes" if "the mother's mental health is threatened"; and, 71.6 percent stated "yes" if "the unborn baby is expected to be deformed." Only 9.9 percent of the respondents agreed that "all abortions should be prohibited"; 90.1 percent of the respondents disagreed. The circumstances and percentage of categorized response are presented in Table 2.

Metropolitan New Orleans

A study by Harter and Beasley (1967) found 483 Catholic or Protestant New Orleans women to be generally less favorable toward permissive abortion than the participants of the previously cited surveys. A majority of these New Orleans women favored permissive abortion only

TABLE 2

ATTITUDES OF RESIDENTS VIEWING TELEVISED
ABORTION SYMPOSIUM*

Circumstance	Yes	No	Depends	No Answer
Do you think abortions should be allowed when the mother's life is in danger?	86.5	12.0	0.8	0.7
Do you think abortions should be allowed when the pregnancy resulted from rape?	77.4	21.4	0.3	0.9
Do you think abortions should be allowed when the mother's mental health is threatened?	73.1	25.0	0.9	1.0
Do you think abortions should be allowed when the unborn baby is expected to be deformed?	71.6	27.7	0.7	0.0
Do you think that all abortions should be prohibited?	9.9	90.1	0.0	0.0

*Source: R. R. Hartman, Medical implications of the current abortion law in Illinois (ISMS symposium), Illinois Medical Journal, May, 1967, 131, 666-695.

when the pregnancy resulted from incest (60 percent), or when the mother's or baby's health would be harmed if the woman were to give birth (55 percent). A majority did not favor legalized abortion for reasons of rape (46 percent favorable), mental illness (32 percent favorable), a woman's already having more children than she can care for (5 percent favorable), or a woman's not wanting more children (2 percent favorable). However, 28 percent of this group believed that a woman should have the right to decide whether she should or should not have an abortion. The circumstances and percentage of categorized responses are presented in Table 3.

The less permissive "appearing" attitude of these women seems at least partially attributable to the statistical method used to categorize the percentage of favorable response. This New Orleans sample had a much larger percentage of respondents who evaded taking a clear stance toward abortion than did the samples in the previously cited surveys. In not one of these prior studies did more than 14 percent of the respondents fail to take a "pro" or "con" stance over the entire set of specific "circumstance" items. The percentage of New Orleans women who were noncommittal in their response to the seven circumstantial items asked by Harter and Beasley were 23, 26, 15, 3, 13, 21, and 12. To determine the percentage of New Orleans women favoring permissive abortion over the various circumstances, these noncommittal respondents were grouped

TABLE 3

ATTITUDES OF NEW ORLEANS WOMEN TOWARD
PERMISSIVE ABORTION*

Circumstances	Yes	No	Don't Know
If a woman became pregnant because a man, not her husband, forced her to have relations with him, do you think she should have the right to have an abortion?	46	31	23
If a pregnant women is mentally ill or loses her mind, do you think she should be allowed to have an abortion if she, or her husband, thinks she should?	32	41	26
If a woman or young girl is made pregnant by her father or brother, do you think she should be allowed to have an abortion?	60	24	15
If a woman does not want any more children, but becomes pregnant, do you think she should be allowed to have an abortion?	2	95	3
If a woman already had more children than she can care for in her situation, but becomes pregnant, do you think she should be allowed to have an abortion?	5	82	13
Do you think a pregnant woman who has some sickness or ailment, which might cause harm to her or her baby if she gives birth to the child, should have the right to have an abortion?	55	24	21
Do you think that the decision to have or not to have an abortion should be the right of every woman?	28	60	12

* Source: C. L. Harter, & J. D. Beasley, A survey concerning induced abortions in New Orleans, American Journal of Public Health, November, 1967, Vol. 57, No. 11, 1937-1947, and; raw score data provided by Dr. C. L. Harter in personal communication on September 24, 1970.

with those who opposed abortion. This approach sharply reduced the percentage of abortion supporters in comparison with the percentage which would have been determined had the more conventional method of including only those expressing an opinion been used. If these "noncommittals" are excluded, the Harter and Beasley (1967) data show the following percentages of New Orleans women to be favorable or unfavorable toward abortion in the stated circumstance: rape (60 percent favorable, 40 percent unfavorable), mental illness (44 percent favorable, 56 percent unfavorable), incest (71 percent favorable, 29 percent unfavorable), woman does not want more children (3 percent favorable, 97 percent unfavorable), woman already has more children than she can care for (6 percent favorable, 94 percent unfavorable), woman having sickness which would harm her or baby (69 percent favorable, 31 percent unfavorable), decision to abort should be the woman's right (32 percent favorable, 68 percent unfavorable). This statistical treatment brings the findings of Harter and Beasley into much closer accord with those of other surveys.

That Catholics constituted 60 percent of the New Orleans sample also tended to generate a less favorable attitudinal stance than observed in more broadly representative samples. Other evidence that Catholics tend to be less favorable toward permissive abortion than persons claiming a preference for Protestantism, Judaism, or Agnosticism is cited in Table 5 on page 172.

The high frequency of "noncommittal" responses within this predominantly Catholic sample is intriguing. This "uncertainty" may suggest that these Catholics are experiencing unusual conflict between acknowledging personal feelings and beliefs which tend to approve of permissive abortion and their need to adhere to the teaching of their Church which condemns abortion.

Good Housekeeping Poll

Among 1,000 members of the "Good Housekeeping Consumer Panel" (female readers of Good Housekeeping magazine), 72.3 percent favored abortion law reform; 22.5 percent did not favor reform, and; 5.2 percent gave no answer (The GH poll, 1967).

Those composing the Consumer Panel reacted to legalized abortion in essentially the same manner as had the persons composing the previously reported national surveys. Abortion was favored by the majority if: (1) the pregnancy resulted from rape or incest (85.9 percent); (2) the pregnancy endangers the woman's health (84.1 percent); and (3) the baby is likely to be seriously defective (78.5 percent).

A majority of the women disapproved of legalized abortion if: (1) the woman is married but does not want any more children (11.1 percent favorable); (2) the woman feels the family income is not sufficient to support another child (14.6 percent favorable); and (3) the woman

is not married (15.5 percent favorable). The circumstances and percentage of categorized response are presented in Table 4.

TABLE 4

ATTITUDES OF "GOOD HOUSEKEEPING CONSUMER PANEL"
TOWARD PERMISSIVE ABORTION*

Circumstances	Yes	No	No Answer
If the woman's health is endangered by the pregnancy:	84.1	12.5	3.5
If she becomes pregnant as a result of rape or incest:	85.9	12.3	1.8
If the baby is likely to be seriously defective:	78.5	17.7	3.8
If the woman feels the family income is too low for another child:	14.6	78.8	6.6
If the woman is not married:	15.5	77.3	7.2
If the woman is married and does not want any more children:	11.1	81.5	7.4

*Reprinted by permission from the October, 1967, issue of Good Housekeeping Magazine. (c) 1967 by the Hearst Corporation.

In summary, national, state, and local surveys have generally found the majority of respondents to favor legalized abortion for medical and fetal indications. These are situations in which the continuance of pregnancy threatens the physical or mental health of the mother and in cases where it appears that the child, if delivered, would be defective. Abortions are also approved in

eugenic circumstances where the pregnancy has resulted from rape or incest.

Permissive abortion is not approved by the majority of survey respondents in social and economic situations in which abortion actually would appear to be a method of birth control. Legalized abortion is not favored for: (1) a pregnant but unmarried woman, (2) a married woman who is pregnant but wants no more children, and (3) a pregnant, married woman who feels the family income is inadequate to provide for a new family member while meeting the needs of presently existing family members.

Attitudes and Demographic Characteristics

Few studies have attempted to investigate the demographic characteristics of persons who are favorable or unfavorable toward the revision of abortion laws. Studies which have been concerned with the relationship between demography and attitude often reveal an inadequate application of statistics to the data and/or have failed to report the statistical techniques used in the data analysis. Nonetheless, the limited number of studies complicated by statistical inadequacies do provide additional knowledge as to what type of person, from the demographic viewpoint, holds what type of attitude toward permissive abortion.

Religion

Data which relate religious preference to attitude toward abortion conclusively reveal Jews to be more liberal toward abortion law reform than Protestants or Catholics and Protestants to be more liberal than Catholics (Kantner & Allingham, 1968; ASA survey of public opinion, 1968; Harter & Beasley, 1967; Public favors abortion, 1966; Rossi, 1967; Westoff, Moore, & Ryder, 1969). Although the rank order of liberalness remains the same among these three religions, for each religious group, individuals who attend church most frequently (Rossi, 1967--Catholics and Protestants; Westoff, Moore, & Ryder, 1969--Catholics, Protestants, and Jews) or who assert that formal religion is of more importance to them (ASA survey of public opinion, 1968; Catholics, Protestants, Jews) are "somewhat" less favorable toward permissive abortion than persons of a similar religious preference who attend church less frequently or do not attribute great importance to formal religion. However, after selecting out of the sample persons who claimed formal religion was of moderate, slight, or no importance to them, ASA survey of public opinion (1968) found that the percentage of Jews who favored New York State abortion law reform only decreased from 98 to 94 percent; Protestants, 83 to 78 percent; and, Catholics, 72 to 63 percent. Even limiting the sample to the "most devout," still resulted in a majority of persons who professed each of the three religions to favor change

in the New York State abortion law. Rossi (1967) and Westoff, Moore, and Ryder (1969) did not report data which would permit a similar analysis of their findings.

Education and Social Class

Research on the relationship of educational level and social class to attitude toward abortion is, at best, meager. Because the research is so limited and these two variables do interact--one's social class status often depends on his educational attainment or vice versa--both variables are presented in this subsection. The available research findings suggest that a favorable attitude toward permissive abortion is linked to both level of education and socio-economic level.

Rossi (1967) "clearly" found that "increasing education is related to more liberal stands on abortion [p. 38]." Westoff, Moore, and Ryder (1969) found that education strongly influenced attitude toward abortion among a national probability sample of some 5,600 married woman under the age of 55. Attitude became progressively more favorable as years of formal education increased. Examining socio-economic status and attitude, Westoff, Moore, and Ryder report that permissive attitude toward abortion also varies directly with the husband's income and occupational status.

In contrast to the "clear" relationships found by Rossi and Westoff, Moore, and Ryder, the Association

for the Study of Abortion Incorporated (ASA survey of public opinion, 1968), surveying New York State residents, categorized as a "marginal difference" its finding that the "better educated, higher-income groups were slightly more favorable to (New York State abortion law) reform [p. 3]."

This seeming discrepancy between the rather "clear" findings of Rossi and Westoff, Moore, and Ryder and the "marginal" findings of the ASA, appears to have resulted from differences in the type of circumstantial questions asked the public. The ASA survey only asked the respondents if they approved abortion in circumstances of rape, incest, defective child, and danger to the mother's life or health--circumstances which generally are approved. However, the surveys reported by Rossi and Westoff, Moore, and Ryder, in addition to asking if the respondents approved of abortion in these "generally approved circumstances," also asked if abortion was approved in the social circumstances of an unmarried woman, a woman who wanted no more children, and a woman from a poverty stricken home--circumstances under which many persons do not approve abortion. Presenting only situations in which abortion is generally approved, as did the ASA survey, would tend to restrict differences between education-economic groups.

Sex

The relationship between sex and attitude toward abortion has not been clearly established. Based on the findings from a representative sample of 1,484 adults, Rossi (1967) asserts, "Men are indeed more liberal toward abortion than women [p. 38]." However, these findings of Rossi were not supported by those of Hartman (1967). Investigating attitude toward abortion in circumstances specified after a medical symposium televised in Chicago, Hartman reports the percentage of women favorable toward legalized abortion ranges from 0.2 percent to 4.3 percent higher over each circumstance than the percentage of men favorable toward abortion in the same circumstance. A third survey which asked New York State residents if they favored or did not favor law reform to legalize abortion in cases of rape, incest, fetal abnormality, and danger to maternal life or health (only circumstances generally approved and thus restricting the degree of possible difference); found "no demonstratable difference" between the attitudes of the sexes (ASA survey of public opinion, 1968).

Marital Status

Only two studies have examined the relationship between marital status and attitude toward abortion. Although statistical tests of differences were not calculated, over each of the five items responded to by

the viewers of the medical symposium held in Chicago, married persons were more favorable toward abortion than single persons (Hartman, 1967). The percentage difference ranged from 5.0 to 13.1 percent and the average percentage difference was 9.0 percent over the five "circumstantial" (Table 2) items.

In contrast to the above survey, the ASA (ASA survey of public opinion, 1968) asking for approval or disapproval of proposed New York State abortion law reform, reports "no demonstrated difference" between the attitude of marrieds and that of singles.

Age

Research findings concerning the relationship between age and abortion attitude are contradictory. ASA survey of public opinion (1968) reports "no demonstrated difference" between age and attitude toward liberalizing the New York State abortion law. However, the Chicago television symposium respondents demonstrated a linear relationship between age and attitude; as age increases (over the age groups; under 21, 21-35, 36-50) attitude toward permissive abortion becomes more favorable. The only survey item for which this linear relationship did not hold concerned the granting of an abortion if the pregnancy is a risk to the woman's mental health. These items are listed in Table 1, p. 151. The percentage of persons responding favorably to this item by the

respective age groups, (a) under 21, (b) 21-35, and (c) 36-50 was: (a) 86.1, (b) 83.4, and (c) 89.6. Westoff, Moore, and Ryder (1969) similarly found that older married women were more favorable toward permissive abortion than younger married women, although the authors point out this association is not "strong."

Harter and Beasley (1967) found that among New Orleans women categorized as 15-24, 25-34, and 35-44 years of age, women aged 25-34 generally were less favorable toward permissive abortion than women in the 15-24 and the 35-44 year old age groups. The youngest age group was the most favorable toward abortion on items concerning pregnancy as a risk to maternal physical or mental health and pregnancy which resulted from rape or incest.

The use of diverse age intervals as units of measurement may partially account for the contrary findings of these efforts to determine the relationship between age and attitude.

Race

One of only two studies investigating the relationship of race and attitude toward abortion is that of Harter and Beasley (1967). Among the seven circumstantial items administered to New Orleans women, the 359 white women were more favorable than the 124 non-white women toward granting an abortion in the cases of pregnancy following rape (76 versus 49 percent) and

pregnancy following incest (81 versus 61 percent). There were no significant differences between whites and nonwhites in their stance toward permissive abortion in the other five items (see Table 2, p. 154, for a listing of the items). Westoff, Moore, and Ryder (1969) report that among their national probability sample of married women, whites "tend" to take a more permissive stance than do nonwhites.

Parity

Harter and Beasley (1967) and Westoff, Moore, and Ryder (1969) also present the only available data concerning the association between parity and abortion attitude. Summarizing their findings, Harter and Beasley state,

On the whole and regardless of subgroupings--with the exception of the "wants no more" item which has a high over-all proportion of "no's"--women of parity 2-3 generally tend to be less opposed to abortion than those of parity 0-1 or those of parity 4 or more, but the differences are not always statistically significant (p. 1941).

Westoff, Moore, and Ryder divided their respondents into one group of women who had had all the children they wanted and a second group who wanted more children. Those who did not want additional children were more favorable toward permissive abortion. These data suggest that as married women attain the family size they desire, they experience a greater need for fertility control and they become more accepting of abortion as a method to limit family size.

Interaction of Demographic Variables and
Attitude Toward Abortion

Several researchers report the interaction of two demographic variables as related to attitude. For the sample of New Orleans women, Harter and Beasley (1967) found interaction effects for race by religion and social class by religion. Catholic and Protestant nonwhites did not differ in their response to any of the seven items. Among the whites, however, Protestants were more favorable toward permissive abortion than Catholics under the circumstances implied in each of the items with the exception of the item which concerned abortion for a married woman who was pregnant but wanted no more children.

An interaction analysis of social class by religion revealed no significant differences over the circumstantial items between Protestants and Catholics in the lower and middle classes. However, in the upper class (composed exclusively of whites) there was a significant difference between Protestants and Catholics over each item again with the exception of the item which refers to a married, pregnant woman who wants no more children.

The interpretation of the interaction effects found by Harter and Beasley is somewhat blurred by the absence of nonwhites in the upper class. However, among Negroes there appears to exist a "uniform social code" which transcends religious and class differences and fosters commonly held attitudes toward abortion. This uniformity

does not appear to exist for whites largely because of upper class Protestants who are more favorable toward permissive abortion than are lower and middle class Protestants or Catholics.

Rossi (1967) and Westoff, Moore, and Ryder (1969) present data which tend to support and explain the findings of Harter and Beasley in their social class by religion analysis. Rossi reports,

Education (strongly related to social class status) has a liberalizing effect for Protestants, but none at all for Catholics as far as their views on abortion are concerned, with the consequence that one finds large religious group differences among the better educated, and insignificant differences among those low in educational attainment (p. 40).

Rossi suggests an explanation for this finding in her identification of differences in the educational experiences of Protestants and Catholics. She states that

large proportions of Catholics receive their education in parochial schools, with the result that the longer Catholics attend school, the greater the likelihood that they accept the views of the Church on matters touching their family and personal lives (p. 40).

Westoff, Moore, and Ryder report similar findings. While white, non-Catholic acceptance of abortion varied directly with years of formal education, this relationship appeared curvilinear for white Catholics. As Catholic women progressed from a grade school education to one through three years of high school, their attitudes became more permissive. This stance, however, became less favorable as they advanced from four years of high

school through four years of college. Also, the attitudes of white, non-Catholic, married females were directly linked with husband's income and occupational status. The larger the husband's income and the greater his job status, the more favorable women were toward permissive abortion. White Catholic women, however, did not demonstrate this direct relationship. Similar to the association between their attitudes and education, they tended to demonstrate a curvilinear relationship so that those from the higher and lower socio-economic strata were more opposed to abortion than white Catholic women of more moderate status.

Trends in Attitude Change

A comparison of the 1967 survey (Kantner & Allingham, 1968) with the three surveys conducted in 1965 (Public favors abortion, 1966; Rossi, 1967; Westoff, Moore, & Ryder, 1969) suggests that over time the general public is becoming more favorable toward permissive abortion (see Table 1, p. 151). Not only is there a substantial increase in the percentage of persons favoring abortion in circumstances of a possibly defective child and rape or incest--circumstances in which the majority of persons earlier favored abortion--but of particular significance is the increased percentage of persons favoring permissive abortion in social and economic circumstances (unmarried, pregnant woman; married woman

who wants no more children; and a woman living in an economically deprived family). The percentage of persons favoring abortion in these social and economic situations is increasing toward a significant minority who may in the near future voice their demands for more liberal abortion legislation than that which is currently being proposed. Most presently proposed legislation is limited to legalizing abortion in circumstances where maternal health is endangered by the pregnancy, there is risk of a defective child, and the pregnancy resulted from rape or incest.

Consistent with the general public's trend of increasing liberalism toward permissive abortion; the attitude among Catholics, as well as Protestants, has become more favorable. A comparison of a 1967 survey with a 1965 survey (see Table 5) reveals a more favorable attitude toward permissive abortion over each circumstantial item for both Catholics and Protestants. Although this trend seems clear, it is noted that only the latest of these polls was conducted after 1965 and there is need for additional recent data to confirm this apparent trend.

Law

The attitude toward induced abortion from the perspective of the law can be assessed in legislative acts, court decisions, and the recommendations of various legal bodies.

TABLE 5

PERCENTAGE OF PERSONS CATEGORIZED BY RELIGIOUS PREFERENCE FAVORING PERMISSIVE
ABORTION IN SPECIFIC CIRCUMSTANCES (NATIONAL SURVEYS)

Rossi (1967) ^a Year of Survey: 1965					Kantner & Allingham (1968) ^b Year of Survey: 1967				
Circumstance	Cath.	Prot.	Jew	Agnost.	Circumstance	Cath.	Prot.	Jew	Other
If the woman's own health is seriously endangered by pregnancy	61	72	100	81	Mother's health endangered	75	89	98	88
If she became pregnant as a result of rape	47	57	97	68	Rape	62	74	93	77
If there is a strong chance of serious defect in the baby ^c	45	56	94	68	Child deformed	50	64	93	73
If she is not married and she does not want to marry the man	13	15	72	45	Woman not married	25	27	62	41
If the family has a very low income and cannot afford any more children	16	20	64	51	Can't afford child	18	25	52	45
If she is married and does not want any more children	13	14	47	47	Don't want	17	20	51	41
					Incest	63	71	90	72

172

^aSource: A. S. Rossi, Public views on abortion, in A. F. Guttmacher (Ed.), The case for legalized abortion now. Berkeley: Diablo Press, 1967, pp. 26-53. The original paper by A. S. Rossi, "Public views on abortion," was issued by the National Opinion Research Center in February, 1966.

^bSource: American attitudes on population policy: Recent trends, Studies in Family Planning, The Population Council, May, 1968, No. 30, 1-7.

^cThe 1965 Gallup Poll (Public favors abortion, 1966) reported almost identical percentages of Catholics (46 percent) and Protestants (56 percent) to have responded favorably to a similarly worded item asking the respondents if they would approve of abortion "where the child may be born deformed."

Legislative Acts

Presently the determination of an abortion's legality rests with each state. The statutes of individual states only apply to abortion performed within that state's geographical boundaries. Consequently, abortion laws vary in their prescription of what circumstances constitute grounds for a legal abortion. A legal abortion in one state may be an illegal abortion in another.

George (1967a) points out that the legislative statutes of Louisiana, Massachusetts, New Jersey, and Pennsylvania provide no circumstances in which an abortion can be performed legally. There are conflicting statutes within the states of New Hampshire and South Carolina. Similar to the four states named above, the statutes of New Hampshire and South Carolina prohibit without exception "attempted" abortion. However, New Hampshire and South Carolina statutes "penalizing actual abortion do justify acts necessary to save the mother's life [George, 1967a, p. 6]."

The remaining states permit an abortion to save the life of the mother. In a distinct majority of these states, peril to the mother's life is the only circumstance in which an abortion is legal. There is, however, a notable recent trend toward statutes which provide for additional circumstances in which an abortion is legally justified. Alabama and Oregon permit abortion to protect

the health of the woman (George, 1967a). More recently nine states have enacted legislation to permit abortion in cases other than those of life and health. Mississippi enacted a bill permitting abortion "in case of danger to (the) mother's life or when pregnancy results from rape [Marley, 1967, p. 527]." California statutes permit abortion for maternal health, rape, and incest (Hall, 1968). Fetal deformity as a condition for legal abortion has been incorporated in the statutes of Colorado, North Carolina, Georgia, Maryland, New Mexico, Kansas, and Arkansas which also provide for legal abortions to protect the woman's physical and mental health and to terminate a pregnancy which resulted from rape or incest (Hall, 1968; Cooke et al., 1968; Where is the abortion battle?, 1969).

Court Decisions

Much controversy attends the issue of whether or not a fetus is accorded legal rights. If the fetus is given legal rights, the "assumption" which follows is that the fetus is a human being in the eyes of the law. If legal rights are not granted, the fetus is "assumed" not to be a human being. However, such "assumptions" remain "assumptions" per se until the court definitively rules that a fetus is or is not a human being and thereby granted or not granted "all rights" accorded to all human beings. The courts have not made such a definitive decision within the last four decades. Prior to this time, a New York

Court of Appeals in 1872 (Lader, 1966a) and a Wisconsin court in 1923 (Rosen, 1967c) ruled that a fetus during the early months of gestation is not a human being.

To determine if a fetus does have legal rights, one must primarily turn to court decisions. However, as in the case of legislative statutes, court decisions are those of individual states and, consequently, the rulings have been inconsistent and contradictory across states. Kinsolving (1964) and Trinkhaus (in Lowe, 1966) assert that in California a fetus is accorded specified legal rights. Trinkhaus states that a fetus has rights to property, inheritance, and not to be injured and that these rights are protected by statute. Recently, however, a California lower judicial court whose ruling emphasized maternal rights contradicted the statutes protecting fetal rights which were discussed by Kinsolving and Trinkhaus. The court reversed a decision made by the California State Board of Medical Examiners who had reprimanded Dr. Joseph P. Shively, chief of obstetrics at St. Lukes Hospital in San Francisco, for aborting a woman who had contracted rubella (German measles) during pregnancy. The lower court specifically ruled that "women were entitled to abortion under the Eighth Amendment to the Constitution, which protects against cruel and unusual punishment, and the Fourteenth Amendment, which guarantees due process of law [Where is the abortion battle?, 1969]."

While introducing the possibility of abortion being legal in many circumstances in which abortion is presently considered illegal, this decision recognizes only maternal rights and in no way implies the existence of fetal rights.

Referring to a New Jersey Supreme Court decision, Trinkhaus (in Lowe, 1966) stated the court:

specifically recognized the right of an existing but unborn child to life. In a situation where the mother refused to have blood transfusions and seriously endangered the life of her fetus, by her refusal, the Court ruled that a guardian could be appointed to take whatever measures were necessary to make sure that the woman would be obliged to submit to the transfusions which would insure the live birth of her baby. Surely, this decision was grounded upon the right of the unborn child to its life (p. 89).

However, a more recent case brought before the New Jersey State Supreme Court closely questions this earlier decision. In 1967 the parents of a child born almost blind, deaf, and mute, sued two physicians for malpractice because they had not prescribed an abortion after the mother had contracted rubella. The State Supreme Court narrowly rejected the parents' claim by a split 4-3 decision (Hooper, 1967).

A similar case occurred in New York State, when a jury's decision clearly favored legalized abortion in the circumstance of possible fetal defects (Abortion refused, 1968). In New York, where legislative law permits an abortion only to preserve the life of the mother, an all male jury composed of five Roman Catholics awarded

100,000 dollars to a rubella defective child and 10,000 dollars to its parents. When five weeks pregnant, the mother contracted rubella. Three doctors, fearing the child would be born with permanent brain damage and physical defects, approved an abortion. However, the chief of obstetrics, a Roman Catholic, rescinded the order when the mother was taken into the operating room. The mother asserted the chief of obstetrics stated the child would be normal and she should not seek an abortion at another hospital. After the birth of a totally deaf, partially blind, spastic, and mentally retarded daughter, the parents sued the hospital. This decision strongly suggests that for this particular legal case the law and the persons implementing it feel that, in the circumstance of rubella, the absence of a child would be better than the existence of that child suffering from severe defects.

Another New York court decision ruled that a grandfather of a child born to a psychotic mother who had allegedly been raped by another patient in a state hospital could bring suit against the state for the child's suffering recoverable damages from the state because she was allowed to be born illegitimate (Abortion and the sick mind, 1965). The court reportedly denied that the question of abortion entered the case and asserted that the case concerned the hospital's negligence. If the plaintiff could prove the rape resulted from the hospital's

negligence in supervision of the mother, then the child could recover damages for being born with the stigma of illegitimacy. However, this decision could be viewed as the law of New York State moving toward approving abortion in cases of illegitimacy, rape, and a severely disturbed mother.

Similar to assertions of Kinsolving and Trinkhaus that a fetus has legal rights, Ryan (1967) after citing court cases in which damages were awarded to a fetus following injury from automobile collisions and a physician's negligence in treating the pregnant woman, asserts that the awarding of such redress illustrates that a fetus does have some legal status. However, these decisions can be interpreted as the granting of redress to the parents for their loss and to provide the parents with funds for the child's resultant medical expenditures, rather than as the awarding of damages to the fetus per se.

To illustrate that life before birth is considered legally different from life after birth; Lader (1966a), Rosen (1967c), and Ryan (1967) discuss the discrepancy between the reporting of "death" prior to and following birth. In contrast to the extensive legal involvement in the death of a child or an adult, prior to 20 weeks after conception (and in some cases 28 weeks), the death of a fetus is considered an abortion, not a delivery, and in no state is a birth certificate or death certificate required. The fetus is not listed on the mother's parity

record. No legal interment is required and the fetus is disposed of as a pathological laboratory specimen.

Further discrepancy in the law's view of the death of a fetus as opposed to the death of a child or an adult is manifested in the different penalties ascribed to abortion in contrast to murder. Edwin M. Schur (in Calderone, 1958) presenting the findings of Professor Fowler Harper of the Yale Law School who reviewed the state laws on abortion, reported on the discrepancy of the penalties during the conference sponsored by the Planned Parenthood Federation of America, Incorporated (Calderone, 1958). Whereas the penalty for a person causing the death of a child or an adult is severe in terms of imprisonment, Schur presented evidence that the penalties for illegal abortion were much less severe. With a wide variation among the states in their penalty for abortion, 5 states do not specify a penalty; 6 states provide a maximum penalty of fine and imprisonment not exceeding one year; 14 states provide a maximum of fine and imprisonment for 5 years; 8 states provide a maximum of fine and imprisonment for 10 years; and 1 state provides a maximum of fine and imprisonment for 14 years. Not only is there a sharp distinction between the punishment for the death of a fetus as opposed to the punishment for the death of a child or an adult, but in 10 states there is also a difference in the severity of the penalty

for causing the death of a quickened fetus as opposed to the penalty for causing the death of a fetus which is not quick (George, 1967a).

Recommendations of Legal Bodies

The most noted recommended legislation, which has been adopted in the proposed law revision of many states, is that presented by the American Law Institute in 1962. This Model Penal Code drafted by the American Law Institute, composed of 1,500 lawyers representing practitioners, judges, and professors, recommended that abortion be legalized when: (1) there is substantial risk that the pregnancy's continuance would gravely impair the physical or mental health of the mother, (2) there is substantial risk that the child would be born with grave physical or mental defect, (3) the pregnancy resulted from rape, incest, or felonious intercourse which would include statutory rape of girls under 16 years of age (George, 1967a; Cooke et al., 1968). The Model Penal Code further stipulated: (1) the abortion must be performed before viability, (2) at least two doctors must submit a written certification of the circumstances justifying the operation, (3) the abortion must be performed by a licensed physician in a licensed hospital (Cooke et al., 1968).

Confusion Within the Law

In addition to the diverse penal codes among the states, legislative acts and court decisions within states

have also come into conflict. Judicial decisions have made abortion legal in circumstances previously held to be illegal by legislative statute. Massachusetts and New Jersey legislative acts prohibit abortion without exception. However, the Supreme Judicial Court of Massachusetts revised this position of Massachusetts law by allowing a physician to perform an abortion when the woman's life or health was imperiled (George, 1967a). Similarly, the New Jersey Supreme Court ruled a physician could perform an abortion to save the life of the mother.

In Iowa and in New York legislative statutes permit abortion only if the operation is necessary to save the mother's life (Schur, in Calderone, 1958). However, an Iowa court justified a physician's performing an abortion for a mentally disturbed woman, and; a New York lower court (discussed on pp. 175-176) awarded damages to a rubella infant and its parents because it was allowed to be born defective. Because of the court's ability to interpret legislative acts and, consequently, to "revise" legal statutes, judicial decision can be a major instrument in the establishment of new abortion policies.

A dramatic paradox of the law occurred when the parents brought and won a suit against a New York hospital for allowing the birth of their rubella defective child while concurrently 10 reputable California physicians were fearing the loss of their licenses for aborting a woman

who had also contracted rubella during pregnancy. An abortion performed on a woman having rubella while pregnant was not legal by legislative statute in either state (Abortion refused, 1968; Hall, 1966; ASA survey of public opinion, 1968).

The lack of precise legal definitions for such terms as "substantial risk," "gravely impair," "health," and "rape" provides for uncertainty in the interpretation and the application of the laws. The fear of possible repercussions stemming from this uncertainty appears to be a prominent factor causing: (1) a reduction in the total number of therapeutic abortions; (2) the inconsistency among physicians and hospitals in the circumstances for which they will approve and perform an abortion; and (3) the establishment of abortion committees with several persons making the decision to perform an abortion which, through support in numbers, reduces the fear and risk of legal confrontation for their abortion practices.

Trends in the Attitude of the Law

The law's attitude toward permissive abortion has become and is clearly becoming more favorable. This is demonstrated in: (1) the large number of states in which bills proposing to liberalize abortion laws as provided in the Model Penal Code of the American Law Institute have been introduced into the state legislature, (2) the passage

and implementation in a growing number of states of abortion laws patterned after the American Law Institute's Model Penal Code, (3) the introduction of a bill in the Wisconsin legislature which proposed to repeal all abortion statutes (Rosen, 1967c) and the introduction of a bill into the Michigan legislature to legalize abortion for any woman who only needs the consent of her physician (Legal abortions argued, 1969), and (4) recent court decisions which have legalized abortion in states where legislative statutes previously had prohibited the operation.

Medicine

The law's lack of clarification of the circumstances in which abortions can be performed legally has caused many physicians, fearful of reprisal, to refrain from terminating a pregnancy for any reason. Nevertheless, there remain a number of physicians who have chosen to perform abortions in flagrant violation of the law. Packer and Gampell (1959), Statement by the committee (1965), Kummer and Leavy (1966), and George (1967a) point out that many of the pregnancies terminated for health, humanitarian, and eugenic considerations have been prohibited by state law. Surveying hospitals in the San Francisco Bay and Los Angeles areas of California, Packer and Gampell (1959) found that three-quarters of the reporting hospitals admitted that they had granted abortions in circumstances for which an abortion would violate the state law. Kummer

and Leavy (1966) assert this is also true of at least 90 percent of the therapeutic abortions scheduled at one of New York's leading hospitals and in other leading hospitals throughout the country. This open violation of the law by many physicians suggests that the medical profession's attitude toward abortion is more permissive than that of the law which generally permits an abortion only if it is necessary to save the woman's life. In the present section, the medical profession's attitudes toward abortion will be investigated by reviewing attitude surveys conducted among physicians and by examining the recommendations of various medical organizations.

Attitude Surveys

In general, findings of attitude surveys conducted among physicians have favored legalized abortion when the pregnancy: (1) threatens maternal physical or mental health, (2) resulted from rape or incest, (3) would appear to result in a defective child. Physicians do not appear to favor permissive abortion for socio-economic reasons such as: (1) poverty, (2) a mother wanting no more children, and (3) the mother's being unmarried.

National Survey

Modern Medicine (Abortion: The doctor's dilemma, 1967) conducted an attitude survey among the nation's practicing physicians. Of the 40,089 practitioners who

returned the questionnaire, 86.9 percent favored the liberalization of abortion laws. Among fields of specialization, psychiatrists (94.6 percent) were the most favorable while obstetricians and gynecologists (83.7 percent) were the least favorable toward liberalized abortion laws.

The physician's religion was found to significantly influence his attitude. Of the physicians who indicated they were not Roman Catholic or were of no denomination, 93.3 percent favored more liberal laws. Among doctors who identified themselves as being Roman Catholic, only 49.1 percent approved the liberalization of the laws.

Table 6 summarizes the finding of this study, giving the percentage of physicians who approve of legal abortions under the stated conditions.

State Surveys

New York. Hall (1965b) conducted a survey among the 2,285 physicians in New York State who were registered with the American Medical Association as obstetricians and/or gynecologists. The physicians were asked: (1) if they preferred the current New York State abortion law (stipulating that abortion is unlawful unless necessary to preserve the life of the mother or the fetus) to remain unchanged, or (2) if they preferred the revision of this statute in accordance with the recommendations of the

TABLE 6

PHYSICIANS' ATTITUDES TOWARD PERMISSIVE ABORTION
IN SPECIFIED CIRCUMSTANCES*

Circumstance	Percent Favorable
Substantial risk of maternal death	76.5
Pregnancy after rape or incest	75.1
Direct, positive evidence of fetal abnormality	71.7
Substantial risk to maternal physical health	69.7
Possibility of fetal abnormality (rubella exposure, Rh incompatibility, inheritable disorders)	62.7
Substantial risk to maternal mental health	60.6
Substantial risk of maternal suicide	58.6
Substantial risk to maternal emotional health	44.5
Illegitimacy	29.1
Socioeconomic reasons	26.6
At the request of the pregnant woman, for any reason	14.3

*Source: Abortion: The doctor's dilemma, Modern Medicine, April 24, 1967, 12-14+.

American Law Institute. Briefly restated, the recommendations of the American Law Institute were that abortion be legal in circumstances where: (1) there is substantial risk that the continuance of the pregnancy would gravely impair the mother's physical or mental health, (2) there is substantial risk that the child would be born with grave physical or mental defect, and (3) the pregnancy resulted from rape or incest.

Scorable returns were obtained from 1,350 (59.1 percent) of the physicians. Among these 1,350 respondents, 1,152 (85.3 percent) favored liberalization of New York State's abortion law as proposed by the American Law Institute; 198 (14.7 percent) favored retention of the state's existing law.

New Hampshire. Two surveys were conducted among the 800 members of the New Hampshire Medical Society (Abortion legislation, 1969). Each survey asked the physicians if they were in favor of or opposed to a legislative bill proposing liberalized abortion. The bill would legalize abortion when continuation of the pregnancy would "more than likely" result in: (1) the woman's death, (2) "serious permanent impairment" of maternal physical or mental health, (3) a child with "grave and permanent" physical or mental defects, or (4) when the pregnancy was the result of rape or incest (New Hampshire, 1969). One survey was conducted by the

president of the New Hampshire Medical Society who personally favored the bill. This survey found 80 percent of the physicians favored and 20 percent opposed the proposed legislation. The second survey was conducted by two physicians who "strongly opposed" the legislation. Of the state's physicians, this second survey found 65 percent favored and 35 percent opposed the bill.

Illinois. Among 3,000 respondents to a statewide survey of the Illinois State Medical Society, a distinct majority of the physicians favored the legalization of abortion in circumstances where the pregnancy: (1) resulted from forcible rape, statutory rape, or incest; (2) severely risked the physical or mental health of the mother; (3) posed a risk of suicide by the mother, and (4) was expected to result in a deformed child (MDs urge changes in abortion law, 1968). The percentages of physicians responding favorably toward legalized abortion in specified situations is presented in Table 7.

South Dakota. In February and March of 1965, the Trinity Lutheran Brotherhood of Rapid City, South Dakota sponsored a survey in which abortion questionnaires were mailed to "some 511" of the state's physicians (Munson, 1968). Scorable returns were obtained from 256 of 268 respondents. Of the South Dakota physicians who expressed an opinion, a majority favored permissive abortion in cases of rape, incest, and a "feeble-minded" mother.

TABLE 7

THE ATTITUDES OF 3,000 ILLINOIS PHYSICIANS TOWARD
LEGALIZED ABORTION IN SPECIFIED
CIRCUMSTANCES*

Circumstance	Percent Favorable
Forcible rape	87
Grave threats to the mother's physical health	86
Incest	82
Expected deformity of the fetus	79
Severe risk to the mother's mental health	76
Statutory rape	73
Risk of suicide by the mother	72

*Source: MDs urge changes in abortion law,
Illinois State Register, Springfield, Illinois, 1968.

However, a majority of the doctors did not favor legalized abortion in circumstances of maternal physical or mental health, a defective child, or socio-economic concerns. These findings, given in Table 8, suggest that these South Dakota physicians were less favorable toward permissive abortion than their colleagues in the national, New York, New Hampshire, and Illinois surveys.

For the circumstances of "statutory rape" (Table 8), the number of South Dakota physicians who would permit an abortion sharply decreases as the age of the female

TABLE 8

THE ATTITUDES OF 256 SOUTH DAKOTA PHYSICIANS TOWARD
LEGALIZED ABORTION IN SPECIFIED
CIRCUMSTANCES*

Circumstance	Percent Favorable
Patient is emotionally disturbed. Psychiatrist urges termination of the pregnancy on grounds she is not suitable for motherhood at this time.	43
Patient is of borderline physical fitness and it is felt that further childbearing would seriously impair her ability to care for her present children.	42
Patient is a bonafide victim of forcible rape	
She is 16 or more years old	66
She is 14 to 16 years old	72
She is 12 to 14 years old	78
She is under 12 years old	80
Patient is a victim of statutory rape	
She is 16 or more years old	27
She is 14 to 16 years old	48
She is 12 to 14 years old	63
She is under 12 years old	69
Patient is known to have taken thalidomide or to have had German measles (or some other condition similar) at, say, one month ges- tation. She fears blighting of child (there is strong likelihood) and wants to be aborted.	49

TABLE 8--continued

Circumstance	Percent Favorable
Patient has been impregnated by her father or brother or first cousin. (Her marriage to any one of these is forbidden by law, because of increased probability of genetic abnormalities.)	
She is 16 or more years old	54
She is 14 to 16 years old	64
She is 12 to 14 years old	71
She is under 12 years old	74
Patient is feeble-minded and has been duped or seduced into pregnancy.	65
Patient is sole breadwinner for her children and her invalid husband, and her pregnancy will require that she leave her job.	17
Patient is a widow, or divorcee, and breadwinner for her two children aged 12 & 14. Her pregnancy is from an indiscretion and bids fair to shatter her family.	12
Patient is married and feels she has enough children. This pregnancy has occurred despite conscientious efforts at contraception.	10

*Permission to present these data was granted by Trinity Lutheran Church (Burnell A. Lund, Pastor), 402 Kansas City St., Rapid City, South Dakota, sponsor of the survey.

increases. A similar relationship also obtains for the "forcible rape" and "incest" items, although it is markedly more distinct for the "statutory rape" item. One questions whether this inverse relationship is a function of concern for the younger female's possibly being less able to "cope" with the physical and mental experience, and/or a function of a punitive attitude directed toward older "girls" for their "suspected willingness" to participate in sexual activity. Also, as the circumstance appears to indicate a greater willingness (most willing to least willing--statutory rape, incest, forcible rape) on the part of the female to engage in the sexual relationship resulting in pregnancy, fewer physicians favor legalized abortion. This holds for each age category across circumstances and certainly suggests that a punitive orientation toward sexual activity is influential in determining the physicians' attitudes toward abortion. Interestingly, the Illinois survey also revealed that the percentage of physicians favoring legalized abortion progressively decreased over the ordered circumstances of forcible rape, incest, statutory rape.

Local Survey

Rosenberg and Silver (1965) sent questionnaires designed to elicit attitudes and practices concerning psychiatric indications for therapeutic abortion to 100 randomly selected psychiatrists who were in private

practice in northern California. Sixty-nine psychiatrists returned the questionnaire. Without specifying exact figures, Rosenberg and Silver state:

virtually all respondents reported that suicide potential and psychosis were positive indications for recommendation. Also, a major proportion felt that a history of severe postpartum or severe antecedent mental illness should be among the criteria.

The opinion that the present laws are inadequate was virtually unanimous and a wide variety of other recommendations for change was suggested. A substantial number felt that socio-economic factors, rape, incest, and extreme youth were factors which should be considered. Other indications suggested by a few were psychosis of the father, congenital diseases, problems of health and fitness and age of the mother or father, unwillingness to have children, divorce after conception, adultery and narcotic addiction (pp. 408-409).

Recommendations of Medical Organizations

Medical organizations, consistent with the response of physicians to attitude surveys, have recommended legalized abortion when: (1) the continuance of pregnancy would impair the mother's physical or mental health, (2) the pregnancy resulted from rape or incest, and (3) there is risk that the child would be born defective.

At a June, 1967 meeting of the American Medical Association, the 242-member House of Delegates voted to change its 96-year-old policy statement on therapeutic abortion (Easing abortion rules, 1967; AMA policy on therapeutic abortion, 1967). The new policy states:

the American Medical Association is opposed to induced abortion except when:

- (1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or
- (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or
- (3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;
- (4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and
- (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals (AMA policy on therapeutic abortion, 1967, p. 544).

Hall (1968) reports that other medical organizations such as the New York Academy of Medicine, the New York State Medical Society, the American Association of Planned Parenthood Physicians, and the California Medical Association also have publicly endorsed the liberalization of abortion laws. Similarly, the Florida Medical Association (MD gets 1-day probation, 1969), the Maryland Ad Hoc Committee to Study the Abortion Law (Recommendation of the Ad Hoc Committee, 1967), and the American Medical Woman's Association (Abortion and the law, American Medical Woman's Association Journal, 1966) have recommended the revision of abortion laws.

Religion

Catholicism

The most outspoken religious body is the Roman Catholic Church. Life created by "natural law" with the union of egg and sperm is considered "involute," "innocent," and "worthy of utmost sanctity." According to this viewpoint, destruction of the fetus is an immoral crime and is often considered analogous to murder. The Vatican Council has stated, "From the moment of its conception, life must be guarded with the greatest care, while abortion and infanticide are unspeakable crimes [McCormick, 1967, p. 716]."

The official position of the Roman Catholic Church is stated in Casti connubii issued in 1930 by Pope Pius XI. He declared "The life of each (mother and child) is equally sacred and no one has the power, not even the public authority, to destroy it [Lader, 1966a, p. 95]." More recently, Pope Pius XII has elaborated upon Casti connubii in stating, "There is no man, no human authority, no science, no 'indication'--whether medical, eugenic, social, economic or moral--that can show or give juridical title for a deliberate and direct disposing of an innocent human life [McCormick, 1967, p. 716]."

"Double Effect"

Pope Pius XII's wording, the "deliberate and direct" destruction of a fetus implies there may be

conditions in which a pregnancy can be "normally" terminated. These "conditions" are stated in the principle of double effect. This concept refers to the operation as an innocent act which results in a good effect (saving the life of the mother) and in a not intended bad effect (the death of the fetus). Good and Kelly (1951), in discussing the concept of double effect, identify four conditions which are necessary for its "lawful" application.

1. The original action must be morally good or indifferent in itself.
2. The good effect must not be the result of the bad effect, but both the good and evil effects must be the immediate result of the original action, or the evil effect must follow from the good effect rather than vice versa. Evil cannot be used to obtain a good end.
3. There must be a proportionally serious reason for doing the original action and permitting the evil effect. The good effect must be of equal or greater value than the evil.
4. The evil result which is foreseen must not be intended nor approved, but only permitted (p. 23).

In applying these conditions specifically to the performance of an abortion by a physician, Good and Kelly state:

There is no question of choices between saving the life of the mother and saving the life of the child, or of killing one to save the other. The physician does not directly will the death of either. Mother and child have an equal right to life. The physician has no right to kill the mother to save the child or to kill the child to save the mother. In the case of the pregnant woman, he has two patients and is equally responsible for both (p. 24).

To illustrate the application of the double effect principle, Good and Kelly present the following examples:

1. An operation to control hemorrhage during pregnancy but before viability which saves the mother's life but may result in the fetus's death is morally lawful.
2. A hysterectomy for cancer in a pregnant uterus which saves the life of the mother and indirectly results in the death of the fetus is morally lawful.
3. An abortion to avoid the birth of a defective child is morally unlawful as the direct intentions are the destruction of the fetus and the parents possibly being more socially secure.
4. Any operation with the "direct intention" of saving the life of the mother and destroying the fetus is morally unlawful.

The principle of double effect is most vulnerable when a physician is confronted by the situation where both mother and child would die if the pregnancy was not terminated. Vulnerability results from the husband's not wanting to witness the death of his wife when medically it could have been prevented. Also, vulnerability is inherent in the concept of double effect because its "lawful" application requires a correct abstract level

of intent, or more appropriately, the proper use of semantics. If the person who requests or performs the abortion were to reason, "I am requesting or performing this operation to save the mother's life, the child's death is not intended," the operation is morally lawful. However, the operation is morally unlawful if one were to reason (not knowing what doctrine dictates he reason) that "both my wife and my child cannot live; I love my wife and together we may be able to have other children. Consequently, I wish to save her life although I know the operation will destroy the fetus."

In stating what he felt was the most appropriate action when both mother and child would die without the pregnancy's termination, Pope Pius XII explicitly stated "no" to abortion (McCormick, 1967, p. 718). However, Lader (1966a) asserts that today most Catholic physicians and hospitals do adhere to the principle of double effect.

"Mediate" Versus "Immediate Animation"

Catholicism prohibits abortion because it fears the condemnation of an unbaptized soul--a soul whose time of origin remains in doubt in the minds of Catholic theologians. This time of ensoulment has been postulated in the differing theories of mediate and immediate animation. A distinct minority of the Cathologians today adhere to the theory of mediate animation which was the

position of Thomas Aquinas. According to this theory, the rational or vital principle which is man's soul is not present at conception but rather animates the somatic counterpart after the organism has passed through vegetative and sentient stages. The exact period of gestation at which this animation occurs has not been stated by the proponents of this theory.

In opposition to the theory of mediate animation is the theory of immediate animation. Theorists holding this viewpoint assert that the soul, being the rational principle of man, is present at the moment of conception and immediately animates or vivifies the somatic counterpart.

Wassmer (1967) states that "traditional moralists" attempt to resolve the uncertainty of the time of animation by "insisting that this problem of the moment of rational life in the fetus is a doubt of fact regarding mediate or immediate animation [p. 60]." Wassmer further asserts that in situations involving doubts of fact, when the doubts concern life, the safer course, rather than probabilism, must be followed. The safer course concerning abortion is to apply the theory of immediate animation--that rational life (or the soul) is present from the moment of conception--and, consequently, to prohibit the operation. The use of the theory of immediate animation as the safer course and the

consequent prohibition of abortion is accepted by most of the Catholic clergy.

Although advocating the principle of the safer course, Catholic moralists may permit abortion in the circumstances of rape. This less safe course has resulted from moralists considering that rape is a circumstance where "there were other 'situational' values at stake, and where apparently the obligation to accept the safer course ceases to be present [Wassmer, 1967, p. 61]." With the precise moment of conception uncertain and the exact moment of animation unknown, the woman is "given the benefit of the doubt" and allowed to use a douche after rape "as late as 10 hours after the assault [Wassmer, 1967, p. 61]."

A possible "situational value" in the case of rape may be found in the writing of Drinan (1967a) who asserts that canon law allows a rapist victim to prevent conception because it resulted from the aggression of an unjust aggressor. Drinan stresses that the action taken following rape is not meant as abortion per se, but rather it is intended as an act of prevention to eliminate the possibility of conception.

In summary, the principle of double effect, "situational values" and uncertainty of the time of animation, may provide rather rare occasions for the morally lawful termination or prevention (as in the

case of rape) of pregnancy. However, the dominant position of the Roman Catholic Church is one of condemning all abortion while stressing the sanctity and inviolableness of the life of an innocent fetus which has a God-given right to life.

Judaism

Cohen (1967) asserts that the Jewish attitude toward abortion varies among the three principal denominations--Orthodox, Conservative, and Reform. This variation results from the absence of a single authority of religious law which is accepted across these denominations; neither does such a central authority exist within individual denominations.

Orthodox Judaism

Of the three major denominations, Orthodox leaders are reportedly more opposed to abortion law reform than leaders affiliated with the Conservative and Reform denominations (Lader, 1966a; Rights & wrongs of abortion, 1967). The Orthodox rabbis' stronger opposition to liberalized abortion results from their adherence to the classic source of religious legality as found in the Bible and Talmund. The Biblical reference to abortion (previously discussed in Chapter V, p. 123) is that of Exodus 21:22-23. This passage concerns the fine levied by the husband upon the man causing his wife to abort,

or, if the woman was physically injured, the comparable physical punishment levied upon the man for injuring the woman. In the Jewish interpretation of Exodus 21:22-23, the fetus is not considered a "man" and its death is not considered murder.

The only reference to abortion in the Talmund concerns the fetus as a threat to maternal life in which case the Talmund permits abortion (Jakobovits, 1967). Until the child's head or greater part of its body has emerged from the birth canal, the mother's life is given preference over that of the child. After such anatomy of the child has emerged, neither the child's nor the mother's life can be sacrificed for the sake of the other. A second passage of the Talmund is consistent with that described above. In referring to a fetus whose presence poses a threat to maternal life, this second passage states that "such a child, being in 'pursuit' of the mother's life, may be destroyed as an 'aggressor' following the general principle of self-defense [Jakobovits, 1967, p. 129]."

Summarily, Jakobovits asserts that these passages from the Bible and the Talmund by implication have formulated the attitude, "(1) that the only indication considered for abortion is a hazard to the mother's life, and (2) that, otherwise, the destruction of an unborn child is a grave offense, although not murder [p. 129]."

This would be the attitude most prevalent among Orthodox rabbis.

Reform Judaism

Reform Judaism is the denomination whose rabbis are the most liberal toward permissive abortion. In contrast to the Orthodox Jew's skepticism of the responsa, Reform Jews are more apt to accept these more recent rabbinical interpretations of and elaborations upon the classic sources of Jewish law. Whereas the Bible and the Talmund did not discuss nor rule upon the "moral legality" of abortion in circumstances other than that of pregnancy as a risk to maternal life, the responsa do concern the "moral legality" of abortion in other circumstances. However, it must be remembered that the responsa are rabbinical rulings and, consequently, express the attitudes of individual rabbis--attitudes more often accepted among Reform than Orthodox Jews.

Maternal life and physical health. Lader (1966a) discusses the rabbinical ruling of Elizer Deutsch (1850-1916) and the later ruling of Isaac Klein as being consistent with the Talmund ruling permitting an abortion to preserve the life of the mother. Further, Lader quotes Rabbi Solomon B. Freehof:

Solomon of Skola in Responsa (1878) says that if it is within the first forty days of the pregnancy, there is no possible objection to an abortion; but even if it is older, the danger to the mother's life and health determines if an abortion may be performed (p. 98).

Psychological health. The responsa are consistent in the approval of abortion for psychological considerations. Cohen (1967) points out the teaching of Rabbenu Tam who asserted that "impairment of any part of the body is to be regarded as having potential fatal consequences, and a disturbed mental and emotional state can certainly be regarded as a condition of impaired health [p. 171].\" Similarly, Jakobovits (1967), illustrating Jewish approval of abortion in psychiatric circumstances, refers to a seventeenth century responsum which \"permitted an abortion in a case when it was feared the mother would otherwise suffer an attack of hysteria imperiling her life [p. 134].\" Cohen (1967) further asserts that if reputable psychiatrists have associated the woman's neurosis or psychsis to the pregnancy, \"the psychiatrically oriented Jewish authority of our time [p. 171]\" would approve of an abortion for a married or unmarried suicidal woman regardless of her possible moral violations.

Defective fetus. Lader (1966a) states that recent Jewish responsa, as described by Rabbi Solomon B. Freehof in Recent Reform Responsa, approve abortion when the mother has contracted German measles during pregnancy.

Since there is a strong preponderance of medical opinion that the child will be born imperfect physically, and even mentally, then for the mother's sake (i.e., her mental anguish now and in the future), she may sacrifice this part of herself (Lader, 1966a, p. 98).

Illegitimacy. Abortion in the case of rape is not discussed in the responsa, but abortion is discussed in relation to adultery and, by implication, to incest. Jakobovits (1967) states that an eighteenth century authority considered that the fetus of an adulterous should be destroyed. By committing adultery, a capital offense--like incest--in Biblical law, the woman forfeited the child's life. However, Jakobovits further asserts that other authorities and a more recent responsum, in contrast to this eighteenth century ruling, maintain that such a distinction should not be made between the bastard and legitimate fetus. Consequently, one may argue as does Jakobovits, that the responsa, for the most part, do not permit abortion in cases of adultery or incest.* However, such an argument does not appear to be consistent with the context in which these rabbinical rulings were made. The responsa appear to question abortion as a further means of punishing an adulterous for her capital crime. The context of such rulings does not relate to a woman's "wanting" an abortion in circumstances of adultery or incest. Consequently, the responsa do not appear to

* Although Jakobovits argues that Jewish law does not permit abortion in cases of adultery, incest, or "otherwise illegitimate relations," he paradoxically adds that Jewish law "imposes fearful disabilities on the products of such unions (adultery and incest) . . . it debars children born under these conditions from marriage with anyone except their like [p. 140]."

concern today's woman's "request" to abort a fetus which is the product of adultery, incest, or rape.

In general, it appears that many Reform rabbis would approve abortion in cases where a pregnancy imposes a risk to maternal physical or mental health, or would result in a defective child. The absence of responsa discussing abortion in circumstances of illegitimacy or socio-economic concern prevents an accurate clarification of Reform rabbinic attitude toward abortion in these situations.

Conservative Judaism

The Conservative's attitude toward permissive abortion has not been determined. However, Cohen's (1967) description of the extent to which each of the three major Jewish denominations adheres to traditional Jewish law, as opposed to adjusting its practices to meet contemporary needs, strongly suggests that the "Conservative attitude" lies between Orthodox approval of abortion only in cases of risk to maternal life and the more liberal stance of Reform Judaism.*

*"Orthodox Judaism seeks to perpetuate Jewish law and practices as they have been transmitted from the past, since it believes that all of ancient Jewish law is based upon Revelation. Reform Judaism seeks to adjust Jewish practices to contemporary needs, and maintains that it is free to deal with Jewish law as it deems necessary and advisable. It has, therefore, departed from many Jewish traditional practices. Conservative Judaism, the youngest of the denominations, believes in maintaining the framework of law, but also in reinterpretation of the law,

In summarizing and discussing the Jewish authority's attitude toward abortion, the Jewish attitude toward permissive abortion appears to vary widely among, as well as within, the three major Jewish denominations. This variation in attitude results from the lack of a central authority of Jewish law among and within Jewish denominations. In contrast to the restrictive attitudes of Orthodox rabbis, favoring abortion only when necessary to preserve the mother's life, several Reform rabbis have expressed an extremely liberal position. Rabbi Israel Margolies feels abortion should be the exclusive choice of the parents, and Rabbi Albert Plotkin feels all restrictive abortion laws should be abolished (Lader, 1966a). However, Lader himself an extreme liberal toward permissive abortion, states that the attitude expressed by Rabbis Margolies and Plotkin is "a minority view."

While the basic Jewish position places the life and health of the mother above that of the fetus, and raises no religious obstacles to the destruction of the fetus for medical necessity, there is little support for the abolition of all abortion laws (Lader, 1966a, p. 99).

Many rabbis have demonstrated they favor the revision of present abortion laws. The North California Board of Rabbis has supported law reform in California

which is the result of historic evolution. It has neither adhered to the rigidity of Orthodoxy nor gone to the extreme of Reform [Cohen, 1967, p. 172]."

(Kerby, 1967). The Federation of Jewish Philanthropies also supports law reform (Hall, 1968) as does the New York Federation of Reform Synagogues which supports proposed law reform in New York (Rights & wrongs of abortion, 1967). Also, 1,300 Jewish and Protestant clergymen in 334 California cities and towns supported abortion reform in that state (Star, 1965). Other rabbis have asserted their favorable position toward permissive abortion by joining with Protestant clergymen in forming organizations which council pregnant women in the continuation of their pregnancy or refer the women to skilled abortionists (Rosen, 1967c; Ross & Kupferberg, 1969).

Protestantism

Among the many Protestant denominations, and among federations within denominations, attitudes toward abortion range from conservative to liberal. Many denominations have not stated an official abortion policy, but recently an increasing number have been declaring their position toward permissive abortion.

Interdenominational--National

The Protestant Churches in the United States have issued only one interdenominational policy statement on induced abortion (Lader, 1966a; Drinan, 1967b). This policy was formulated by the General Board of the National Council of Churches in February of 1961. The Board asserted:

Protestant Christians are agreed in condemning abortions or any method which destroys human life except when the health or life of the mother is at stake. The destruction of life already begun cannot be condoned as a method of family limitation. The ethical complexities involved in the practice of abortion related to abnormal circumstances need additional study by Christian scholars (Drinan, 1967b, p. 713).

Because the word "health" in the policy statement is not descriptively defined, the Council's position is subject to the interpretation of approving abortion in circumstances where the pregnancy threatens the mother's mental as well as physical health. Stating that additional study is required before assuming a stance toward abortion in "abnormal circumstances" appears to refer to the Council's uncertainty of approving or not approving abortion when there exists the possibility that the child may be born defective. However, for all other possible reasons (illegitimacy; married women who want no more children because of poverty, already having more children than she feels she can care for properly, or because of her increasing age; and pregnant women recently divorced) the Council condemns the practice of abortion.

Interdenominational--State

The New York State Council of Churches has endorsed the liberalization of abortion laws so as to permit abortion when: (1) the health of the mother is threatened, (2) there is substantial reason to believe

the child would be mentally or physically defective, and (3) the pregnancy resulted from rape or incest (Campaign to make legal abortion easier, 1967). Similarly, the California Council of Churches has endorsed abortion law reform (Kerby, 1967).

Interdenominational--Local

In late 1964, Munson (1966) polled 12 Protestant ministers including "the top clergymen of Rapid City's (South Dakota) six leading non-Roman churches," to assess their attitudes toward permissive abortion.* Although Munson did not attempt to determine the ministers' attitude toward abortion in socio-economic circumstances, he found "a strong sentiment (about 81%) favoring the allowance of abortion for mental or physical unfitness, for rape or incest, for abnormalities of the fetus, and for feeble-minded-mothers whose relatives request it [Munson, 1966, p. 28]."

Denominations

United Church of Canada. In 1960 the United Church of Canada declared: "If, in the judgment of reputable medical authorities, the continuation of pregnancy seriously endangers the physical or mental health of the mother, therapeutic abortion may be necessary [Lader, 1966a, pp. 99-100]."

*Munson, 1968, personal communication.

United Presbyterian Church. In discussing the possible priority of saving the mother's life or the child's life, the 1962 General Assembly of the United Presbyterian Church stated, "This must be decided on the basis of the specific medical problems involved [Lader, 1966a, p. 99]."

American Baptist. One of the most liberal policies toward permissive abortion is that issued by the American Baptists. In May, 1968 at its Boston convention, the American Baptists approved (by a vote of about three to two) a resolution which would make it possible for a woman to procure an abortion for any reason during the first three months of pregnancy. More specifically, the resolution stated that during the first 12 weeks of pregnancy, abortion should be a personal decision and should be performed upon request. After this period, it was advocated that abortion be performed only when the pregnancy: (1) endangers the physical or mental health of the woman, (2) would result in a physically or mentally defective infant, or (3) resulted from rape, incest, or "other felonious acts [Abortion resolution, 1968]."

Unitarian-Universalist. In stating its liberal abortion policy, the 1963 General Assembly of the Unitarian-Universalists urged legalized abortion if:

there would be a grave impairment of the physical or mental health of the mother; the child would be born with a serious physical or mental defect; pregnancy resulted from rape or incest; there

exists some compelling reason, physical, psychological, mental, spiritual or economic (Drinan, 1967b, p. 714) .

American Lutheran Church. An attitude of growing favorableness toward permissive abortion is demonstrated by the American Lutheran Church. Included in a 1952 report on Planned Parenthood was a reference to abortion which stated:

Abortion must be regarded as the destruction of a living being, and, except as a medical measure to save the mother's life, will not be used by a Christian to avoid an unwanted birth. A Christian must come to accept the unintended pregnancy as a part of God's superior planning, and willingly welcome the new child as a gift from Him (Curran, 1967, p. 155) .

In 1963, this policy was broadened from granting abortion only to save the mother's life to allowing abortion in circumstances of risk to maternal mental or physical health. After its January, 1963, meetings, the Church Council of the American Lutheran Church stated:

In our judgment therapeutic abortion is permitted when: a) the life of the mother is involved; b) where the mother's health is threatened with severe physical or mental impairment; c) but not in cases of possible deformity (a few years ago popular opinion condemned Hitler for proposing euthanasia for deformed people) (Drinan, 1967b, p. 714) .

However, a draft of a proposed statement of the Commission on Research and Social Action presented to the 1968 General Convention of the American Lutheran Church took a stance more liberal than that presented in the 1963 position paper. Abortion would be permitted when pregnancy results from rape or incest and occurs for a

"mother barely in her teens." This proposal, in contradiction of the 1963 statement, would grant the parents of a predicted defective child the choice of an abortion.

The 1968 proposal specifically stated:

Laws governing therapeutic abortion need to be amended in a more broadly permissive direction. Laws should permit a therapeutic abortion not only when the mother's life is endangered but also when her health is threatened with severe physical and mental impairment. Laws should be liberalized to permit a therapeutic abortion in the instance of a child conceived of incest or forcible rape or to a mother barely in her teens. In none of these instances is the child likely to be the product of mutual desire or conscious choice, a wanted child as a "heritage from the Lord." Where there is a substantial risk that the child might be born with grave mental or physical defect, the parents might also be given the option of a therapeutic abortion (Drinan, 1967b, p. 714).

Episcopal Church and The Church of England.

Similar to the American Lutheran Church, the Episcopal Church and The Church of England have also displayed an attitude toward permissive abortion which has become progressively more favorable. In permitting abortion only "at the dictate of strict and undeniable medical necessity [Drinan, 1967b, p. 713]," representatives of the American Protestant Episcopal Church and of the Anglican Communion at the Lambeth Conference held in 1958, established a restrictive policy toward therapeutic abortion. Drinan (1967b) terms this document "one of the most severe of all non-Catholic contemporary ecclesiastical pronouncements

on abortion [p. 714]." The 1958 policy specifically stated:

In the strongest terms, Christians reject the practice of induced abortion, or infanticide, which involves the killing of a life already conceived (as well as a violation of the person-ality of the mother), save at the dictate of strict and undeniable medical necessity. The plight of families, or indeed of governments, trapped in hopeless poverty and overpopulation, may well help us understand why they think abortion more merciful than the slow starvation which looms ahead. Still, the sacredness of life is, in Christian eyes, an absolute which should not be violated (Drinan, 1967b, pp. 713-714).

In contrast to the position taken at the 1958 Lambeth Conference is a later stance taken by the Episcopal Church's Department of Christian Social Relations which declared that abortion "is probably decided among Episcopalians on the basis of the moral judgment of the individual, her family, the parish priest, and her physician [Lader, 1966a, p. 99]." As a reflection of this more recent statement, the Episcopal Dioceses of New York and Albany have favored revision of the New York State abortion law (Abortion and mental health, 1967).

Similar to the trend of increased liberalism among Episcopalians, a committee of the Church of England established by the Church Assembly Board for Social Responsibility published a report in December, 1965, in which abortion was approved when:

a mother's life or well-being and, indirectly, that of her family are endangered by a pregnancy; and this situation it (the committee's report) says, could arise when the child was conceived as the result of

rape or incest, or when there is a calculable risk that the child will be born defective or deformed (Canavan, 1966, p. 740).

The report also cautioned against abortion for convenience and spoke of the necessity to maintain "the general inviolability of the fetus and its right to live and develop [Canavan, 1966, p. 740]."

In February, 1966, the Church Assembly of the Church of England

voted a "welcome" [a technical term indicating something less than full endorsement] to this report because "it stresses the principle of the sanctity of life for the mother and fetus and urges the Church to preserve and demonstrate a balance between compassion for the mother and proper responsibility for the life of the unborn child" (Canavan, 1966, p. 741).

In summary, many Protestant denominations have not publicly stated an official position toward permissive abortion. In the 1950's and the early 1960's, several denominations issued vague statements which were severely restrictive in their approval of therapeutic abortion. Abortion was condoned if necessary to save the mother's life and for some denominations to preserve the mother's mental or physical health. However, more recently some of these denominations have altered their policy to permit abortion in an increasing number of circumstances. Such policy revisions suggest a trend of increased support for permissive abortion among Protestant denominations. American Baptists and Unitarian-Universalists have issued the most liberal abortion policies in which abortion may

be condoned in socio-economic circumstances as well as in cases of rape or incest, risk to maternal health (mental and physical), and risk of the child's being born defective.

Consistent with several denominations becoming more favorable toward permissive abortion, many Protestant clergymen (with Jewish rabbis) have displayed an increased favorableness toward permissive abortion by forming agencies to counsel pregnant women and/or assist them in finding a competent abortionist (Rosen, 1967c; Los Angeles clergymen, 1968; Monroe, 1969; Ross & Kupferberg, 1969). Also, Protestant clergymen were among the 1,300 religious leaders (Protestant clergymen and Jewish rabbis) from 334 California cities and towns favoring abortion law reform (Star, 1965).

Attitude Toward Abortion: Recent Developments

The prior discussion of research findings has suggested an "apparent" trend of increasing permissiveness toward legalized abortion. More recent data, however, have clearly established this trend. The attitudes of the public and of the law most notably reflect this progressive permissiveness.

General Public

A majority of the public has consistently expressed approval of abortion for reasons of maternal mental or physical health, fetal deformity, or rape or incest. The

public, however, had been less reluctant to approve of abortion for socio-economic reasons. Among the respondents of the studies conducted during 1965 (Public favors abortion, 1966; Rossi, 1967; Westoff, Moore, & Ryder, 1969), generally less than 20 percent of the public favored legalized abortion for socio-economic reasons--unwed mother, economically deprived family, desired family size already attained (see Table 1, p. 151). In a 1967 survey (Kantner & Allingham, 1968), however, roughly 25 percent of the respondents approved of abortion under these circumstances. More recent surveys have crystallized this growing trend of permissiveness toward abortion under socio-economic conditions. These favorable attitudes have, for the most part, been directed toward the repeal of abortion laws. Of the respondents participating in a Louis Harris poll conducted for Time magazine (Changing morality, 1969), 64 percent felt "abortions should not be a matter of law but should be left to the prospective parents and their doctor [p. 27]." Sixty percent of the Catholic respondents agreed, reflecting that Catholic laymen as well as the general public have become more favorable toward abortion.

A second survey conducted by Gallup found 40 percent of the 1,500 respondents favored "abortion on demand [Colorado abortion reform assessed, 1969, p. 53]." This study also reveals a dramatic increase in the number

of persons who would approve abortion for socio-economic reasons and favor the repeal of abortion laws. The discrepancy in the percentage of favorable response between the two 1969 surveys is most likely the result of the "more harsh and vague" phrase of "on demand" which was used in the Gallup poll. This wording may tend to lower the percentage of favorable response from that expected had the wording been "less severe and more descriptive" as was that used in the Louis Harris survey.

Law

Many state legislatures have recently passed more liberal abortion laws. Recent court decisions have also given support to permissive abortion policies.

Legislative Acts

From 1967 through May 8, 1970, the legislatures of 16 states have adopted new abortion legislation (Lader, 1970). The most restrictive of these new laws was passed in Mississippi where abortion is legal if performed to save the mother's life or when the pregnancy resulted from rape. In 10 states, an abortion may be legally performed if the pregnancy: (1) threatens the mother's life; (2) would impair her physical or mental health; (3) would result in a mentally or physically defective child; and (4) resulted from rape or incest. States having such statutes include: Arkansas, Colorado, Delaware, Kansas,

Maryland, New Mexico, North Carolina, Oregon, South Carolina, and Virginia.* The states of Georgia and California have passed similar laws. Georgia, however, does not legally permit abortion if the pregnancy resulted from incest and California does not permit abortion if the pregnancy may produce a defective child. Alaska and Hawaii have legalized abortion for any reason. It must be performed in a hospital; the fetus must be "nonviable" (roughly first six months of pregnancy), and; the woman must have been a resident of the state for at least 90 days. New York has passed the most liberal law, allowing abortion for any reason and having no residency requirement. The only stipulations are that the operation be performed by a licensed physician and that it be done during the first 24 weeks of pregnancy.

Although Washington is not included among the 16 states, both legislative houses approved and the governor signed a bill which went to the state's voters in the November, 1970, election as a referendum on the state's existing law. The bill was approved by the voters and when enacted, it will permit abortion for any reason

*Georgia and North Carolina statutes state "health" and do not specify physical and/or mental health. Arkansas, Delaware, and North Carolina do not include statutory rape when permitting abortion if the pregnancy resulted from rape. Virginia law specifies that the husband must give his consent if the abortion is to be performed when the pregnancy may result in a defective child.

during the first 16 weeks of pregnancy. The woman must have been a Washington resident for 90 days, and; if she is under 18, she must have the approval of her parents or if she is married and living with her husband, she must have his consent (Lader, 1970; Cook, 1970; Plans to lower, 1970).

Also, of the 29 states which permit abortion only to save the life of the mother, "at least one-third [p. 73]" have pending legislation or court cases which could greatly modify their current prohibitive laws (Lader, 1970).

Further evidence of the growing approval of permissive abortion is the introduction into the United States Senate of a proposed national abortion law which is similar to the liberal New York law (When abortion is made easier--, 1970). That such legislation has even been introduced to the national lawmakers certainly reflects the increased acceptance of legalized abortion.

Court Decisions

Recent court decisions have also demonstrated growing approval of permissive abortion. In September, 1969, the California Supreme Court ruled invalid the California abortion law which permitted abortion only to save a woman's life.* The Court rules the law was

*This California law was repealed and California now permits abortion when pregnancy threatens the mental or physical health of the mother or results from rape or

"too vague and an improper encroachment on women's fundamental right to choose whether or not to bear children [Constitutional rights, 1970, p. 66]."

A November, 1969, United States District Court decision overruled the Washington, D.C. law which allowed abortion only if necessary to preserve the mother's life or health (Cook, 1970; Abortion and the courts, 1970; Abortion law voided, 1970). Judge Gerhard A. Gesell ruled the law unconstitutional because: (1) it may violate a woman's right of chosen parenthood; (2) its wording of perserving life and health was too vague; and (3) it presumed a physician's guilt rather than his innocence, requiring him to justify his performing an abortion.

In March, 1970, three federal judges composing a Wisconsin United States District Court also ruled that restrictive abortion laws were unconstitutional. The Court declared the state could not invade a woman's right to refuse pregnancy during its early stages (Cook, 1970; Revised abortion laws, 1970).

These court decisions clearly reflect the growing judicial support for policies of permissive abortion. This trend may also be expected to have a significant impact upon abortion legislation and future court rulings. Similar suits challenging prohibitive abortion laws have

incest. This Court decision reversed the 1967 conviction of a physician who had been convicted of referring a woman to an abortionist when the older law was still in effect.

been filed in New Jersey, Texas, Illinois, and Kentucky (Revised abortion laws, 1970; When abortion is made easier--, 1970) and are being proposed in Indiana and South Dakota (Abortion law voided, 1970). In the fall of 1970, the United States Supreme Court is scheduled to hear an appeal of the United States District Court's ruling that the prohibitive Washington, D.C. law was unconstitutional. If the Court's decision favors permissive abortion, states would uniformly be expected to greatly modify their existing prohibitive abortion laws in accordance with the Court's ruling. If the Court's decision does not favor permissive abortion, current public and legal attitudes would suggest that abortion reform would only be "delayed."

CHAPTER VII

A STUDY OF INDUCED ABORTION: ATTITUDES, KNOWLEDGE, PERSONALITY CORRELATES

Phase I

Statement of the Problem

Methodological flaws are common in existing research studies of attitudes toward abortion. Only one prior study (Westoff, Moore, & Ryder, 1969) was found which reported reliability estimates of its attitude measure. Not one study was found which reported validity estimates. Without these estimates, the findings of the studies are statistically questionable. Furthermore, the statistical techniques used in the data analysis are rarely described. Many other studies have been restrictive in design, ignoring attitude over demographic variables. Among those which have not made this error, inconsistent findings predominate.

Only one study has attempted to assess the public's knowledge of abortion. This study was conducted by Oliver Quayle and Company for the Association for the Study of Abortion (ASA survey of public opinion, 1968).

New York residents were found to be ignorant of the New York State abortion law statute and to think a medically performed abortion more dangerous than it actually is.

With the exception of the national opinion surveys reported by Rossi (1967) and Westoff, Moore, and Ryder (1969), studies attempting to relate personality characteristics and attitudes have been virtually nonexistent. These surveys examined the relationship of education to attitudes toward abortion.

Considering both these limitations and the lack of previous studies conducted to determine attitude toward abortion, knowledge of abortion, and personality traits associated with attitudes, the present study was designed to:

1. Determine, with an empirically derived reliable and valid attitude measure, the general attitude toward permissive abortion and the attitude toward abortion is specific circumstances.
2. Investigate the relationship between attitude toward abortion and demographic variables.
3. Assess, with an empirically derived measure, the public's knowledge of abortion.
4. Identify personality traits related to a more favorable and less favorable attitude toward permissive abortion.

Materials

A booklet was composed of, in the order of their presentation, an information face sheet; the Abortion Attitude Inventory (AAI); a Likert item assessing the respondent's general attitude toward permissive abortion; the Abortion Questionnaire (AQ); the Gordon Personal Profile (GPP); the Gordon Personal Inventory (GPI); and the Survey of Interpersonal Values (SIV). This booklet was designed to be self-administered and to require 40 minutes to 1 hour for completion.

Information Face Sheet

The information face sheet given in Appendix A p. 399 requests the respondent's age, marital status, sex, religious preference, occupational and educational achievement. Response to this form provide the data necessary to determine the relationship between demographic variables and attitude toward abortion.

Abortion Attitude Inventory

Developed for the present study was the Abortion Attitude Inventory (AAI), a 17-item set of Likert statements assessing the respondent's general attitude toward induced abortion, as well as, his attitude toward permissive abortion in specified circumstances (Michelman, 1969). Test-retest (2-week interval) reliability coefficients of .94 and .91 were calculated for the AAI. An

internal consistency estimate of reliability was determined as .93. "Self-estimate validity" coefficients of .81 and .85 were also calculated. "Self-estimate validity" was determined by correlating the individual's general attitude score (the summed score of all 17 items) with his score on the general attitude item discussed in the following section. A reproduction of the AAI is presented in Appendix B, p. 400.

General Attitude Item

The respondents were asked, "My general attitude toward the permission of abortion is:" and they were requested to respond "strongly favor," "tend to favor," "neutral," "tend to oppose," or "strongly oppose." This Likert item was included in the booklet to enable AAI "self-estimate validity" coefficients to be determined from the general sample as a whole and across demographic variables.

Abortion Questionnaire

Also constructed for this study was the Abortion Questionnaire (AQ) to measure knowledge of abortion (Michelman, 1969). The content of these 24 multiple choice items was based on authoritative sources (Lader, 1966a; Lowe, 1966) and concerned pertinent information regarding socio-economic groups, races, religions, economic data, physiological aspects, and the general

and specific incidence of abortion (legal and illegal) in the United States. A test-retest (half-hour interval) reliability coefficient of .82 and an internal consistency reliability coefficient of .19 were determined for the AQ. For a preliminary form of the AQ, which differed from the final AQ only in the response alternatives of one item and in one response alternative of a second item, a test-retest (2-week interval) reliability coefficient of .47 was determined. The low internal consistency reliability estimate was attributed largely to the AQ's measuring knowledge over many areas (physiological aspects, economic data, etc.) pertinent to abortion. The rather low test-retest reliability coefficients were attributed primarily to the AQ's requiring very specific knowledge, the AQ's multiple choice format requiring difficult discriminations between response alternatives, and respondent guessing. The AQ's test-retest reliability estimates were considered sufficient for the present study. The magnitude of these estimates suggests caution, however, in the interpretation of its findings. A reproduction of the AQ is given in Appendix C, p. 403.

Gordon Personal Profile, Gordon
Personal Inventory, and Survey
of Interpersonal Values

Gordon's Personal Profile (GPP), Personal Inventory (GPI), and his Survey of Interpersonal Values (SIV) were selected for the present study because of their apparent

reliability and validity characteristics and their being self-administered tasks each requiring approximately 15 minutes to complete. Also, these instruments assess a large number of reportedly rather discrete personality traits. Their use facilitated investigation of the relationships of a rather broad set of dimensions of the individual's personality and his attitude toward permissive abortion.

Gordon Personal Profile. The GPP (Gordon, 1963a) provides a measure of four aspects of personality: Ascendancy (A), Responsibility (R), Emotional Stability (E), and Sociability (S). Fuller definitions of these personality attributes are provided in Appendix D, p. 406. The GPP is composed of 18 items. Four statements representing the four personality traits are grouped so that two are high preference and two are low preference. The respondent selects the statement "most" like himself and the statement "least" like himself from each tetrad. Validity correlations with peer ratings of college students ranged from .47 to .73. Three of the four personality trait scores correlated more than .50 with counselors' trait ratings. Split-half reliability coefficients based on a sample of 140 college students are A = .88, R = .85, E = .88, S = .84, and Total = .94 (Gordon, 1963a).

Gordon Personal Inventory. The GPI (Gordon, 1963b) yields measures of the following four personality traits; Cautiousness (CA), Original Thinking (OT),

Personal Relations (PR), and Vigor (VI). Definitions of these four GPI traits are also given in Appendix D, p. 406. The GPI is composed of 20 sets of tetrads. Validity correlations were not obtained for the GPI as they were for the GPP. However, considering that the procedure for the development of the GPI was similar to that of the GPP (utilization of factor analysis and item analysis), and noting the high validity correlations for the GPP, the GPI was included in the test battery. Split-half reliability coefficients based on a sample of 168 college students are: CA = .83, OT = .83, PR = .83, VI = .80, and Total = .88 (Gordon, 1963b).

Survey of Interpersonal Values. Defined by what high scoring individuals value, the SIV (Gordon, 1960) assesses the following six traits; Support (SUP), Conformity (CON), Recognition (REC), Independence (IND), Benevolence (BEN), and Leadership (LEA). These traits are more fully defined in Appendix D, p. 406. The SIV is a 30-item isipative instrument with each item consisting of a triad of statements. For each triad the respondent indicates the statement as representing what is most important to him. Three different value dimensions are represented within each triad. Validity coefficients between SIV scores over the six traits and self-ratings made 1 week apart ranged from .47 to .69 for 98 male college students and .54 to .73 for 69 female college

students. Test-retest reliability coefficients derived from a sample of 79 college students were as follows: SUP = .83, CON = .86, REC = .78, IND = .89, BEN = .83, and LEA = .88 (Gordon, 1960).

Procedure

Booklets were administered to residents of Lansing and East Lansing through face-to-face contact at the respondent's door and also to students enrolled in an introductory psychology course at Michigan State University within the classroom setting. In the summer of 1967, 62 booklets were distributed to Lansing residents in the lower income districts of High Street, McKinley Street, Vermont Avenue, Center Street, Case Street, and Court A. Among middle income Lansing residents living on Fernwood Street, LaSalle Boulevard, Midvale Avenue, Lee Boulevard, Kipling Boulevard, LaSalle Gardens, and South Holmes Street, 64 booklets were distributed. Sixty-two persons residing in an upper income district of East Lansing--Hitching Post Road, Belmonte Circle, Old Mill Road, Walbridge Drive, and Meadowbrook Lane--also received booklets.

The socio-economic status of the districts was estimated by the appearance of the respondent's home and the surrounding neighborhood. A more accurate estimate of each individual's socio-economic status (resident and student) was determined when the research material was analyzed. Occupational and educational data obtained

from the information face sheet were used to compute the Hollingshead (1957) Two Factor Index of Social Position. From residential appearance, socio-economic status was estimated as upper, middle, or lower class. Using the Hollingshead index, five class positions were determined. For the data analysis using Hollingshead's index of five classes, class I was considered the upper class; classes II, III, IV were combined as the middle classes; and class V was judged the lower class. Classes II, III, IV were combined for statistical convenience following a post-hoc inspection of the data.

Each booklet was numbered to enable the recording of the number distributed. Assigning the same number to booklets distributed to spouses made possible the determination of the extent of agreement between spouses concerning their attitude toward abortion.

Each person given a booklet was asked to complete the items without the aid of authoritative sources or consultation with another individual. From the comments of several persons returning the questionnaires, it seemed quite likely that some respondents had consulted with someone prior to their responding to the items. Four persons were known to have collaborated with others. They seemed to have sought advice primarily in answering the AQ for which the general sample's number of correctly answered items did not exceed that expected by chance. Pertinent

to their possibly collaborating to answer the AAI, if people were to "vote" on circumstances in which they felt abortion should be legally permitted, they might naturally seek the opinions of others.

All booklets distributed to residents were collected during door-to-door calls, except for two returned by mail. A minimum of three return visits was made before the hope of retrieving these data was abandoned. In this manner scorable returns were eventually collected from 89 residents, or 47 percent of the potential sample. Among this sample were 16 married couples (32 individuals).

Booklets were also administered to 46 undergraduates who, for course credit, volunteered for an experiment entitled, "You and a relevant issue of today." The students, like the residents, were given unlimited time to complete the questionnaires. From the group of 46 students, 42 (91 percent) returned scorable booklets. The 42 students and 89 residents composed the general sample of 131 respondents.

During the administration of the booklet, students were asked if they would volunteer the percentile rank of their scores on the College Qualification Test (CQT)--an examination required of all students prior to entering Michigan State University. The raw scores of each entering student are converted to percentile ranks based on a comparison of the scores of the present entering class with

those of the class which entered Michigan State University the previous year. Thirty of the 42 students granted permission to obtain this information. Students' percentile rankings served as intelligence estimates and were used to investigate a possible relationship between intelligence (CQT percentile rank) and attitude toward abortion.

Returned booklets for both residents and students were considered unscorable and excluded from the present study if any one of the following conditions existed:

1. Omission of three or more items of the AAI.

If one or two items were omitted, the average score for the completed items was determined to be the score of the unanswered items.

2. Omission of five or more items of the AQ. If less than five items were omitted, each omitted item was scored as incorrect. Rarely did an individual omit less than five items. If items were not answered, generally eight or more items were left unmarked.

3. Omission of three or more items of the GPP.

4. Omission of three or more items of the GPI.

5. Omission of three or more items of the SIV.

Considering the omission of three or more items as spoiling the GPP or GPI or SIV is the criterion suggested by the author of these questionnaires. Almost all

booklets determined unscorable had three or more items omitted from one of the three Gordon measures of personality traits.

Hypotheses

General attitude toward abortion and permissive or prohibitive attitudes toward abortion under specifically defined circumstances are to be "descriptively" assessed. Elaborating upon and broadening this descriptive analysis, are the following hypotheses presented by category headings:

Attitude Toward Abortion and Demographic Variables

1. Residential status. Students are more favorable toward abortion than Lansing area residents.
2. Sex. Males are more favorable toward abortion than females.
3. Marital status. (a) Single persons are more favorable toward abortion than married persons.
(b) There is no difference in attitude toward abortion between husband and wife.
4. Religious preference. (a) Protestants are more favorable toward abortion than Catholics.
(b) Jews are more favorable toward abortion than Catholics. (c) Agnostics are more favorable toward abortion than Catholics.

(d) Jews are more favorable toward abortion than Protestants. (e) Agnostics are more favorable toward abortion than Protestants. (f) Agnostics are more favorable toward abortion than Jews.

5. Socio-economic status. (a) Class I (upper class) is more favorable toward abortion than the combined classes II, III, IV (middle classes). (b) Class I is more favorable toward abortion than class V (lower class). (c) The combined grouping of classes II, III, IV is more favorable toward abortion than class V.
6. Age. Age is inversely correlated with favorable attitude toward abortion.

Knowledge of Abortion

7. The public has virtually no factual knowledge of abortion.
8. There is no correlation between knowledge of abortion and attitude toward abortion.

Attitude Toward Abortion and Personality Attributes

The following null hypothesis is presented for the relationship of personality attributes and attitudes toward abortion:

There is no correlation between attitude toward abortion and each of the attributes of intelligence, Ascendancy, Responsibility, Emotional Stability, Sociability, Cautiousness, Original Thinking, Personal Relations, Vigor, Support, Conformity, Recognition, Independence, Benevolence, and Leadership.

Phase II

Statement of the Problem

Several studies have been conducted to determine the attitude toward permissive abortion among physicians (Abortion: The doctor's dilemma, 1967; Hall, 1965b; MDs urge changes in abortion law, 1968; Abortion legislation, 1969; Rosenberg & Silver, 1965) and religious leaders (Munson, 1966). However, the methodological errors which characterize attitude studies among the general public (Chapter VII, p. 223) frequently recur within these studies of professional groups. With empirically derived measures, the present study purports to investigate and compare; first, the attitude toward abortion, and; second, the knowledge of abortion among selected professional groups of Michigan religious leaders, physicians (gynecologists and/or obstetricians), legislators, and businessmen.

Procedure

All persons participating in Phase II of the present study were mailed the AAI and AQ. Included with the questionnaires was an introductory form letter (see Appendix E, p. 409) explaining the purpose of the study and requesting the individual's cooperation. A stamped, self-addressed, return envelope was also enclosed with the questionnaires. An additional form was included for specific professional groups. The religious leaders were asked to specify their religious denomination; the physicians were asked to indicate whether they were practicing gynecology and/or obstetrics; the legislators were asked to identify themselves as a member of the house or senate. No additional personal information was requested from the groups. It was felt that asking for demographic information would seriously impair the percentage of returns.

Religious Leaders

The materials were mailed to 218 leaders of religious groups of all faiths from the greater Lansing area. These religious leaders included all those listed by the Greater Lansing Council of Churches. Seventy-three (33 percent) returned scorable materials. Of these, 73 AAI forms and 68 AQ forms were scorable. The number of scorable returns categorized by religious denomination is presented in Appendix F, p. 410.

Physicians

The physician sample was a group of 200 gynecologists and/or obstetricians randomly selected from a list of 310 Michigan Boarded specialists presented in the Directory of Medical Specialists (1965). These physicians were chosen because of their presumed greater knowledge of abortion. Ninety-eight, or 49 percent, of the physicians participated in the study. Scorable returns were obtained for 98 AAIs and 88 AQs.

Legislators

The materials were mailed to all members of the 1967-1968 State of Michigan Legislature--109 members of the House of Representatives and 38 members of the Senate. Scorable returns were obtained from 39 (27 percent) of the legislators; 37 members of the house, 1 senator, and 1 unknown. Considering that only one return was known to have come from a member of the senate, the responding legislators were not subdivided into house and senate categories. These scorable materials included 39 AAIs and 34 AQs.

Businessmen

The sample of businessmen constituted 200 persons randomly selected from approximately 800 members of the Firm Head organization (company representatives) of the Greater Lansing Chamber of Commerce. Seventy-nine

(40 percent) returned scorable materials--79 AAI's and 75 AQs.

Hypotheses

In addition to providing a descriptive analysis of each professional group's attitude toward permissive abortion under specific circumstances, phase II purports to test the following null hypotheses:

1. There is no difference in attitude toward abortion among groups of religious leaders, physicians (gynecologists and/or obstetricians), legislators, and businessmen.
2. There is no difference in the knowledge of abortion among groups of religious leaders, physicians (gynecologists and/or obstetricians), legislators, and businessmen.

CHAPTER VIII

A STUDY OF INDUCED ABORTION: ATTITUDES, KNOWLEDGE, PERSONALITY CORRELATES-- RESULTS

Phase I

Attitude Toward Abortion

For the general sample (89 Lansing area residents and 42 Michigan State University students), the mean general abortion attitude score (AAI) was 43.8 (SD = 15.4) with scores ranging from 17 to 84. The possible range of AAI scores was from 17 to 85, with numerically larger scores signifying a more restrictive attitude toward permissive abortion than the numerically smaller scores.

As shown by the Table 9 data, among these 131 general sample respondents who expressed an attitude other than "neutral," a majority favored permissive abortion if: (a) the pregnancy resulted from rape, (b) the woman is legally judged to be an unfit mother, (c) there is a strong possibility of a malformed child, (d) the woman is found to be psychologically unfit, (e) the woman's life is endangered by child-delivery, and (f) the child would

be born into a family where it would be unwanted and treated as such. A majority also asserted there were circumstances in which they would consider an abortion and disagreed that an abortion should never be permitted.

An abortion was not favored by the majority under conditions in which: (a) a woman is pregnant but unmarried, (b) any woman is requesting an abortion, (c) the woman is from a poverty stricken home, (d) the woman is 45 years of age or older, and (e) a woman is pregnant and is obtaining a divorce from her husband.

Inconclusive differences in Table 9, where the majority differs from the minority by not more than 6 percent, were found on items concerning permissive abortion when the child would be unwanted and treated as such (53 percent PRO, 47 percent CON), the woman is pregnant but unmarried (47 percent PRO, 53 percent CON), the woman is pregnant and is obtaining a divorce from her husband (47 percent PRO, 53 percent CON). A more detailed account of the general sample's attitudes toward abortion is presented in Appendix G, Table G1. The percentage of persons who responded specifically "strongly agree," "tend to agree," "neutral," "tend to disagree," or "strongly disagree" to each AAI item is specified in Table G1.

TABLE 9

RESPONSE PERCENTAGE FOR THE GENERAL SAMPLE
(N = 131) FOR EACH AAI ITEM

Items	Response Percentage	
	Agree	Disagree
1. Abortion should be permissible in cases of pregnancy following rape.	89	11
2. A woman judged by the courts to be an unfit mother should not be granted an abortion.	32	68
3. After a woman has had an abortion, misfortune will probably follow.	11	89
4. An abortion should be allowed if a woman is pregnant but unmarried.	47	53
5. Abortions should not be granted when there exists a strong possibility the baby would be malformed.	25	75
6. An abortion should be granted to any woman requesting one.	23	77
7. The wife from a poverty stricken home (yearly income less than \$3,000) should be granted an abortion.	40	60
8. A woman 45 years of age or older should be granted an abortion on request.	41	59
9. A woman judged to be psychologically incapable of being an adequate mother should be allowed an abortion.	62	38

TABLE 9--continued

Items	Response Percentage	
	Agree	Disagree
10. An abortion should not be allowed if a woman is pregnant and is obtaining a divorce from her husband.	53	47
11. A woman who loves children would never consider an abortion for herself.	30	70
12. An abortion should never be permitted.	13	87
13. (If female) There are circumstances under which I would consider having an abortion. (If male) There are circumstances under which I would approve of my wife's or girlfriend's having an abortion.	77	23
14. Probably most women requesting an abortion are irresponsible.	08	92
15. If a woman's life is endangered by the delivery of a baby, an abortion should be performed.	80	20
16. After an abortion a woman could feel satisfied and comfortable with her decision and its results.	69	31
17. In a family where a child is unwanted and would be treated as such the wife should be granted an abortion.	53	47

Attitude Toward Abortion and Demographic Variables

The rated AAI item responses for persons classified by the demographic variables of residential status, sex, marital status, religious preference, and socio-economic status are presented in Appendix H, p. 415. These data reveal that groups within demographic classifications differed in their attitudes toward abortion under various specified circumstances (e.g., of those expressing an attitude other than "neutral," 62 percent of the male and 46 percent of the female respondents strongly favored or tended to favor permissive abortion when the child would be born unwanted and treated as such).

Residential status. The students were found to be more favorable toward permissive abortion ($p < .05$) than were the Lansing area residents. The between group t value was -1.74 . For Lansing area residents ($N = 89$), the $\overline{AAI} = 45.4$ ($SD = 16.1$); for Michigan State University students ($N = 42$), the $\overline{AAI} = 40.5$ ($SD = 13.4$).

Sex. Although the between group t (-1.57) did not achieve statistical significance, there was a trend for males to be more favorable toward permissive abortion than females. For 71 females, the $\overline{AAI} = 45.8$ ($SD = 16.0$); for 60 males, the $\overline{AAI} = 41.5$ ($SD = 14.5$).

Marital Status. Only 5 of the 131 respondents acknowledged being divorced (2) or widowed (3). Consequently, this analysis was restricted to married and

single persons only. There was a trend for singles to be more permissive than marrieds about abortion. The between group t value was -1.34 ; for 83 marrieds, $\overline{AAI} = 45.0$ ($SD = 16.2$); for 43 singles, $\overline{AAI} = 41.1$ ($SD = 13.4$).

Among 16 married couples, the Pearson product-moment correlation between the AAI scores of husbands and wives was $.55$ ($p < .05$; two-tailed). For the husbands, $\overline{AAI} = 44.6$ ($SD = 15.7$); for the wives, $\overline{AAI} = 42.1$ ($SD = 16.5$).

Religious preference. T tests of difference were calculated among the four religious classifications of Catholicism, Protestantism, Judaism, and Agnosticism. The Unclassified category was not subject to the t test analysis because of the heterogeneity of religious preferences held by the five individuals constituting this classification. T tests revealed that Protestants were more permissive about abortion than Catholics ($p < .001$; $t = -5.229$); Jews were more permissive than either Protestants ($p < .005$; $t = -2.888$) or Catholics ($p < .001$; $t = -4.444$); and Agnostics were more permissive than either Protestants ($p < .001$; $t = -7.325$) or Catholics ($p < .001$; $t = -9.511$). The pertinent data are summarized in Table 10.

TABLE 10
RELIGIOUS PREFERENCE AND ATTITUDE TOWARD
ABORTION SCORES

Religious Preference	<u>N</u>	Mean	Standard Deviation
Catholicism	32	56.5	15.3
Protestantism	82	42.0	12.3
Judaism	7	27.6	14.8
Agnosticism	5	23.6	4.8*
Unclassified	5	36.4	8.4

*Because the variance of the AAI scores between the Agnostic sample and any one of the other three samples was not homogeneous (determined from the F test), a t formula (Hays, 1963, p. 322) accounting for nonhomogeneity of variance was used.

Socio-economic status. T tests revealed that class I (the highest socio-economic grouping) was more favorable ($p < .025$; $t = -1.990$) toward permissive abortion than the combined grouping of classes II, III, and IV (which differed little from each other). Class I was also more favorable than class V ($p < .025$; $t = -2.088$). Although not reaching statistical significance, the combined grouping of classes II, III, and IV tended to be more favorable toward permissive abortion than class V ($t = -1.208$). The pertinent data for each of the five socio-economic classes are presented in Table 11.

TABLE 11
SOCIO-ECONOMIC STATUS AND ATTITUDE TOWARD
ABORTION SCORES

Socio-economic Class	<u>N</u>	Mean	Standard Deviation
Class I	32	38.8	14.7
Class II	36	44.5	12.3
Class III	23	44.4	18.3
Class IV	33	45.9	16.0
Class V	7	52.3	16.8

The Pearson product-moment correlation between socio-economic class raw scores prior to their being categorized into one of the five classes and AAI scores was .19 ($p < .05$; two-tailed). For the 131 persons, the mean socio-economic class raw score was 30.3 (SD = 17.1) and the mean AAI score was 43.8 (SD = 15.4).

Age. The Pearson product-moment correlation between age and attitude toward abortion was .00. For the 131 persons whose ages ranged from 17 to 80, the mean age was 35.1 (SD = 15.8) and the mean AAI score was 43.8 (SD = 15.4).

Interaction Effects Between Attitude
Toward Abortion and Paired
Demographic Variables

No statistically significant interaction effects occurred between attitude toward abortion and each

possible combination of two categorized demographic variables which included residential status, sex, marital status, religious preference, and socio-economic status. These data are summarized in Table 12.

While none of the interaction effects analyses reached the .05 level of significance, the .10 level attained by the analysis of Sex X Marital Status warranted further investigation. The pertinent data for these variables are presented in Table 13.

Using Scheffé's (1959) method of analysis, no significant differences were found between single males and married males or single females or married females. However, with the less rigorous $\underline{t}$ test (two-tailed) single males were found to be more permissive toward abortion than married males ($p < .02$; $\underline{t} = 2.463$), single females ($p < .05$; $\underline{t} = 2.370$), and married females ($p < .02$; $\underline{t} = 2.653$).*

*Because the variance of the AAI scores for single males was not homogeneous with that of married males, single females, or married females, a $\underline{t}$ test formula (Hays, 1963, p. 322) taking into account nonhomogeneity of variance was used.

TABLE 12

INTERACTION EFFECTS BETWEEN ATTITUDE TOWARD ABORTION
AND PAIRED CATEGORIES OF DEMOGRAPHIC VARIABLES

Interaction	Variables	df	MS	F	p
Sex and Religion (Catholics, Protestants, Jews, Agnostics, Un- classifieds)	Sex	1	198.8	1.18	.28
	Religion	4	2202.1	13.12	.01
	Interaction	4	168.5	1.00	.41
Sex and Class	Sex	1	614.8	2.72	.10
	Class	4	353.4	1.56	.19
	Interaction	4	304.0	1.34	.26
Sex and Resident Status	Sex	1	676.0	2.93	.09
	Resident Status	1	561.7	2.43	.12
	Interaction	1	306.6	1.33	.25
Sex and Marital Status	Sex	1	625.2	2.73	.10
	Marital Status	1	347.7	1.52	.22
	Interaction	1	630.8	2.75	.10
Religion and Class (Catholics, Protestant)	Religion	1	4625.8	26.25	.01
	Class	4	244.0	1.39	.24
	Interaction	4	85.7	.49	.75
Religion and Resident Status (Catholics, Protestants, Jews)	Religion	2	373.6	1.72	.18
	Resident Status	1	695.8	3.20	.08
	Interaction	2	98.3	.45	.64
Religion and Marital Status (Catholics, Protestants, Jews)	Religion	2	2945.0	16.66	.01
	Marital Status	1	402.7	2.28	.13
	Interaction	2	37.9	.21	.81
Class and Resident Status	Class	4	252.9	1.11	.35
	Resident Status	1	1557.9	6.86	.01
	Interaction	4	166.0	.73	.57
Class and Marital Status	Class	4	218.9	.94	.44
	Marital Status	1	1069.9	4.61	.03
	Interaction	4	104.5	.45	.77
Resident Status and Marital Status	Resident Status	1	127.6	.55	.46
	Marital Status	1	344.3	1.47	.23
	Interaction	1	1.0	.01	.95

TABLE 13

MARITAL STATUS OF MALES AND FEMALES AND
ATTITUDE TOWARD ABORTION SCORES

	Males			Females		
	<u>N</u>	Mean	SD	<u>N</u>	Mean	SD
Singles	23	36.7	9.6	20	46.2	15.5
Marrieds	36	45.0	16.2	47	45.0	16.3

Knowledge of Abortion

For the general sample the mean number of AQ items answered correctly was 5.6 (SD = 2.1). This mean number of correct responses did not differ significantly from that expected by chance ($z = .415$). The general sample, on the average, answered correctly less than 25 percent of the 24 AQ items. No individual among the 131 persons answered correctly more than 50 percent of the items. The range of correct responses was from 1 (three persons) to 12 (two persons). Figure 1 depicts the number of items answered correctly by each individual of the general sample. An analysis of the knowledge of abortion within demographic classifications is presented in Appendix I.

Knowledge of Abortion Related to
Attitude Toward Abortion

Among the general sample, AQ scores were inversely related to AAI scores ($r = -.29$; $p < .005$, two-tailed) showing that those more knowledgeable about abortion were

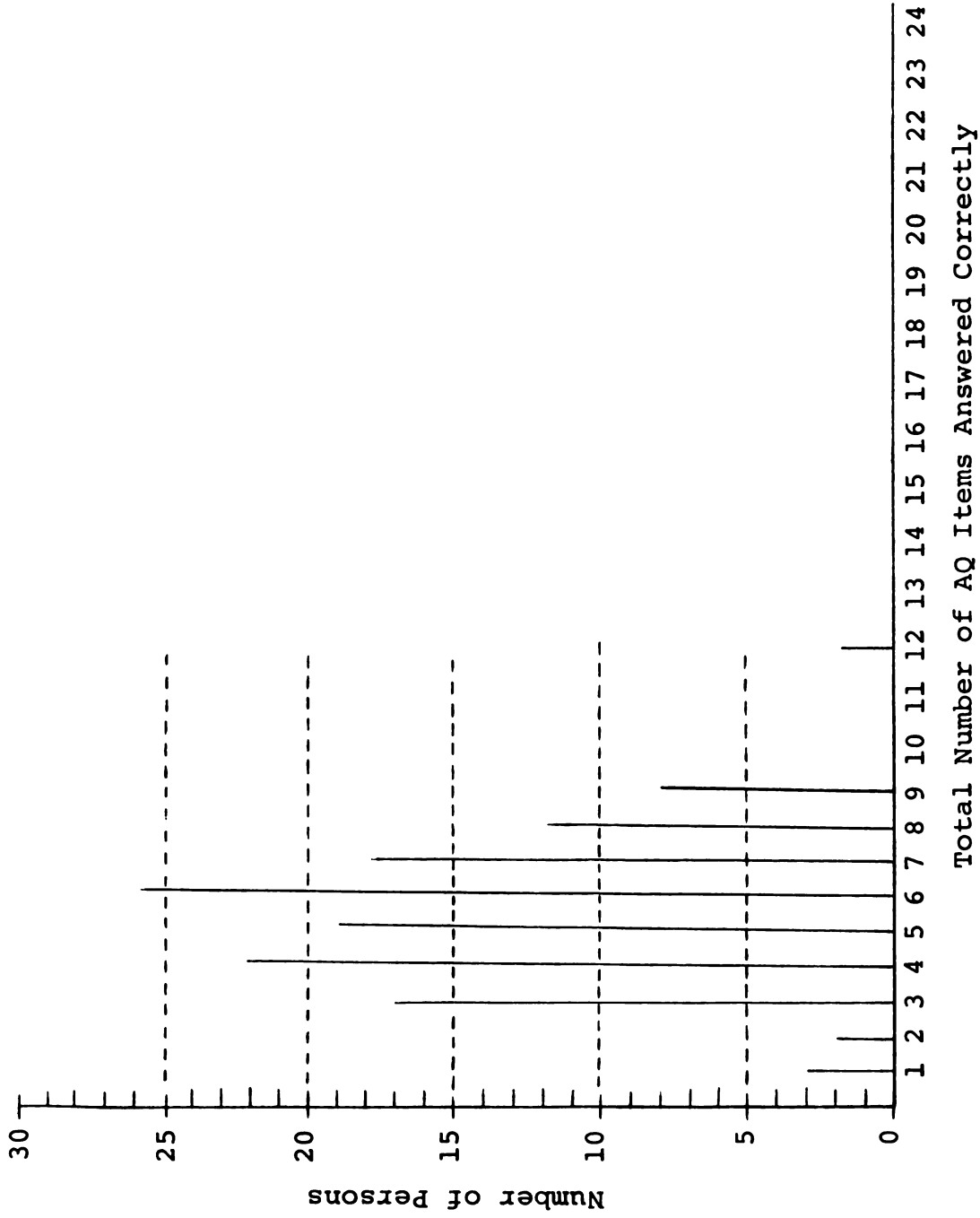


FIGURE 1

TOTAL NUMBER OF AQ ITEMS ANSWERED CORRECTLY BY EACH
INDIVIDUAL IN THE GENERAL SAMPLE

more permissive in attitude toward abortion than were the less informed. For the 131 persons constituting the general sample, $\overline{AAI} = 43.8$ (SD = 15.4) and $\overline{AQ} = 5.6$ (SD = 2.1).

Comparing the AQ scores of the 10 individuals most favorable toward abortion (AAI = 17-23) with the AQ scores of the 10 persons least favorable toward abortion (AAI = 70-84), those most favorable in attitude were more knowledgeable about abortion ($p < .05$; $t = 2.143$, two-tailed). For the 10 persons most favorable toward permissive abortion, $\overline{AQ} = 7.6$ (SD = 2.0); for the 10 individuals least favorable, $\overline{AQ} = 5.2$ (SD = 2.7).

The relationship between knowledge of abortion and attitude toward permissive abortion among individuals categorized by demographic variables is presented in Table 14. A negative correlation represents a relationship between relatively more knowledge of abortion and favorable attitude toward abortion. A positive correlation indicates a linkage between relatively limited knowledge of abortion and a less favorable attitude toward abortion.

Personality Attributes and Attitude Toward Abortion

For the sample of 30 Michigan State University undergraduates, CQT scores correlated $-.34$ with AAI scores ($p < .04$, one-tailed; $p < .07$, two-tailed), suggesting that the more intelligent students were more positively

TABLE 14

PRODUCT-MOMENT CORRELATIONS BETWEEN ABORTION
KNOWLEDGE AND ATTITUDE BY DEMOGRAPHIC
CLASSIFICATIONS

Demographic Classification	<u>N</u>	Knowledge Mean	Attitude Mean	<u>r</u>
<u>Residential Status</u>				
Student	42	5.1	40.5	-.51*
Lansing Area	89	5.8	45.5	-.24*
<u>Sex</u>				
Male	60	5.6	41.5	-.34*
Female	71	5.6	45.8	-.25*
<u>Marital Status</u>				
Single	43	5.1	41.1	-.51*
Married	83	5.9	45.0	-.24†
<u>Religious Preference</u>				
Protestantism	82	5.6	42.0	-.22*
Catholicism	32	5.1	56.5	-.09
Judaism	7	7.6	27.6	-.33
Agnosticism	5	7.6	23.6	-.17
Unclassified	5	5.0	36.4	-.45
<u>Socio-economic Status</u>				
Class I	32	6.6	38.8	-.18
Class II	36	5.5	44.5	-.26
Class III	23	5.2	44.4	-.41†
Class IV	33	5.3	45.9	-.39*
Class V	7	4.6	52.3	.81*

† $p < .06$; two-tailed* $p < .05$; two-tailed

inclined toward permissive abortion than were the less intelligent. Among these 30 students whose average age was 18.8, the $\overline{CQT}$ percentile rank was 57.2 (SD = 29.9) and the $\overline{AAI}$ was 40.3 (SD = 14.3). CQT percentile scores ranged from 02 to 94.

For the general sample, 5 of the 14 personality attributes assessed by the GPP, and the GPI, and the SIV proved significantly correlated with AAI scores. Higher scores on the personality measures of Original Thinking ($p < .001$), Independence ($p < .001$), and Ascendancy ($p < .05$) were linked to a more positive stance toward permissive abortion than were lower scores. An inverse relationship was obtained between AAI scores and the attributes of Benevolence ($p < .01$) and Conformity ($p < .05$), where higher attribute scores were linked with a more unfavorable view of permissive abortion than were lower scores.

Although the required level of statistical significance was not achieved, persons scoring high on the personality measures of Leadership ($p < .06$) and Sociability ($p < .11$) also tended to be more permissive toward abortion than persons scoring low on these measures.

A complete account of all Pearson product-moment correlations between the AAI and the 14 personality attribute measures is given in Table 15. (An individual's raw attribute scores were converted to percentile ranks

according to the norms presented in the respective test manuals.) Negative correlations show that a more permissive attitude toward abortion was associated with higher scores on the personality measures; positive correlations show that higher scores on the personality variables were associated with a less permissive stance on the AAI.

TABLE 15

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY
ATTRIBUTES AND ATTITUDE TOWARD ABORTION

Attributes	<u>r</u>
<u>GPP:</u>	
Ascendancy	-.21*
Responsibility	.05
Emotional Stability	-.06
Sociability	-.14
<u>GPI:</u>	
Cautiousness	.05
Original Thinking	-.31***
Personal Relations	-.03
Vigor	-.09
<u>SIV:</u>	
Support	-.03
Conformity	.18*
Recognition	.06
Independence	-.30***
Benevolence	.23**
Leadership	-.17

* $p < .05$; two-tailed

** $p < .01$; two-tailed

*** $p < .001$; two-tailed

A multiple regression analysis of the personality traits with attitude toward abortion and a factor analysis of the personality traits are presented in Appendix J. A correlation analysis of personality traits and attitude toward abortion by demographic classifications is presented in Appendix K.

A Comparison of Knowledge of Abortion and
Personality Traits Between Persons Most
Favorable and Least Favorable
Toward Permissive Abortion

Among the 131 persons constituting the general sample, the 10 individuals with the most favorable attitude toward permissive abortion [AAI scores 17-23; $\overline{AAI} = 20.6$ (SD = 2.4)] and the 10 persons with the least favorable attitude [AAI scores 70-84; $\overline{AAI} = 74.3$ (SD = 4.7)] were compared across their AQ scores and personality trait scores assessed by the GPP, GPI, and SIV using the two-tailed t test. Those having the most favorable stance toward abortion scored significantly higher on measures of Original Thinking ($p < .002$), Independence ($p < .05$) and possessed more knowledge of abortion ($p < .05$). They also tended to score higher on measures of Ascendancy ($p < .10$), Vigor ($p < .20$), and Sociability ($p < .20$). Individuals most opposed to permissive abortion tended to score higher on the measure of Conformity ($p < .10$). These findings are consistent, in general, with the

correlation findings between attitudes and personality attributes for the total general sample.

Phase II

Attitude Toward Abortion and Knowledge of Abortion Among Businessmen, Legislators, Physicians, and Religious Leaders

Attitude Toward Abortion

As shown in Table 16 attitudes toward abortion were found to differ significantly ($p < .001$) among businessmen, legislators, gynecologists and/or obstetricians, and religious leaders.

TABLE 16

ONE-WAY ANALYSIS OF VARIANCE OF ATTITUDE TOWARD
ABORTION AMONG PROFESSIONAL GROUPS

Source of Variance	df	MS	<u>F</u>	<u>p</u>
Between Categories	3	2690.8	14.64	0.001
Within Categories	285	183.8		
Total	288			

Using Scheffé's (1959) method of analysis to compare attitude between professionals, businessmen ($p < .001$), physicians ($p < .005$), and legislators ($p < .05$) were each more favorable toward permissive abortion than were religious leaders. Businessmen, clearly the most supportive toward liberalized abortion

among the four professional bodies, were significantly ($p < .025$) more favorable than were the physicians. No significant difference in attitude was found between legislators and physicians or legislators and businessmen. The pertinent data for each of these four groups are presented in Table 17.

TABLE 17
ATTITUDE TOWARD ABORTION AMONG PROFESSIONAL
GROUPS

Groups	<u>N</u>	Mean	Standard Deviation
Businessmen	79	36.32	12.68
Legislators	39	42.69	14.49
Physicians	98	43.02	14.45
Religious Leaders	73	50.89	13.25

The responses given to each AAI item by individuals of each professional group are presented in Appendix L. These data demonstrate striking differences among the professionals in their attitudes toward abortion under various specified circumstances. For example, of those who expressed an attitude other than "neutral," 57 percent of the businessmen, 33 percent of the legislators, 30 percent of the physicians, and 10 percent of the religious leaders strongly favored or tended to favor granting an abortion to a woman who was pregnant but unmarried. For

the circumstance of a "wife from a poverty stricken home," 60 percent of the businessmen, 36 percent of the physicians, 34 percent of the legislators, and 13 percent of the religious leaders reporting "non-neutral" attitudes strongly favored or tended to favor permissive abortion.

Knowledge of Abortion

Knowledge of abortion was found to differ significantly ($p < .001$) among gynecologists and/or obstetricians, legislators, religious leaders, and businessmen, see Table 18.

TABLE 18
ONE-WAY ANALYSIS OF VARIANCE OF KNOWLEDGE OF
ABORTION AMONG PROFESSIONAL GROUPS

Source of Variance	df	MS	<u>F</u>	<u>p</u>
Between Categories	3	233.0	43.08	0.001
Within Categories	261	5.4		
Total	264			

Using Scheffé's (1959) method of analysis, physicians were found to possess more knowledge of abortion ($p < .001$) than each of the other groups. Legislators, religious leaders, and businessmen did not differ between themselves. The pertinent data for each of these four groups is presented in Table 19.

TABLE 19
KNOWLEDGE OF ABORTION AMONG PROFESSIONAL GROUPS

Groups	<u>N</u>	Mean	Standard Deviation
Physicians	88	9.60	2.39
Legislators	34	6.56	2.31
Religious Leaders	68	6.09	2.39
Businessmen	75	6.07	2.19

Of the four professional groups, only the physician's AQ scores differed significantly from that expected by chance ($p < .02$; $z = 2.439$, two-tailed). The AQ scores of legislators ($z = .890$), religious leaders ($z = .659$), and businessmen ($z = .646$) did not exceed the chance level. Although the physicians' AQ scores differed from chance, on the average, they answered correctly less than 41 percent of the 24 AQ items. Legislators, religious leaders, and businessmen, on the average, answered correctly less than 28 percent of the items.

Knowledge of Abortion and
Attitude Toward Abortion

For religious leaders ($p < .01$) and businessmen ($p < .05$), AQ scores were significantly correlated with AAI scores, suggesting that within these two professional groups individuals who are more knowledgeable of abortion are more favorable toward permissive abortion than are

persons possessing less knowledge. The relationship between knowledge of abortion and attitude toward abortion for each professional group is presented in Table 20.

TABLE 20
PRODUCT-MOMENT CORRELATIONS BETWEEN KNOWLEDGE
OF ABORTION AND ATTITUDE TOWARD ABORTION
AMONG PROFESSIONAL GROUPS

Groups	<u>N</u>	Knowledge Mean	Attitude Mean	<u>r</u>
Businessmen	75	6.07	36.08	-.25*
Legislators	34	6.56	43.91	-.23
Physicians	88	9.60	42.76	-.04
Religious Leaders	68	6.09	50.51	-.32**

*p < .05; two-tailed

**p < .01; two-tailed

CHAPTER IX

A STUDY OF INDUCED ABORTION: ATTITUDES, KNOWLEDGE, PERSONALITY CORRELATES-- DISCUSSION

Phase I

Attitude Toward Abortion Among the General Sample

The respondents of the general sample (89 Lansing and East Lansing residents and 42 Michigan State University undergraduates) are more favorable toward abortion than have been the respondents of previous national and local surveys (Public favors abortion, 1966; Rossi, 1967, West-off, Moore, & Ryder, 1969; Kantner & Allingham, 1968; Harter & Beasley, 1967; The GH poll, 1967). This permissiveness is reflected primarily in greater approval of legalized abortion in an increasing number of social and economic circumstances.

Like respondents in previous studies, the individuals composing the present sample clearly favored permissive abortion when the pregnancy: (1) presents a risk to maternal physical or mental health, (2) presents a risk of a defective child, (3) is the result of rape.

Only a very small percentage (generally less than 20 percent) of the respondents in prior attitude research studies have been in favor of legalized abortion in socio-economic circumstances such as: an unwed mother, poverty, and if the mother did not want more children. More recently, Kantner and Allingham (1968; discussed in Chapter VI, Table 1, p. 151) found the percentage of persons favorable toward abortion in these situations to have increased to between 20 and 30 percent. An even greater increase in the percentage of persons holding a favorable position toward abortion for socio-economic reasons was found in the present study. A majority of this sample favored legalized abortion in the socio-economic circumstances of: (1) a woman judged by the court to be an unfit mother, and (2) a child which would be born unwanted and treated as such. Furthermore, a "strong" minority (the percentage favorable is stated in parentheses) favored abortion in additional socio-economic situations when: (1) the woman is pregnant but unmarried (47 percent); (2) the woman is pregnant and she is obtaining a divorce (47 percent); (3) the woman is 45 years of age or older (41 percent); (4) the wife is from a poverty stricken home (40 percent).

A distinct majority of the present respondents also asserted they would not "affectively condemn" a woman who seeks an abortion. To the contrary, they felt that a

woman who might seek this operation could be responsible, love children, and feel satisfied and comfortable with her decision to have the abortion and also with the results of this decision. One practical implication of these data is that they inform the woman who does want an abortion (when legally available) that a distinct majority of her compatriots will not be disapproving. It has been suggested that in many foreign countries where more liberal abortion has become legal, women still seek and subject themselves to the dangers of "underground" abortionists, because in their having to "publically" apply for the operation, they feel they would be criticized for their wanting and having the abortion (Marley, 1963). Rather than risk the "expected" criticism for having a legal abortion, many women are thought to still obtain a "private" illegal abortion. Informing women of this substantial public support for having an abortion (when the laws have become more liberal in the United States and the application procedure to obtain a legal abortion is strictly a private matter) may deter many from feeling the necessity of continued patronage of the "private," but more dangerous, illegal abortionist.

Also noteworthy was the finding that 77 percent of the respondents assert there are circumstances in which they would consider an abortion for themselves (female respondents), or (male respondents) circumstances in which

they would consider abortion for their wife or girlfriend. That many women will continue to seek an illegal abortion, regardless of prohibitive laws and hazards to their health, is suggested by this finding (even though the specific circumstances are not stated) that many persons openly admit they personally would consider abortion. Additional support for the continued patronage of the illegal abortionist is found in the magnitude of the estimated incidence of illegal abortion and in the extreme difficulty of enforcing restrictive abortion laws--difficulty enhanced, in part, by society's covert approval of abortion.

An Account of the Present Findings

To account for the respondents of the present sample being more favorable toward permissive abortion than were the persons surveyed in previous studies, three possible explanations are offered and discussed.

1. Characteristics of the measuring instrument.

The AAI presents a greater number of items concerning abortion under a greater number of circumstances than have been offered in previous studies. Because increasing the number of items serves to enhance the accuracy of attitude measurement, this instrument appears to more accurately assess the respondents' attitudes than have the more restricted measures used in previous studies. The finding that respondents of this sample tended to be

more permissive toward abortion may have resulted, in part, from the use of this more accurate, precise, and detailed measure. By assessing attitude over a greater variety of circumstances, the AAI allows the respondent to express attitudes over many aspects of the issue rather than limiting the expression of attitude to only a few items. Such a limited expression may result in the researcher's misperception of the respondent's more "global" attitude. The AAI may find people more favorable toward permissive abortion but some of this favorableness may have previously existed but could have been "invisible" because of insensitivities in the attitude measures used. Also, the 5-point Likert items making up the AAI permit a more precise measure of abortion attitude than do the "yes, no, undecided" 3-point items typically used in previous attitude surveys.

An important finding which has practical implications for abortion attitude research is provided in an illustration of the accuracy of the AAI and its permitting more precise conclusions from the data. Only 23 percent of the persons composing the present sample favored the granting of an abortion to any woman who requests one. From this finding, the researcher or reader provided with little additional information--as has been the case in many surveys using attitude measures with a limited number of items--may infer or conclude that "Only 23 percent of

the population favors abortion for unwed pregnant women." The error of such an inference is apparent when it is recalled that the present research also shows that the smallest percentage of favorable response to legalized abortion was 40 percent to any other AAI item. These individual items represented almost all of the circumstances (see Chapter VIII, pp. 242-243) which might conceivably have been subsumed in this "very general" item of granting an abortion on demand to any female. This clearly illustrates the importance of the wording of specific items and the caution which must be exercised in the interpretation of more "general" items. In the present example, the specification of a circumstance in which a woman may want an abortion appears to have yielded a greater percentage of permissive response than that which may have been inappropriately inferred from the response to this more general item which did not specify the circumstance. Essentially, conclusions as to whether people do or do not favor legalized abortion in a specific circumstance cannot be drawn unless the people are asked what their attitude would be in that specifically stated circumstance. This point is further demonstrated by inconsistencies in the findings of Harter and Beasley (1967). They found that 28 percent of their respondents thought that the "decision to have or not to have an abortion should be the right of every woman" while only 5 percent of these same persons felt that a woman "should

be allowed to have an abortion" if she is pregnant but already has more children than she can care for in her situation. Only 2 percent of their respondents thought a woman should be allowed to have an abortion if she becomes pregnant but does not want any more children (see Chapter VI, page 156).

The large number of "circumstantial" items in the AAI enables the researcher to draw conclusions pertinent to specific situations and reduces the inappropriate inferences as to the respondent's attitude toward abortion in specific but unstated circumstances from his response to a "general circumstantial" item.

2. Characteristics of the general sample. The sample may be biased by being composed entirely of Michigan residents (persons residing in Lansing and East Lansing and students attending Michigan State University) and by its underrepresentation of lower class (class V) respondents.

Certainly the restriction of the sample to Lansing and East Lansing residents and students may result in findings which could differ from those of either more conservative or more liberal regions. However, the present sample's responses to items which concern the granting of abortion in cases of maternal health and rape compare very closely with the trend of responses to similar items among representative national samples. This

similarity of response suggests that, while regional differences are important, the area restriction of the present sample did not seem to produce unrepresentative trends.

Because the underrepresented class V persons are the least favorable toward permissive abortion, it is conceivable that the response of this total sample would be less favorable toward legalized abortion had class V people been more accurately (proportionally) represented. Many of the items which most sharply differentiate the attitudes of class V from those of the remaining classes are the "affective items"--concerning the aborting woman's responsibility, love of children, her satisfaction with her decision and its results, and misfortune after the operation. Class V respondents are also much less favorable toward abortion in circumstances of poverty, unwed motherhood, and when the child would be unwanted and treated as such.

However, class V persons are not as opposed to legalized abortion as are some of the upper classes in circumstances where a woman 45 years of age or older, or a woman pregnant and obtaining a divorce, is seeking an abortion. For these situations, among the five classes, class V ranks first and third, respectively, in being more favorable toward permissive abortion. Also a majority of class V respondents, as do a majority of

those in all other classes, favor permissive abortion for reasons of: (1) risk to maternal physical or mental health, (2) rape, (3) a court-judged unfit mother, and (4) risk of fetal deformity. Furthermore, although class V is the most "affective condemner" of women who seek an abortion, 80 percent of the class V respondents (second largest percentage among the five classes) state there are circumstances in which they would seek an abortion.

Consequently, it appears safe to conclude that the extent of the favorable response to permissive abortion would have been lower had the sample, as a whole, been more representative of the class V population. However, it also appears that this lowered percentage of favorable response would not significantly alter the finding of a trend of increased favorableness (compared to earlier samples) toward legalized abortion.

3. Changing attitudes. Over time attitudes toward abortion have become more permissive. Because the present sample is reasonably representative and because the AAI provides an accurate assessment of respondent attitude, the most plausible conclusion which can be drawn from the present findings is that these data demonstrate the trend of increasing public permissiveness toward abortion. The origin of this trend of growing permissiveness was earlier suggested in the findings of studies discussed in Chapter VI, pp. 151, 170). Its continuance is

reflected in the findings of the present study and its subsequent advancement is demonstrated in more recent surveys (Changing morality, 1969; Colorado abortion reform assessed, 1969; discussed in Chapter VI, pp. 216-218).

Knowledge of Abortion

That the general sample participants did not exceed the chance level in the number of AQ items answered correctly strongly implies that the general public possesses little, if any, factual knowledge about the practice of legal and illegal abortion. This general lack of valid information undoubtedly serves to enhance the number of women who experience physical injury from the "work" of an illegal, unskilled abortionist or from their own attempts at self-induced abortion. Unaware of which "abortion techniques" may result in their physical impairment, or even death, women may attempt self-induced abortion or permit others to "operate" on them with faulty and dangerous procedures which may ultimately result in physical injury, permanent impairment, or death. Perhaps if women were made aware of the "abortion techniques" which often produce harmful results, the number of illegal abortion injuries and deaths could be reduced. However, it also seems reasonable to suggest that many women who seek illegal abortion may be so "desperate" for the operation that the method used to induce abortion and

its consequences are of little momentary importance. Nevertheless, the dissemination of factual knowledge concerning abortion and conditions in which it can be a dangerous procedure may serve to prevent some women from physical harm or death.

Finding that people lack a factual knowledge of abortion also suggests that many persons' attitudes toward abortion do not incorporate an awareness of the reality of abortion. In forming and expressing attitudes which may affect a policy which could influence the lives of countless persons, certainly a factual knowledge of abortion should encompass the formation and expression of these attitudes. To foster the necessary relationship between abortion attitudes and knowledge, information pertinent to induced abortion--its practice, incidence, and consequences--should be widely and openly disseminated among the public. While books are presently the main avenue of dissemination, more extensive use of television, radio, and newspaper articles might be appropriately and successfully applied toward this goal.

Attitude Toward Abortion Related to Knowledge of Abortion

Although people, in general, possess very little factual knowledge of abortion, it is notable that those persons who are more knowledgeable are more favorable toward legalized abortion. While the direction of

causation, is unclear, this finding supports the active dissemination of factual knowledge in that the wide availability of such information might importantly influence persons' attitudes toward abortion law revision. More specifically, it appears that dissemination of such factual data may foster a more permissive stance toward legalized abortion.

Attitude Toward Abortion and Knowledge of
Abortion Among Demographic Groups of
the General Sample

Residential Status

That the students are more favorable toward permissive abortion than are the Lansing and East Lansing residents is specifically and dramatically illustrated in the greater student approval of legalized abortion for social and economic reasons. For the following socio-economic circumstantial items, the bracketed numbers represent the percentage difference in favorable response for students and city residents: unwed mother (35), poverty stricken home (26), woman 45 years of age or older (25), any woman requesting an abortion (24), child unwanted and treated as such (17), woman pregnant and obtaining a divorce (16). See Appendix H, Table H1.

Although the students assume a more permissive stance toward abortion, they tend to possess less factual knowledge of abortion than do the city residents, although neither group correctly answers items above the chance

level (see Appendix I). However, within each of these demographic categories, attitude and knowledge are related such that persons who are more knowledgeable of abortion are more favorable toward legalized abortion.

These findings suggest that students, through college curricula and the related academic environment, may be more pointedly aware of and impressed with the need for more immediate solutions to problems which, in general, foster suffering and hardship among mankind. Several of the more obvious and debated situations which adversely effect mankind are those of poverty, parent-damaged unwanted children, forced marriage, a woman's agony of bearing an unwanted child, and overpopulation. More to MSU students than to Lansing and East Lansing residents, permissive abortion may be seen, in part, as a method and one's right to alleviate individual suffering and societal pain. Because the composition of the residential status groups is very similar to that of the marital status groups, the subsequent section may lend additional information to the above discussion.

Marital Status

In paralleling residential status differences, single persons tend to be more favorable toward permissive abortion while the marrieds tend to possess more factual knowledge of abortion. Also, for both marrieds and

singles, increased knowledge is associated with a more permissive attitude.

Because most of the singles in the present sample were MSU students and most of the married respondents were city residents, the present discussion of attitudes relative to marital status is complicated by and intertwined with the influence of the academic setting, as opposed to the residential setting, discussed in the previous section. However, the more permissive stance of the singles may reflect their concerns of not being ready to personally assume the responsibility of parenthood in addition to their sensitivity to the alleviation of human hardship. Also, a single person's possible concerns of illegitimacy and his wanting to exercise a personal choice of having or not having a child in such a situation may have a "halo effect" in his response toward permitting legalized abortion in other social or economic circumstances.

In making the marriage commitment, the individual typically expresses more of a desire to assume the responsibilities of parenthood. Also, a married person may feel he conceived and raised a child in times of personal hardship and these feelings may foster a "halo effect" in a more general disapproval of abortion. He may expect others to be able and/or willing to raise children in times of hardship as he has done. As a married person he is unaware that his "life style"

(social and economic), regardless of hardships, may be more stable than that of singles.

When expressing their attitudes toward permissive abortion, marrieds may also be influenced by feelings of hostility toward their pregnancies and/or experiences of child rearing. For these people, expressing a favorable stance toward permissive abortion may be confusingly intertwined with having to "admit to themselves" such socially taboo feelings of hostility toward children. Society generally asserts that parents should always love their children, a stance implying that feelings of hostility toward their pregnancies and children are taboo. Expressing a less favorable attitude toward permissive abortion may serve to keep these psychologically disturbing feelings of hostility out of the respondent's "awareness."

However, because abortion may have actually been considered by married persons with overtly or covertly unwanted children, marrieds may have been more motivated than singles to seek out factual information pertinent to the practice of abortion. Consequently, married persons may possess more factual knowledge of induced abortion.

Sex

The finding that males tend to be more permissive toward legalized abortion than do females does not support a common contention that, "If womens' attitudes, as

opposed to mens' attitudes, were observed, our present abortion laws would be different." A more appropriate statement might be, "If the attitudes of men and women, particularly men, were incorporated in law by legislative and/or court action, our present abortion laws would be different."

Because males and females were not found to differ in the extent to their knowledge of induced abortion, knowledge does not appear to be a factor influencing their difference in attitude. The males' more permissive stance is considered to reflect, in part, a male's being more able to have and openly express negative feelings about raising unwanted children. Society is more tolerant of a male's, rather than a female's, expressing feelings of not wanting to parent a child. From the early days of childhood, society teaches the female that she "should" want children regardless of whether a child born to an adult female is actually wanted or unwanted. These early and persistent teachings, as well as a woman's biological make-up and functioning, often may make it difficult for her to "admit" a child is unwanted.

In terms of their response to individual AAI items, males and females tend to express similar attitudes toward abortion in economic and medical circumstances. Males are appreciably more permissive toward legalized abortion than women for social indications, particularly in the case of an unwed mother and when the child is unwanted and would

be treated as such. That males so respond under these two particular circumstances, possibly suggests or predicts that a male who is "forced" into marriage because of an illegitimate pregnancy and/or is confronted with an unwanted child may treat the child in a manner which is detrimental to the child and ultimately to society. While the male's attitude toward abortion as expressed in these two circumstantial items may be seen by some persons as an evasion from responsibility for sexual conduct, it seems more important to "put aside" this moralistic judgment and "hear" that the male may be expressing his fear of future adverse treatment of such a child and that he is asking to use abortion as a method to "eliminate" an undesired situation so that he does not later harm his unwanted child.

As earlier reported in Chapter VI (p. 164), findings of sex differences in attitude toward abortion have varied between studies and no clear conclusions could be drawn. Rossi (1967) reported males to be more favorable, Hartman (1967) found females "somewhat" more favorable, and ASA survey of public opinion (1968) found "no demonstratable difference" in the attitudes of the sexes. Inspection of male and female response to individual items in the present study yields suggestions as to why prior studies have found inconsistent sex differences. Males and females of the present study, in general, tend to hold similar attitudes toward permissive abortion for medical or economic reasons.

However, males appear to be much more favorable toward abortion for social indications. Thus, among studies of sex differences in attitude, the contradictory findings may be, partly, a function of the specific instrument used to measure attitudes. Possibly because the instrument (AAI) offered more items inquiring of one's attitude toward abortion for social reasons than did the previous instruments, a tendency for males and females to differ in their attitudes toward abortion was determined. This overall trend of difference in attitudes apparently was due to a specific difference in male and female attitudes toward abortion for social indications. Consequently, to measure existing sex differences in attitudes, the attitude measure must have a number of items seeking one's approval or disapproval of legalized abortion for social indications.

Interaction Between Respondents' Sex and Marital Status

Because the interaction between attitude and sex by marital status approached statistical significance ($p < .10$), these data were further explored. It was subsequently found that single males appear to be more favorable toward permissive abortion than each of the remaining groups--single females, married males, and married females--who were very similar in their general attitude. This finding possibly lends some clarification to the previous two sections (Sex and Marital Status)

suggesting that more for single males, as opposed to singles and males as discrete categories, the possibility of parenthood causes apprehension, fear, and concern. The single male's general lack of readiness to become a father and possible feelings of being inadequate as a father may influence him to be more permissive toward abortion than:

- (a) single women who look forward to fulfilling the "mature woman's role" of motherhood, which they have been taught to seek and to anxiously anticipate from early childhood on,
- (b) married mothers who are actually living this "dream" of mature womanhood or who, lacking children, anticipate their role as a mother, and
- (c) married males who, if they do not have children, have at least committed themselves through marriage to the possibility of being a father and of dealing with related fears, or who, if they are fathers, have more generally, on some level, dealt with their earlier fears and concerns of fatherhood.

Age

Because the younger MSU students were more permissive toward abortion than were the Lansing and East Lansing residents, one might expect that age would correlate significantly with attitude. However, this was not the case. There was no significant relationship between age and attitude. In general, the attitudes of older and younger persons are similar. This finding suggests that the growing trend of increasing

permissiveness toward induced abortion is not localized within what opponents of permissive abortion might term the more "liberal and rebellious youth," but rather permeates the attitudes of persons of all ages.

This lack of linkage between age and attitude is consistent with the findings of ASA survey of public opinion (1968) but is contrary to the findings of Hartman (1967) and those of Harter and Beasley (1967). This discrepancy in the findings may have resulted from the lack of using specific age intervals for the purpose of analysis in this study as did Hartman (1967) and Harter and Beasley (1967). While both approaches, isolating or not isolating age intervals, are statistically sound, the present approach of using the age and attitude score of each individual as a discrete case gives a more complete picture of the actual relationship between age and attitude.

Just as there was no linkage between age and attitude, there was no significant relationship between age and knowledge of abortion. Although older people have the benefit of additional years during which they could have sought information, older and younger persons generally do not differ in the extent of their knowledge of abortion.

Religious Preference

Of the three major religions sampled in the present study, Catholics were most opposed; Jews, most favorable; and Protestants, intermediate, in their attitudes toward permissive abortion. A majority of Catholics favor legalized abortion only in the circumstance of rape. However, an examination of the percentage of Catholics favoring abortion in specified situations and comparing these data with that of previous studies (Public favors abortion, 1966; Rossi, 1967; Kantner & Allingham, 1968) does lend support to the evidence that among Catholic laymen there is a trend of increasing permissiveness toward legalized abortion. Although somewhat less favorable of abortion for medical indications, the response of the Catholics composing the present sample demonstrates among Catholics this trend of greater approval of abortion in social, eugenic (such as possible fetal deformity), and economic circumstances.

Protestants and Jews of the present study responded to the AAI items so as to support the findings of national surveys which suggest a trend of increasing Protestant and Jewish approval of legalized abortion for medical, eugenic, social, and economic reasons. A majority of both Protestants and Jews in the present sample favor legalized abortion in medical (physical and mental health) and eugenic (rape and fetal deformity) circumstances;

also, in cases where a woman has been judged by the court to be an unfit mother and where a child would be born unwanted and treated as such.

While a large minority of the Protestants in this sample favor legalized abortion in the social and economic circumstances of an unmarried woman (46 percent), a woman pregnant and obtaining a divorce (45 percent), a woman 45 years of age or older (38 percent), and a poverty stricken home (37 percent); a majority of Jews approve abortion in these situations.

That Catholics are least; Protestants, moderate; and Jews, most favorable toward legalized abortion can be viewed as a reflection of the extent to which abortion is of specific moral concern to each of these religious groups. As discussed in Chapter VI, the Catholic Church has been very outspoken both toward the general public and within its constituency in its nearly absolute disapproval of permissive abortion. The Protestant churches, as a whole, do not take a strong outspoken stance either for or against legalized abortion and leave the development of such a stance to the individual denominations. Therefore, attitudes differ among the Protestant churches and little organized fervor is attached to either pro or con positions assumed by each denomination. That many Protestant denominations have not stated an official position toward legalized abortion, may serve to

demonstrate that Protestants, in general, are uncertain of their stance and, therefore, tend to be relatively moderate in their attitudes. For the early Hebrew religion, abortion was prohibited by the religion's leaders apparently as an approach to maintaining the civilization's existence (see Chapter V). However, Judaism has progressively stated that an abortion policy should be relevant to society's present needs rather than relying upon vague, early Hebrew scripture writings. This growing tendency within Judaism to adopt a stance toward permissive abortion which is consistent with society's needs, would permit Jews to hold a relatively liberal position toward abortion.

Both the present and prior research studies show that Catholic laymen take a much more liberal stance toward abortion than strict adherence to Catholic doctrine would permit. The principle of double effect and "situational values" (see Chapter VI) would permit some favorable response toward permissive abortion in the respective cases of risk to maternal life and pregnancy following rape. However, with many Catholic laymen approving of abortion in medical (health) and eugenic (fetal deformity) circumstances, and their growing approval of abortion in social and economic situations, a significant proportion are expressing their dissent with the Catholic Church's official prohibitive position.

Persons claiming a preference for Catholicism, Protestantism, and Judaism did not differ significantly in the extent of their knowledge about induced abortion. However, Jews tended ($p < .10$) to be more knowledgeable than Catholics. Within religious groups, only for Protestants was there a significant relationship between attitudes toward abortion and knowledge of abortion--greater knowledge was associated with more permissive attitudes. These findings suggest that Catholics, as the "extremists" opposing permissive abortion, may tend to "shut out" factual information more so than Jews who are the "extremists" in support of permissive abortion. However, neither Catholics nor Jews presently appear able to "alter" their "extremist" attitudes through available abortion information. The traditionally greater "knowledge seeking" behavior of Jews may serve to reinforce existent "liberal" attitudes while the Catholics' relative "avoidance" of factual knowledge may serve to maintain their relatively restrictive attitudes.

Contrary to the Catholics and Jews, Protestants, who as a group hold a position toward permissive abortion which is intermediate to those positions of Catholics and Jews, do demonstrate among themselves that a more favorable attitude toward abortion is related to greater knowledge of abortion.

The practical importance of these findings is found in the "suggested" conclusion that persons moderate in their abortion attitudes may become more favorable toward legalized abortion if they were presented more factual information pertinent to abortion. However, persons with "extremist" attitudes may have their attitudes relatively unaffected by such information. In an attempt to alter the stance of "extremists" (more so than "moderates"), one may need to introduce emotional aspects associated with the factual material rather than just present "isolated" factual data. For maximum effect, such factually related emotions should be consistent with current emotions which are strongly felt by the individual. Although a person may express attitudes opposed to permissive abortion, generally he also has emotions which would suggest a more permissive approach. For an individual opposed to legalized abortion in certain circumstances, "cognitive dissonance" may be fostered by emphasizing emotional aspects of factual data so that this new emotional input reinforces as many as possible of the already existing emotions which would permit a more permissive stance toward abortion in that circumstance. For example, someone may be opposed to legalized abortion for unwed mothers but also have strong emotional feelings that children should not be physically abused by their parents and that children should not

maliciously destroy others' property. Presenting factual data which show that a large percentage of the "battered children" and children who frequently destroy property are the offspring of unwed mothers; and, emotionally linking this knowledge with the person's already existing feelings about "battered children" and destructive children, may facilitate an attitude shift toward a more permissive attitude toward abortion for unwed mothers. Certainly the "validity" of one's attitude held prior to this new "emotional-factual" input would be more questioned, perhaps for the first time, than had the factual data been presented in "emotional isolation." Consequently, while the vector of an attitude may not completely shift with the first presentation of such emotional-factual material, the attitude may become more vulnerable to alteration with the presentation of subsequent emotional-factual data.

Socio-economic Status

Similar to the findings of Rossi (1967) and ASA survey of public opinion (1968), the present study found a significant relationship between socio-economic status and attitude toward abortion--persons of higher socio-economic standing were more permissive toward abortion than were persons of lower standing. With the respondents categorized into discrete socio-economic classes, persons of highest class standing (class I) were distinctly more favorable toward legalized abortion than were persons with

least class standing (class V). Class I members also held a more permissive position than did persons composing the combined middle classes (classes II, III, IV). Class II, III, and IV persons tended to be more permissive toward abortion than were class V persons.

A tentative explanation of this discrepancy in class attitude concerns the "meaning" of a child for higher as opposed to lower class members. The more educated, higher income individual has the capability of possessing a relatively greater number of materialistic goods and of developing many skilled and creative activities. However, the poorly educated, low income person possesses relatively few material goods and he has less opportunity to develop activities which society would consider creative or skilled. Consequently, more so for the more deprived individual than for the "well-to-do" person, a child may become a materialistic possession as well as an affective possession which serves as a symbol to the more deprived individual that he also is a productive, creative, worthwhile, and potent person. To a certain extent, the greater the number of children produced in a deprived family, the more likely a male may feel he is an adequate and powerful person and a female may receive assurance that she is worthwhile for her "creation" and mothering of her offspring. For a lower status individual to assume an extremely favorable stance toward permissive abortion, he would have to

"devalue" one of the very few methods through which he attempts to generate a sense of self-worth and, consequently, he would also be "devaluing" his own self-concept. Such a personal devaluation would be extremely threatening and even thoughts of condoning abortion would be attached to threatening feelings of personal devaluation. Defensive counter-measures may often serve to maintain and enhance a more negative stance toward legalized abortion in such persons. Even though legalized abortion might enable a socially and economically deprived parent to improve the financial condition of his family and enhance the general well-being of each family member, these "benefits" would not be "appreciated" because the deprived individual's most immediate concern is to prove his self-worth and he sees the procreation of children as his accessible way of satisfying this concern.

Support for this tentative hypothesis which accounts for the difference in abortion attitudes among the upper and lower classes is suggested in finding that class V persons appear distinctly more negative toward permissive abortion in their response to the "affective" AAI items (misfortune after abortion, item #3; a woman who loves children, #11; irresponsible woman, #14; feel satisfied and comfortable, #16). See Appendix H, Table H5.

Whereas the "function" of children for different class members is suspected of being a strong influence in determining class differences in attitude toward abortion, the amount of factual knowledge of abortion possessed by members of different classes does not appear to be a factor influencing class differences in attitude. Perhaps because no social class reached the "threshold" of above-chance knowledge, no significant differences were observed between classes. However, when considering the relationship between attitude and knowledge within classes, a finding somewhat similar to that reported for groups categorized by religious preference was determined. Among the "middle classes" (classes II, III, and IV), relatively moderate in their stance toward abortion relative to the more permissive class I attitude and the more prohibitive class V attitude, class III and class IV demonstrate a relationship between the extent of their knowledge and their attitude--with the more permissive attitude being associated with more factual knowledge about abortion. The relationship did not achieve statistical significance for class II members. The more permissive class I also reveals no significant relationship between knowledge and attitude. However, class V, which is most disapproving of permissive abortion, does demonstrate a significant association between knowledge of abortion and attitude toward abortion, but this relationship is the opposite direction of that earlier reported for the "moderate middle classes." For

class V respondents, a more permissive attitude is related to a lesser amount of knowledge. To account for this relationship among class V persons, it may be that the progressive accumulation of knowledge which indicates that a class V individual's welfare might be enhanced if abortion laws were more permissive comes into increasing conflict with his needing to produce children to most immediately develop and/or maintain feelings of self-worth. Because class V persons have found procreating children to be one of the few available methods to establish immediately needed feelings of self-worth, thoughts of endorsing permissive abortion become dissonant with those of procreating children--the increased personal welfare which might accompany more permissive abortion policies may be viewed as too far distant to satisfy immediate needs of self-worth. The resolution of such dissonance could be achieved by expressing attitudes more opposed to legalized abortion and having less "awareness" of factual data pertinent to induced abortion.

Personality Attributes and Attitude
Toward Abortion

Among those undergraduates who volunteered their CQT scores, students who scored higher on the CQT were more permissive in their stance toward abortion than were students who scored lower. This finding suggests that more intelligent students are more favorable toward legalized abortion than are less intelligent students.

Among the general sample, persons who scored higher on the measures of Original Thinking ($p < .001$), Independence ($p < .001$), Ascendancy ($p < .05$), Leadership ($p < .06$), and Sociability ($p < .11$) were more favorable toward permissive abortion than persons who scored lower on these measures. For the traits of Benevolence ($p < .01$) and Conformity ($p < .05$), persons scoring higher on these measures took a less favorable stance toward permissive abortion than did persons scoring lower.

These findings from the general sample imply that a person more favorable toward legalized abortion is inclined to possess traits which characterize him as an effective, liked, and innovative leader.* He displays a greater interest in dealing with and in solving thought-provoking problems. Perhaps the abortion issue itself is such a problem. In solving these problematic situations, he likes to use his own mind to arrive at the problems' solution. As an unusually confident and self-assured individual, the person more favorable toward legalized abortion is also more able to present his personal ideas in working toward a group solution of problems.

The person less favorable toward permissive abortion tends to be more passive, dependent, less

*In explaining the implication of these attributes related to attitude findings, strong adherence is given to the definition of these attributes as presented in Appendix D (p. 406).

self-assured, and often restricted in social contacts. Rather than increase his understanding of a problem (such as abortion), he is reluctant to gain knowledge which might be pertinent to the problem's solution. He simply dislikes or takes little interest in finding a solution to such problems. He generally adheres to what his reference group has stated to be correct, accepted, and proper. The person more opposed to permissive abortion appears less able to view abortion as a "newly discovered" problem. He is less able to understand that: (a) society's overt prohibitive abortion mores have not been congruent with society's widespread covert use of abortion, and (b) that the approach to this widespread use of "illegal" abortion may need to be changed from that of ineffective, unpracticed, and difficult to enforce prohibitive mores. He dependently conforms to reference group philosophy which generally dictates that the use of abortion is bad or immoral and should not be permitted. Consequently, with his dislike and disinterest in dealing with and working out solutions to such thought-provoking problems and his strict adherence to descriptions of abortion as wrong or immoral, the person less favorable toward permissive abortion finds it difficult to view the induced abortion situation "realistically," rather he "sees" the situation "emotionally" and does not contribute toward its solution.

Of interest is the finding that persons less favorable toward permissive abortion scored higher, on the average, on the Benevolence measure. Benevolence viewed with respect to abortion could refer to concern for the mother, fetus, or child after birth. Apparently the Benevolence of persons less favorable toward legalized abortion more strongly relates to concern for the existence of the fetus than for the welfare of the mother. A person more permissive in his stance toward abortion may be more involved with solutions to the specific problem and not as "emotionally involved" with what is for him an abstract fetus, mother, or child.

The development of sound, general public policy on such matters probably requires some degree of emotional detachment rather than high emotional involvement with either the mother and/or the fetus. Although persons less favorable toward abortion are more Benevolent by this particular index, the scores of persons more favorable toward legalized abortion still fall within the average range of Benevolence scores for the general public. Thus, persons favorable toward induced abortion appear to have "some emotional involvement" for the mother and/or fetus, but much of their involvement apparently concerns the mother's total well-being. Consequently, the general pattern of personality attributes linked with the attitude findings suggest that persons more favorable toward

permissive abortion are capable of finding a solution to the abortion problem. These supporters of permissive abortion appear more able than persons with a less favorable stance toward abortion to derive a solution which could be generally accepted by society.

Personality Attributes and Attitude Toward
Abortion Among Demographic
Classifications

Appendix K presents the relationship between personality attributes and abortion attitudes for each demographic subdivision of the general sample. However, the present discussion only concerns the findings relevant to: (a) persons who profess a preference for one of the three major religions, (b) women, and (c) class V respondents. These data best demonstrate how personality traits may relate to attitudes toward legalized abortion.

Catholics

Among the three major religions--Protestantism, Catholicism, and Judaism--persons professing Catholicism were found to be the most opposed to liberalized abortion. Because Catholics have often been considered (Lader, 1966a; Kinsolving, 1964; Hall, 1968) to be the main source which blocks legislative passage of more liberal abortion laws, it is of particular interest to focus upon the personality attributes and the attitudes of the Catholics ($N = 32$) which compose the present sample.

While those Catholics more favorable toward permissive abortion scored higher on measures of Independence ($p < .005$) and Emotional Stability ($p < .07$), Catholics more opposed to legalized abortion scored higher on measures of Conformity ($p < .05$), Benevolence ($p < .05$), and Vigor ($p < .09$). These findings imply that among Catholics, those who take a more permissive stance toward abortion are much more able to make their own decisions and tend to be more well-balanced and relatively free from anxieties and nervous tension than do Catholics holding a less permissive stance. The more anti-abortion Catholics adhere more rigidly to (Church) regulations and stated dictates of what is accepted and proper and tend to be more anxious, hypersensitive, nervous, and have lower levels of frustration tolerance than do more permissive Catholics. Also, Catholics more opposed to legalized abortion tend to appear more benevolent and more active and energetic than do Catholics more favorable toward abortion.

These findings can be interpreted to support the view that Catholics more opposed to legalized abortion use their traits of greater conformity and vigor to protect themselves from their relatively more prevalent feelings of anxiety and nervousness. Conformity structures and restricts the number of situations and ways of thinking about situations which otherwise could increase the person's anxiety and frustration. Conformity also enables

these more anxious individuals to adopt a limited number of clearly defined specific ways to "vigorously" deal with restricted and defined situations. The vigorous, active, and energetic manner of dealing with a strict and narrowly defined situation further serves to ward off anxiety for the individual by limiting the time he would otherwise have to confront his thoughts, desires, or situations which could render him more anxious. Those Catholics, opponents of legalized abortion, may guard against increasing their already more prevalent anxiety by strongly adhering unquestioningly to Church dictates and reacting vigorously in ways which are limited by the Catholic's conformity to such strict, specific, and limited Church regulations. Their stance toward abortion is dictated for them and it is stated to be absolutely prohibitive. Consequently, they need not consider the implications to mother, child, family, and society in a variety of difficult situations for which a woman may request an abortion. This limiting and structuring of the "abortion situation" may provide security for an otherwise more confused and anxious Catholic. Also, he can now react and he is encouraged to react in a vigorously outspoken, prohibitive manner toward proposals for more permissive abortion laws. If the vigorous activity of the anxious Catholic, prohibitive toward permissive abortion, were more generalized, he would probably score relatively higher on the measure of Original Thinking--developing

new ideas and liking to deal with and to solve a variety of difficult thought-provoking problems. However, his greater need for conformity, limits, and structure to protect himself against increased anxiety if he were to expand his scope of creative ideas and attempt to deal with and solve a greater variety of problems, restricts his development of Original Thinking.

An important implication which one may be able to derive from this discussion is that the strongest Catholic opposition to abortion law revision may actually be coming from a relatively small number of Catholics who would become more anxious and confused if abortion were not dealt with as dictated by the narrow and, for them, psychologically protective Papal position toward abortion. However, this small number of Catholics is a very active outspoken group which mistakenly may be interpreted as speaking for all Catholics. Hall (1968) points out that attitude polls have shown that the majority of Catholic laymen do favor more permissive abortion laws.

Protestants

Among the present sample of Protestants ($N = 82$)--holding a moderate stance toward abortion as compared to the more prohibitive Catholic stance and the more liberal Jewish position--those more favorable toward permissive abortion scored higher on measures of Ascendancy ($p < .05$),

Vigor ($p < .06$), Original Thinking ($p < .08$), Leadership ($p < .11$), and Independence ($p < .12$). The more prohibitive Protestants scored higher on the measure of Benevolence ($p < .05$). These data strongly suggest that the Protestants more favorable toward legalized abortion--as compared to those Protestants less favorable--are more likely to create their own ideas, arrive at their own decisions, and find possible methods of dealing with and solving problem situations while working actively, energetically, and effectively as a confident, self-assured leader or group member.

It is to be noted that, contrary to the Catholic data, within the Protestant sample, those most favorable toward permissive abortion were the more "vigorous." However, for these more permissive Protestants, their activity and energy were accompanied by qualities of self-confidence, self-assuredness, and a desire to make their own decisions in working with a variety of difficult problems. On the other hand, the activity and energy of these more prohibitive Catholics were accompanied by qualities of conformity, nervousness, tension, and a low level of frustration tolerance. Such a comparison of persons and their traits and attitudes appears to support the earlier contention that the vigor of the most prohibitive Catholics when applied to a limited and structured situation would serve the function of

protecting them from anxiety. The vigor of the self-confident, independent Protestants most favorable toward abortion, however, could be more used as a tool to implement their own ideas and to solve a greater variety of problem situations rather than to function as a defense for anxiety.

Jews

Among the small sample of persons expressing a preference for Judaism ($N = 7$), those more favorable toward permissive abortion scored higher on the measure of Independence ($p < .05$); those less favorable scored higher on measures of Responsibility ($p < .06$), and Conformity ($p < .11$).

Because this Jewish sample consists of only seven persons, any discussion must be highly speculative. The Jews as a minority group may view their upward mobility as a necessity for their "survival." To move upward in the social structure often requires the avoidance of premarital pregnancy and restriction of family size. The Jews more opposed to permissive abortion may more "responsibly conform" to established birth control measures; but the Jews more favorable toward permissive abortion may be less vigilant in their use of contraception and, consequently, view abortion as a necessary way to prevent unwanted pregnancies which would hamper this upward mobility. However, the highly speculative

nature of this interpretation must be re-emphasized in view of this minute sample. It must be also noted that the Jews as a group were significantly more permissive toward abortion than were the Catholic and Protestant samples. Even these Jews who scored highest on the Responsibility measure were still relatively very permissive toward abortion.

Females

Among the sample of females ($N = 71$), women more favorable toward legalized abortion scored higher on measures of Original Thinking ($p < .005$), Independence ($p < .01$), and Leadership ($p < .07$) than did women more opposed to legalized abortion. Women less favorable toward permissive abortion scored higher on measures of Recognition ($p < .06$), Benevolence ($p < .09$), and Conformity ($p < .10$). Of particular interest is the finding that women more opposed to legalized abortion are apparently in greater need of recognition ("being looked up to and admired, being considered important, attracting favorable notice, achieving recognition"--Gordon, 1960, p. 3) than are women more favorable toward permissive abortion. A suggested interpretation of this finding is that a woman more opposed to legalized abortion is more likely than a woman more favorable toward abortion to use her children as instruments to gain admiration, importance, and favorable attention. For a woman more

opposed to abortion, having children may be one of the few methods she "knows" of proving her womanhood and self-importance. A young child's dependence upon her for his survival provides her with attention and feelings of importance. As her child grows he "admires" her as an "all knowing mother" and as he continues to grow the woman more prohibitive toward abortion can vicariously live her offspring's accomplishments. She also receives admiration and attention from her friends for her child's deeds.

A woman more favorable toward abortion may feel feminine, important, admired, and attended to through other accomplishments as well as that of bearing children; but for a woman more opposed to abortion, bearing children may be one of very few ways she knows of to prove her possibly doubted femininity and importance. In extreme cases, some women who are more opposed than are other women to permissive abortion may produce children which function as pawns to gain their desired "recognition" in the socially approved role of mother.

Class V

Because class V persons would appear to benefit most from the passage of more permissive abortion laws through the alleviation of economic hardship and frustration, enhancement of upward socio-economic mobility, and reduction of the number of suffering deprived persons, it seems paradoxical that class V is the class

most opposed to abortion law revision. The relationships among the attitude and personality attributes for persons belonging to this class is, therefore, of special interest. One possible explanation of the class V attitude toward abortion was presented on pages 287-291 of this chapter. For class V persons, the only personality attribute which was found to correlate significantly with attitude toward abortion was that of Personal Relations ($p < .05$). Those persons more opposed to legalized abortion were found to have greater faith and trust in people and to be more tolerant, patient, and understanding than those class V persons more favorable toward permissive abortion. Because of the considerable possibility that this finding could have occurred by chance--only one of the 14 relationships was found to be statistically significant--and because only five persons compose the present sample of class V respondents, these attitude-attribute findings for class V persons must be considered quite speculative.

To account for the finding that class V persons more opposed to legalized abortion score higher on the measure of Personal Relations, it is suggested that these people, more prohibitive in their abortion stance, are more accepting of their pregnancies and are more patiently, faithfully, and trustingly hopeful for "the best." While their pregnancies and resultant children provide these people with feelings of self-worth, they will hope that

"somehow" their financial and social situation will become better for them and their "growing" family.

Phase II

Attitude Toward Abortion and Knowledge of Abortion Among Businessmen, Legislators, Physicians, and Religious Leaders

Attitude Toward Abortion

Businessmen were found to be clearly the most favorable and religious leaders the least favorable toward legalized abortion. Physicians (obstetricians and/or gynecologists) and legislators, similar in their general attitude toward abortion, occupied close intermediate positions. Businessmen expressed a permissive stance toward abortion in each of the circumstances presented in the AAI items with the exception of their disapproval of granting an abortion to any woman requesting one. They favored legalized abortion for social and economic reasons as well as for medical and eugenic indications.

A majority of physicians, legislators, as well as religious leaders favored permissive abortion in cases of rape, fetal deformity, risk to maternal health, and a psychologically unfit mother. Unlike the religious leaders, a majority of physicians and legislators also favored abortion for a court-judged unfit mother. A majority of none of these professional groups favored abortion in the socio-economic circumstances of: a

pregnant but unmarried woman, any woman requesting one, a poverty stricken home, a woman 45 or more years of age, a woman pregnant and obtaining a divorce, a child which would be unwanted and treated as such. However, a greater percentage of physicians and legislators were more favorable toward permissive abortion in each of these socioeconomic circumstances than were religious leaders; a significant minority of physicians and legislators favored legalized abortion in each of these situations with the exception of that of granting an abortion to any woman who requested one.

In seeking plausible explanations for the difference in attitudes among these four professional groups, the professional orientation of each group serves as a useful benchmark. Businessmen appear to react to the granting of an abortion as they would react to a business problem. They seek the most immediate, expedient, and practical solution--that of granting the operation. The businessmen seem less concerned with "abstract and relative morality" and more oriented toward a concrete, immediate solution to the stress-inducing problem of an unwanted pregnancy. Religious leaders, contrary to businessmen, are most concerned with society's official morality and their "personal" interpretation of religious morality which they feel is generally prohibitive of induced abortion.

Physicians with medical responsibility for the well-being of both the woman and the fetus might be expected to have split feelings about permissive abortion and, therefore, to be relatively moderate in their stance toward legalized abortion. The definition of their "responsibility" toward the mother and toward the fetus seems to vary among physicians. At one extreme, some physicians may see delivering the fetus--although the mother may die as the result of childbirth--as fulfilling their responsibility toward both the fetus and the mother. At the other extreme, some physicians may see their aborting a "bastard" as fulfilling their responsibility to an otherwise possible deprived, suffering, and devalued "fetus," and also to the mother. However, for a distinct majority of physicians, regardless of whether they aborted or did not abort the fetus, it would seem that they would feel that they could not completely fulfill the responsibility they feel toward the woman who requests the operation and at the same time completely fulfill the responsibility they feel toward the fetus (or vice-versa). Thus, a physician's "prescription" of abortion may be seen as fulfilling his responsibility for treating the best interest of the woman. However, this same "treatment plan" may contradict to some extent his feelings of responsibility for the fetus. A physician's differential weighing of his responsibility felt toward the mother with that felt toward the fetus in specified situations in which

an abortion has been requested would strongly influence his attitude toward abortion in those situations. Physicians could be expected to be moderate in their stance toward permissive abortion when compared to the more permissive stance of the businessmen and the more prohibitive stance of the religious leaders because: (a) a physician's differential weighing of responsibility may vary over the circumstances for which a woman might request an abortion, and (b) a physician may feel a need to find a number of situations for which he would, and a number of situations for which he would not, perform an abortion so as to feel he is "equivalent" in his best acknowledgment of the needs of both the mother and fetus.

Legislators, like physicians, also held a "moderate attitude" but such a stance is postulated for reasons other than to resolve the cognitive dissonance of conflicting direct and personal responsibilities which seem the physician's lot. For a legislator "moderation" would seem to be the position most likely to appeal to a majority of his constituency--a constituency with which he must be in overt agreement or else risk the loss of his legislative position. If unaware of the public's attitudes, or if he felt his personal attitude might conflict with that of a "significant" number of his constituents, a legislator might well be reluctant to express his personal attitudes. Such reluctance seems

reflected in the finding that of the four professional groups sampled in the present study, legislators returned the smallest percentage of questionnaires. Also, 4 of the 39 legislators who returned a scorable form of the AAI did not respond to the AAI item asking (if the respondent was female) "There are circumstances under which I would consider having an abortion," or (if the respondent were male) "There are circumstances under which I would approve of my wife's or girlfriend's having an abortion." Although the questionnaire was to be scored anonymously, apparently these legislators were fearful that their identity and response to this item might somehow become known and jeopardize their relationship to their constituents.

Knowledge of Abortion

Among these four professional groups of businessmen, legislators, physicians, and religious leaders, only the physicians (obstetricians and/or gynecologists) correctly answered AQ items above the chance level. Their higher scores seem congruent with their necessary knowledge of techniques to induce abortion, greater awareness of the possible physical complications, and confrontation in medical journals with articles pertinent to various aspects of induced abortion. However, even these medical specialists correctly answered an average of less than 41 percent of the AQ items, while each of the other

professional groups on the average answered correctly less than 28 percent of the items. These findings demonstrate that professional groups, including the physicians, as well as the general public earlier discussed, possess very little general (social, economic, medical, etc.) knowledge of induced abortion. The acquisition of such knowledge would appear to be of particular importance--even a necessity--for legislators who presently are delegated the prime responsibility for the development of laws which best meet the needs of society. It would seem near impossible for persons to assess the needs of society relative to abortion laws when they lack the factual information pertinent to the actual practice of abortion.

Attitude Toward Abortion Related
to Knowledge of Abortion

For the two professional groups holding the "extremist" positions (the most permissive businessmen and the least permissive religious leaders), a more favorable abortion attitude was related to having more factual knowledge of abortion. The attitudes of the more moderate groups (physicians and legislators) were not significantly linked to amount of factual knowledge. This finding suggests that physicians and legislators are less able than are businessmen and religious leaders to adapt their attitudes to the practical realism of what

may be best for society as would be related to them through their acquisition of factual abortion knowledge. Physicians may be rendered less flexible in modifying their attitudes because of their effort to resolve their anxiety engendered by the cognitive dissonance of conflicting responsibility toward the mother and toward the fetus. Legislators may be less flexible to alter their abortion position because of their concern to present views consistent with the "unknown significant constituency," fearing loss of personal security should their views possibly vary.

CHAPTER X

A REALISTIC SOLUTION OF THE ABORTION DILEMMA

Many authorities consider the abortion dilemma to have a broad basis in legal, social, economic, ethical, medical, political, humanitarian, and moral considerations (Rosen, 1967e; Tietze & Lewit, 1969; David, 1958; Ryan, 1967; The right to abortion, 1969). Of these many facets, the opponents of bills tending toward the liberalization of abortion have most often stressed the moral aspect. These opinions have been expressed in assertions that abortion is the murder of a God-given life and that liberalized abortion policies would lead to increased promiscuity, infanticide, genocide, and even the general moral decay of society (Liberalized abortion, 1960; Senators defeat abortion bill, 1969; Star, 1965; Canavan, 1966; Letters run, 1969). These contentions, however, appear without factual basis and to be highly emotional reflections of individual bias. Proponents of permissive abortion laws, on the other hand, have argued the need of such legislation from social, economic, and humanitarian

perspectives (Rossi, 1966; Kummer & Leavy, 1966). This chapter will review the factual evidence relating to these arguments.

While abortion policies may long be debated among authorities arguing from one or more of these several considerations, the ultimate authority which must resolve the abortion dilemma is the state legislature or the court. In arriving at an abortion policy through law within a democracy, these bodies--as representatives of the people--must base such laws upon the current wants and needs of the people (Ehrlich, 1962; Friedmann, 1967). These law-making bodies cannot legitimately discriminate between divergent religious morals pertinent to abortion. The state, through its laws, cannot reasonably assert that the Catholic belief of human life beginning at conception is "more or less correct" than the Jewish belief of human life beginning at birth. Within a democracy, abortion laws must evolve from the wants and needs of the people. In meeting these wants and needs, legislative and judicial abortion policy should allow the tolerable and harmonious expression of divergent ethical positions within that policy's framework (Friedmann, 1967). Otherwise, large segments of society will respond with indifference or opposition to the policy and render the law ineffective and difficult to enforce. Many writers have asserted that current restrictive abortion legislation exemplifies just such a policy by making it illegal for large segments

of the public to express their ethical position and, as a result, does not receive public support, is disregarded, and is ineffective (Rosen, 1967a; Schur, 1955; Abortion gets its first thorough U.S. airing, 1967; Kummer & Leavy, 1966; George, 1967b). Among the bases for this assertion are: (1) the occurrence of a modal estimate of a million yearly illegal abortions and an estimate that if current abortion laws were enforced two million persons yearly would be prosecuted (Lowe, 1966), (2) current restrictive abortion laws are extremely difficult to enforce (Tolnai, 1939; Star, 1965; Rosen, 1965, 1967a; Abortionist convicted, 1944; Kummer & Leavy, 1966), and (3) physicians using the label of "therapeutic abortion" have openly violated state statutes and performed large numbers of illegal abortions (Kummer & Leavy, 1966; Hall, 1968; Packer & Gampell, 1959; Rosen, 1967a).

Examining the origin of current restrictive abortion laws, most of which were enacted in the 1800's, it becomes obvious that the needs for and purpose of this restrictive legislation do not exist today. These statutes were founded on: (1) the need of the United States for an increased population to settle the expanding Western frontier and to man developing industries, (2) the fact that medically induced abortion was a dangerous procedure in the 1800's, and (3) the Puritans' desire to enforce their sexual morals through legislation (see Chapter V).

Today the United States no longer needs an increased population to populate an expanding frontier or to man its industries. Quite to the contrary, there is much concern about overpopulation. Also, with advancing medical technology, a medically performed abortion is no longer considered a dangerous operation. Dilatation and curettage performed during the first three months of pregnancy is considered safer than a tonsillectomy and is less dangerous than pregnancy and delivery (see Chapter III). Additionally, it is now unacceptable to permit social policies to be dictated by religious ideologies.

To recapitulate, in establishing an abortion policy, legislative and judicial bodies must develop laws consistent with peoples' current wants and needs. To be effective, such laws must be accepted by the public and must allow the expression of divergent ethical beliefs held by significant numbers of persons. Current restrictive abortion laws based on the needs and conditions of the 1800's plainly do not meet these criteria and, consequently, they are generally disregarded and ineffective. It is the thesis of this chapter that the current laws should be greatly revised. This thesis is formulated from findings which demonstrate that the currently applied laws of the 1800's oppose contemporary wants and needs, are detrimental to the public's welfare, and discriminate against the underprivileged sectors of society.

Evidence was presented in Chapter III which unequivocally demonstrated that the nation's poor are less able than their wealthy counterparts to obtain a legal abortion. The indigent also are less able to afford a skilled illegal abortionist and, consequently, suffer a greater percentage of abortion deaths and injuries through their visits to the less skilled abortionist and their attempts at self-induced abortion.

A related discrimination also exists between married and single women (Lidz, 1967; Rosen, 1967e). Even though their circumstances may be quite similar, the married woman obtains a legal abortion more readily and more frequently than does the single woman. This reflects society's punitive orientation toward unwed pregnant women. To demand that a woman deliver an unwanted child because she has had sexual relations only serves to grossly impair the woman's future by using the child as a club against her. In turn, the child becomes a pawn of punishment. Such punitive, destructive action is a reflection of the Puritan's envy and his concern that the woman be punished for her inferred sexual pleasure. It reflects no positive function. Concern for the child exists only in that it can be used to "shame" the woman, restrict her educational and vocational attainment, and generally impair her future prospects.

Also, many women, including marrieds, have been granted therapeutic abortions only on the condition that they would permit themselves to be concomitantly sterilized (Lidz, 1967; Rosen, 1967d; Myers, 1967). Sterilization which permanently prevents child bearing is a distinctly different procedure from that of abortion which permits a woman to later bear children. Sterilization, apart from abortion, has frequently been discussed as being injurious to a woman's psychological well-being (Myers, 1967; Wilson, 1967). Evidence of the harmful effects of sterility were illustrated in several studies discussed in Chapter III (pp. 64-67). Similar to the punitive discrimination displayed toward unwed pregnant women, requiring sterilization as a condition for legal abortion may well reflect the individual physician's veiled expression of hostility and sadism toward a woman who is desperate and has few, if any, acceptable alternatives.

In addition to the physician's personal beliefs, including religious convictions, which may sanction hostility toward female abortion-seekers, the vague wording of statutes and the physician's consequent concern of possible punishment if he were to perform an abortion enhance his anxiety, fear, and anger. The physician may directly displace these anxieties to the abortion-seeker by demanding her consent to sterilization as a

prerequisite to abortion, or he may respond more indirectly by delaying his reaction to the requested abortion until the pregnancy has passed beyond an arbitrary safe period after which a hospital would refuse to abort the woman (Rosen, 1967a). Certainly the vague phrasing of current abortion laws has fostered divergent and sometimes sadistic practices among hospitals and physicians. More importantly, it has resulted in patient care based on the physician's fears and biases, rather than in care based on the patient's needs.

While the current abortion laws invite discrimination and the expression of Puritanical sadism, these laws also can be shown to have even more damaging consequences for countless individuals. It can be shown that restrictive abortion laws adversely affect many pregnant women, prospective fathers, and families. They produce a large number of maladjusted adults who were unwanted at conception and who were subsequently treated in a destructive, unwanted fashion in infancy, childhood, and adolescence. Through their detrimental consequences for women, men, and families, and their fostering of unwanted and maladjusted children, such laws ultimately lower society's level of emotional, social, and intellectual functioning below that which it might otherwise achieve.

It should also be made clear that the broad revision of restrictive abortion laws is not advocated for the purpose of creating a genetically controlled "superior race" as proposed during World War II by Nazi Germany. The ultimate purpose of liberal abortion laws is to foster the ideal of a society of wanted individuals --persons more capable of harmonious and purposeful living within and among themselves.

The Peoples' Needs

Detrimental Effects of Current Restrictive Laws Upon Women

The harmful effects of restrictive abortion laws have been discussed most frequently as they relate to women (Lader, 1966a; Lowe, 1966; Calderone, 1958). Many women are hurt physically and/or mentally from the legal strictures against abortion. Triggered by an unwanted conception, other women harm themselves physically and/or mentally. Whether the women's suffering is inflicted directly by herself, or is a by-product of abortion-seeking, the harm results from her inability to legally obtain an abortion she feels is desperately needed.*

*Many women who conceive and deliver an unwanted child experience the concurrent exacerbation of a neurosis or psychosis. Verbalization of felt needs to be rid of their unwanted conception is inhibited due to culturally induced fears concerning the acknowledgment of such feelings. Nevertheless, these needs and feelings exist and the conflict surrounding their personal acceptance enhances emotional disturbance. The legal acceptance of abortion, suggesting some form of cultural acceptance,

The need for abortion among many women has persisted and will continue to persist regardless of the letter of the law. This has been demonstrated by the persistent high annual incidence of illegal abortion in the face of long-enduring restrictive laws.

Death, Physical Impairment, and
Psychological Disturbance in
Procuring an Illegal
Abortion

From the findings presented in Chapter IV, it is determined that because of a woman's inability to obtain a legal abortion, an estimated 5,000 to 10,000 women die annually and countless others incur serious physical injury seeking an illegal abortion. Women having to obtain an illegal abortion also suffer unmeasurable adverse psychological effects resulting from their fearfully having to knowingly violate the law and their having to trust their well-being to an unknown and often unscrupulous illegal abortionist. From childhood through adult life, persons are socialized to feel fear and guilt for their violation of the law per se. Certainly trusting one's life to an unknown, feared, and perhaps incompetent abortionist would induce stress and anxiety and subject the individual, particularly the woman predisposed to emotional problems, to emotional disturbance. In addition

may enable these women to abort an unwanted conception and/or serve to alleviate much of the culturally induced guilt felt by women who presently deliver an unwanted conception contrary to their needs to abort.

to exacerbating the disturbance of a woman who at the time of becoming pregnant demonstrates emotional maladjustment, this experience may well predispose a previously healthy woman to future emotional disorders.

Suicide

It is clear that pregnant women commit suicide and that unwanted conceptions may precipitate suicide attempts. A review of several studies purporting to demonstrate that the suicide rate among pregnant women is less than that among nonpregnant women (Rosen, 1967a; Barno, 1967; Rosenberg & Silver, 1965) may be useful.

Examining Minnesota statistics (1950-1965), Barno (1967) contrasts the rate of suicide among pregnant women --0.0 to 0.2 per 100,000 population--with that of all women--3.1 to 5.2 per 100,000 population. Surveying three California counties over a three-year (1961-1963) period, Rosenberg and Silver (1965) found three cases of suicide among pregnant women. This figure was contrasted to the statistically predicted figure of 17.6 suicides for women of child bearing age residing in these three counties. In Birmingham, England over a seven-year period, there were no known suicides among pregnant women (Abortion: The doctor's dilemma, 1967).

Although these three cited studies appear to demonstrate that the risk of suicide for pregnant women is less than that for nonpregnant women, these findings

neither negate nor reduce the importance of knowing that some pregnant women do commit suicide. Actually, little is gained from such a comparison of suicide rates. The critical factor is that pregnant women do commit suicide and that an unwanted conception may precipitate this self-destruction. Furthermore, the differences in the suicide rates for pregnant and nonpregnant women as given in the above studies may be greatly overestimated. Dr. Russell S. Fisher, Chief Medical Examiner of the State of Maryland (1967b), asserts that many suicides among pregnant women go undetected because autopsies are not performed if the manner and cause of death are established. In Sweden where autopsies are more frequent, Bengtsson (1947) found that pregnant women committed 19 (8 percent) of the 247 suicides which occurred from 1925-1944 and for which autopsies and post mortems were conducted. In each of the 19 cases, pregnancy was considered the probable "releasing factor [pp. 94-95]" of the suicide. Of additional significance is Bengtsson's finding that 18 of the 19 pregnant suicide victims were unmarried. This finding strongly suggests that the unwed pregnant woman is particularly subject to the risk of suicide.

The three studies first cited concerned suicide during pregnancy. Less research has concerned suicide following pregnancy. However, self-destruction following delivery also may be precipitated by the carriage and/or delivery of an unwanted conception. The length of

follow-up in such research is a critical, often uncontrolled variable. Two Swedish studies purport to illustrate that suicide is a rare occurrence following the delivery of children among women who had earlier requested, but had been refused, a therapeutic abortion. Ekblad (1955) reports that none of the 759 Swedish women whose abortion requests were rejected during 1947 and 1949 committed suicide. Among 344 Swedish women refused a legal abortion, Lindberg (1948) found that prior to the abortion refusal, 62 had asserted they would commit suicide if they were not granted an abortion. None of these 62 women did commit suicide. However, the study of Ekblad and that of Lindberg do not take into account the possibility of suicide among those women granted an abortion had their request been refused. Many of these women granted an abortion in Sweden would not have been granted a legal abortion for the identical reasons in the United States. Ekblad also acknowledges that in other years suicides have occurred among Swedish women whose requests for legal abortion were denied. Reporting upon the outcome of 10 cases in the United States where abortion had been recommended but refused--7 refusals by hospitals and 3 by husbands--Rosen (1967a) found one woman to have committed suicide prior to delivery and another to have killed both herself and her children following delivery. That suicide may more commonly occur after delivery rather than before delivery,

is documented in Barno's (1967) finding that 10 of the 14 suicides occurring from 1950-1965 among Minnesota obstetric patients occurred during the post-partum state. Seager (1960) found that of 42 women hospitalized for emotional difficulties following the delivery of a child, 13 had attempted suicide. This figure was contrasted with two suicide attempts among a control group of 42 women who also were hospitalized but for emotional reasons unrelated to the puerperium. Unwanted conception as a precipitator of "attempted" as well as of "successful" suicide is also of critical importance. Among these women whose hospitalization related to the birth of a child, many overtly admitted their rejection of the child. Others expressed their rejection of the child indirectly in the form of concerns of harming the child and their blaming it for their illness. Beyond revealing that an unwanted conception may foster suicide attempts, Seager's data also reveal an unwanted conception may precipitate emotional disturbance.

Emotional Disturbance

"Post-partum psychosis". The birth of a child has been demonstrated to precede the occurrence of psychotic and neurotic conditions (Pohlman, 1969; Pugh, Jerath, Schmidt, & Reed, 1963). The literature generally has focused on the most severe of these conditions and typically categorized them as post-partum psychoses.

As indicated by the term "post-partum," in most cases the emotional condition becomes manifest following birth rather than preceding birth. Similar conditions do occur, however, during gestation. Studies of these phenomena strongly suggest that the occurrence of such emotional disturbance is especially likely to be precipitated by the birth or anticipated birth of an unwanted child.

The actual incidence of post-partum psychosis is difficult to determine because of physicians' differences in diagnosing and labeling such conditions. Also, many women may manifest the emotional disturbance after their last obstetric contact and, consequently, go undetected, or, should they later become known, their condition may be ascribed to other precipitating factors rather than the birth of an unwanted conception. Reviewing the literature and correcting for the incidence of undetected emotional disturbance, White, Prout, Fixsen, and Fondeur (1957) conclude that from 1 in 300 to 1 in 750 women react with post-partum psychosis to their pregnancy and delivery. The estimated incidence of post-partum psychosis among all female psychiatric patients ranges from 2 to 10 percent. White et al. (1957) assert a more accurate estimate would range from 5 to 7 percent.

These women who have been considered to be suffering from a post-partum psychotic reaction frequently demonstrate marked rejection of the child and/or hostility

toward the child and/or hostility toward the father. Seager (1960) found that more puerpural women than non-puerpural hospitalized women described marked feelings of rejecting the child, experienced phobias of harming the child or husband, and blamed the child for their illness. Zilboorg (1931), Tetlow (1955), and Smalldon (1940) also report the great prevalence of hostility and rejection of the newborn among post-partum psychotic women. Tetlow (1955) further asserts that this maternal hostility and rejection of the child was found "to persist or recur at intervals for some years after the psychosis had subsided [p. 637]."

In addition to puerpural patients' homicidal attempts toward their child and their delusions of their child being disfigured, or themselves poisoning or otherwise harming their child, Brew and Seidenberg (1950) report that some of the puerpural women also were extremely overprotective of their child. They assert that this overprotection is a reaction-formation concealing the mother's actual feelings of rejection and hostility toward the infant.

Smalldon (1940), Zilboorg (1931), and Seager (1960) found that these women were also hostile toward the child's father as well as the child. Smalldon reports this hostility to range from indifference to homicidal attempts.

These psychotic womens' feelings of hostility and rejection of the infant and/or husband have often been associated with the conception's and/or child's being unwanted. Brew and Seidenberg (1950) found that among their 103 post-partum cases, frequently neither of the parents wanted the child and often the conception was not planned. Gordon and Gordon (1957) found a greater incidence of unplanned pregnancies among psychiatric maternity patients as compared to that among psychiatric non-maternity patients. Pohlman (1969) asserts that Gordon and Gordon's (1959) later research also suggests a relationship between a woman's emotional disturbance and an unwanted conception. Smalldon (1940) found that some post-partum psychotic women openly admitted they did not want their child and wished that they had not given birth.

Several researchers (White et al., 1957; Tetlow, 1955; Tobin, 1957; Gordon & Gordon, 1959) discuss the rejection of the child as one of several factors precipitating mental disturbance. Other factors have been discussed, such as general personality disposition, poor marital adjustment, patient's previous poor family history, mother's or child's illness, the birth's exacerbation of responsibilities, and illegitimate conception. Although it seems certain that personality factors, such as a woman's emotional stability prior to

conception, and her current living situation may predispose a woman to post-partum psychosis, the unwanted conception, pregnancy, and delivery are additional stress factors which often exacerbate dormant emotions into the emotional upheaval labeled "post-partum psychosis."

Tetlow (1955) noted a linkage between illegitimacy and post-partum psychosis. Among 67 post-partum patients, a normal control group, and a psychotic control group; none of the normal controls, one of the psychotic controls, and 7 of the post-partum patients reported premarital conceptions. Also, five of the post-partum patients conceived in extra-marital relationships, whereas--even considering previous pregnancies--only one of the normal controls and only one of the psychotic controls reported such an illegitimate conception. Thus 12 of the 67 post-partum patients (or 18 percent) conceived illegitimately. While a variety of personality and social considerations may influence illegitimate conceptions, it may reasonably be assumed that most of these conceptions were unwanted. Such unwanted conceptions, in interaction with predisposing personality and social variables, quite likely precipitated many of these psychoses.

Psychosomatic complications. Although contradictory findings exist, several studies have found a positive relationship between the rejection of pregnancy and the occurrence of such symptoms as nausea, vomiting, prolonged labor, and toxemia. Concerning the association

only of nausea and vomiting with the rejection of pregnancy, Pohlman (1969)--after a review of the relevant studies--suggests that factors other than the outright rejection of conception may more adequately explain excessive nausea and vomiting. He considers a woman's ambivalence toward pregnancy, rather than her outright rejection of the pregnancy, to be such a factor. However, the findings of Zemlich and Watson (1953) led them to hypothesize that among women who express excessive psychological and somatic symptoms, symptomatology expresses their rejection of the pregnancy. Similarly, Despres (1946) found that among 100 pregnant, married women, "those who were not happy with the fact of their pregnancy were significantly more apt to experience nausea and vomiting (and to experience nausea over a longer period of time) than women favorably disposed toward their pregnancy [p. 617]."

Hetzel, Bruce, and Poidevin (1961), in comparing four groups of women who experienced: (1) a normal course of pregnancy, (2) prolonged vomiting, (3) toxemia, or (4) prolonged labor, reported findings which suggest that the rejection of pregnancy adversely affects the woman's physical well-being. Although not achieving statistical significance, a larger percentage of women composing the vomiting, prolonged labor, and toxemia groups--as compared to the number of women composing the control group--

rejected their pregnancies prior to their occurrence.* During pregnancy more unfavorable or indifferent reactions to pregnancy were reported for the prolonged labor and toxemia groups than were reported for the normal pregnancy and the prolonged vomiting groups.

Contrary to the Hetzel et al. (1961) findings which specifically related the rejection of pregnancy to prolonged labor, Pohlman (1969), in reviewing the literature, asserts, "There is little evidence of a link between unwanted conception and labor or delivery problems [p. 286]." However, based upon a review of studies pertinent to toxemia of pregnancy and unwanted conception, Pohlman (1969) also states, "It seems possible that unwanted conceptions, especially when they occur out of wedlock, are more likely than wanted conceptions to lead to eclampsia and preclampsia [p. 284]." Eclampsia and preclampsia were the forms of toxemia focused upon by Pohlman in this review.

Summarizing the detrimental effects of current restrictive abortion laws upon women, it has been demonstrated that these laws which prohibit a woman to abort an unwanted conception for reasons she feels as compelling

*It is of interest to note that among the 54 women composing the group experiencing a normal pregnancy, 18 women also rejected their pregnancy prior to its occurrence. This finding further suggests that the rejection of pregnancy may be a precipitator interacting with other personality and social precipitators to enhance psychosomatic complications of pregnancy.

--be they social, economic, medical, etc.--result in death, physical impairment, and emotional disturbance for many of these women who choose to consciously violate the laws and trust themselves to an illegal abortionist or attempt self-abortion. No form of legislation would appear capable of preventing these women from seeking out an illegal abortionist or from attempting self-abortion.

Other women who experience unwanted conception but who are unable to admit these feelings because of social learning and related feelings of guilt may experience psychological turmoil manifested toward themselves or others. Particularly among unwed women, this event may precipitate a suicide attempt. For still other women, unwanted conceptions may precipitate a post-partum psychosis or other severe emotional disturbance. Typically, these disordered reactions feature the direct or indirect expression of strong anger and rejection toward the child and sometimes toward the father. Less severe in nature, but nevertheless adverse, are the psychosomatic complications experienced by other women who reject their pregnancy. A study by Oster and Tovell (cited in Grandmothers' beware!, 1969) indicated that a high proportion of the 86,000 births during 1967 among women over 40 years of age were not wanted and/or were "medically risky." However, current prohibitive abortion laws generally

preclude legal abortion for even these women. No matter where a woman's experience lies on a continuum ranging from death to psychosomatic complications of pregnancy, laws prohibiting her from aborting an unwanted conception, regardless of the reasons, foster such an adverse experience.

The Fate of an Unwanted Conceptus

That a great number of unwanted children are conceived each year is clearly evident. Among couples composing a 1960 probability sample, 17 percent of the couples (husband and/or wife) openly admitted having at least one unwanted child in their family (Whelpton, Campbell, & Patterson, 1966). However, this finding also must be considered to grossly underestimate the actual number of unwanted children because: (1) persons composing this sample may have been reluctant to admit having an unwanted child, (2) the study did not take into consideration the official governmental estimate of 224,300 illegitimate children (a great majority of which must be considered unwanted) born in 1960 in the United States (Trends in illegitimacy, 1968), and (3) the study considered an unplanned child as wanted even though the parents admitted their wanting a different spacing interval between their children.

Because of both the difficulty in obtaining accurate self-reports and varying definitions of unwanted,

Westoff, Potter, and Sagi (1963) suggest that the number of white couples having unwanted conceptions may most accurately range from 30 to 50 percent. This estimate, however, because it takes into account unwanted conceptions only among white couples whose first marriages remain intact, doubtlessly underestimates the actual percentage of United States couples who experience unwanted conception.

With reference to the percentage of children who are unwanted rather than to the percentage of couples having unwanted children, Westoff (cited in Unwanted births high, 1970) more recently has estimated that 35 to 45 percent of the births in current years are unwanted. This estimate suggests that of the 3,571,000 live births in 1969 in the United States (Monthly vital statistics report, 1970b), 1,249,850 to 1,606,950 were unwanted. Support for Westoff's estimate is suggested by the data of Baldwin, Kalhorn, and Breese (1945) which designated 25 percent of a group of relatively advantaged children from rural Ohio as coming from "rejectant" homes, 29 percent from "acceptant" homes, and the intermediate 46 percent as from "casual" homes. Certainly in the less advantaged settings of urban slums, the incidence of rejected children must be much higher.

Maternal Stress and the Fetus

Accumulating evidence illustrates that emotional stress during pregnancy may adversely affect the fetus. Previous discussion has suggested that carrying an unwanted conceptus can create such stress. Pohlman (1969) has reviewed many of Sontag's studies suggesting that infant feeding difficulties, hyperactivity, irritability, and somatic difficulties may be related to emotional stress during pregnancy. Stott (1958) also presents statistical and case studies suggesting an infant's health, including physical defects, can be affected by psychological and psychosomatic stresses incurred by the mother during pregnancy. Stott (1957) found that a variety of stress factors were significantly more prevalent in pregnancies resulting in children with mongoloid and non-mongoloid defects. Among Stott's sample, four "elderly" women who had determined to have no more children experienced an "anxiety state [p. 1010]" "activated" by their "distress" in discovering their pregnancies. These women later gave birth to children with ill health and/or congenital malformations. The age of these women makes it particularly difficult to ascribe the infants' condition solely to the womens' psychological stress. The womens' physical condition associated with their age may also be a critical variable.

Comparing women experiencing unusual stress with women reporting no stressful experiences during the first trimester of pregnancy, Downs (1946) also found a greater incidence of neonatal pathology among children born to the stress-reporting mothers. Turner's (1956) findings further support the view that the stress of carrying an unwanted conception may itself harm the fetus. Among the total sample of 100 women, Turner found that all 3 women in the sample whose conception was illegitimate (and therefore assumed to be a stressful pregnancy) delivered hyperactive infants. Ferreria's (1960) data offer more conclusive support. He found that deviant infant behavior (operationally defined by nurses' assessments of the infant's amount of sleep, amount of crying, degree of irritability, bowel movements, and feeding behavior) was associated with the mother's attitudes toward the child and pregnancy prior to delivery. On a measure of Rejection of Pregnancy, women whose infants displayed deviant behavior scored at the extremes--either more rejecting or more accepting of their pregnancy--than women whose infants displayed behavior defined as normal. The greater acceptance of pregnancy by some mothers of deviant offspring was considered to reflect a possible defense (reaction formation) against their actual feelings of hostility and/or rejection of the pregnancy. Grimm and Venet (1966) also found a positive relationship between

a woman's desire for pregnancy and her reaction to the baby.

Parental Reaction to Unwanted Births

Parental reaction to an unwanted child and its affect upon the child have been discussed by Menninger (1967), Jenkins (1967), and Zemlich and Watson (1953). Pohlman (1969) recently reviewed much of the relevant literature. A parent's reaction to unwanted offspring can range along a continuum of behaviors including infanticide, abuse, excessive criticalness, neglect (absence, coldness, distance), distinctive overprotection (a defensive reaction to unacceptable feelings of rejection and hostility toward the child), or some combinations of these behaviors. Underlying each of these parental reactions is the parent's hostility toward the unwanted child.

Infanticide. Providing evidence that the incidence of infanticide is more prevalent today than might be expected, is the finding that in Detroit, Michigan, during 1969, there were 135 dead infants found in trash cans (Tanton, Chairman of Michigan Women for Medically Controlled Abortion, cited from the Michigan State News, East Lansing, Michigan, 1970).

Abuse. Child abuse, ranging from severe physical and/or psychological injury to death, is currently

receiving much attention in the United States. Because of reluctance to report such cases, their frequent concealment, and the vague demarcation line between punishment and abuse, statistical reports of the incidence of child abuse tend to grossly underestimate its actual occurrence, although they clearly identify its existence. In Michigan during 1969, there were 873 reported cases of suspected child abuse (Suspected child abuse referrals, 1970). De Francis (1963) found 662 cases of child abuse reported in the nation's newspapers during 1962. Of these 662 children, 178 died; and 81 percent of the fatalities occurred among children less than 4 years of age. H. M. Meredith, Director of the Midland, Michigan County Department of Social Services, reports that among 200 reported cases of child abuse examined by the Michigan Department of Social Services, one-third of the children suffered injuries having long lasting effects (Meredith, 1968). Nine of the 200 children died from injuries and others incurred brain damage, multiple fractures, and internal organ injuries.

Neglect. Child neglect is also a very frequent and perhaps a growing phenomenon. During 1968 the Juvenile Division of the Probate Court of Michigan issued 5,523 new petitions for child neglect--these are cases in which a petition was authorized; the figure does not identify the total number of cases investigated. At the end of 1968,

the court caseload of neglected children was 15,295
(Supreme Court of Michigan, 1968).

Of the many neglected children, a large number are placed in foster homes. As if the child's experience with the original parents were not destructive enough, their foster home placements are also often inadequate. The Child Welfare League of America conducted an extensive study which included 69 agencies located in seven cities. Examining the services available relative to urban needs for foster care the study found:

. . . many children are receiving second best. They are not getting what they need but rather what is at hand. Analysis of 1488 requests for services showed that because of the limited range of services in the community, children often had to be placed in the care that was available regardless of whether it was suitable or not . . . (President's letter, 1969).

The Feelings and Behavior of the Unwanted Child

Broadening the preceding discussion which has concerned several overtly destructive (infanticide, abuse, neglect) manifestations of a child's being unwanted, Jenkins (1967) provides a more elaborate discussion of the psychological effects of being unwanted and the child's resultant behavior. He discusses parental rejection as reflected in the "unsocialized aggressive child," the "overinhibited or overdutiful child given to internal conflict," and the "schizoid child [p. 272]."

Unsocialized Aggressive Child

Jenkins views the hostile, suspicious, destructive, unsocialized aggressive child, incapable of feeling guilt, as the product of overt parental rejection. In addition to attracting the attention of mental health clinics, many of these unwanted children come to the attention of the court. The Michigan Probate Court, Juvenile Division, reported 13,181 petitions authorized as new cases of delinquent children for 1968 (Supreme Court of Michigan, 1968). Qualitative support of the relationship between being unwanted and delinquency comes from Judge Orman Ketcham of the District of Columbia Juvenile Court who reported that "most of the juveniles who come before me were unwanted children [cited in Disease of unwanted pregnancy, 1967, p. 84]." Empirical evidence of this relationship is provided by Forssman and Thuwe (1966) and Kvaraceus (1945). Pohlman (1969) states that the research of Glueck and Glueck (1950) further suggests an association between unwanted conception and delinquency. Glueck and Glueck (1950) found that delinquent boys were more likely to have experienced greater parental rejection, hostility, indifference, and maternal overprotection than had their non-delinquent controls.

Overinhibited Child

Jenkins discusses the overinhibited or overdutiful child, frequently seen in child guidance clinics, as being

excessively sensitive, anxious, insecure, seclusive, depressed, or discouraged. This child strongly adheres to parental approved behavior, fearing he may never attain their love if he does not. He is strongly subject to a psychoneurotic breakdown. If the parents were also inconsistent in what behavior is approved, the likelihood is that the child's emotional disturbance would be even more exaggerated. Jenkins views this child as the recipient of parental rejection in the form of an "unsociable, cold, distant parent, lacking in warmth, perhaps the rejecting but overprotective mother, and perhaps the perfectionistic, hypercritical father [p. 273]."*

Schizoid Child

The schizoid is the third type of child discussed by Jenkins as experiencing parental rejection. This person is seclusive, apathetic toward the outside world, listless, and ineffective in his work and social relations. These

*That overprotection may be a disguised form of rejection was noted earlier in the findings of Zemlick and Watson (1953). They found that women who rejected their pregnancy later responded overly indulgent and solicitous to the infant. Pohlman (1969) reviews several studies illustrating the detrimental effects of overprotection. Certainly the excessively overprotected child senses conflicting parental messages in parental overprotection, becomes angry and torn between dependence and independence, and is less able to express negative emotions. Through his being overprotected as a child, this person may be less able to deal effectively and cope with the often harsh quality of reality he faces in later life.

behaviors are postulated to result from an emotionally rejecting mother who, in overcompensating for her rejection, does not treat the child as a separate being with wishes and desires of his own. In extreme cases, the child may find this mother and her absence of emotional response so frustrating that he withdraws from reality into a personal fantasy world.

Relevant to this discussion of the fate of an unwanted conception is the claim that an unwanted conceptus often later becomes a wanted child. Pohlman (1969), however, reviews literature which strongly indicates that parental feelings of not wanting a child do not change as the child passes from fetal status through childhood. Rosen (1967a) further points out that "the morbid effect of a specific emotionally unhealthy environment on a young child becomes increasingly irreversible as that child grows older [p. 304]." He asserts that the schizoid withdrawal is more frequently found in patients who as adolescents or adults experience schizophrenic breakdowns.

Concluding this section which has focused on the destructive effects of parental hostility and rejection of an unwanted child, is a summary of a study conducted by Forssman and Thuwe (1966). These researchers report follow-up data on 120 Swedish children born after refusal of parental applications for legal abortion. These children were born during 1939-1941 and they were followed

up until they were 21 years of age. Their mental health, social adjustment, and education level were compared with those of a control group. The unwanted children more often experienced an unstable, insecure home environment, more frequently needed psychiatric services, more often displayed antisocial and criminal behavior, were less educated, were in greater need of public assistance between the ages of 16 and 21, and were less free from all of the defects that were studied. These differences were statistically significant. More unwanted children as compared to the number of their controls were also found to have been reported for drunken misconduct and judged unfit for military service, although these differences fell short of statistical significance. Women who were unwanted as children tended to marry and reproduce earlier than their female controls. Compared with their controls, the unwanted were decidedly handicapped in their mental, social, and educational functioning.

Detrimental Effects of an Unwanted Conception Upon the Father

An important but frequently neglected issue concerns the impact of unwanted conceptions upon the emotional well-being of the prospective father. Several studies illustrate that the birth of an unwanted child may precipitate severe emotional consequences for a male. Zilboorg (1931) relates brief case histories of males responding to pregnancy and parenthood with emotional

reactions requiring hospitalization. Such reactions included suicide attempts and "hatred" toward the wife and child. Freeman (1951) also discusses six cases having in common "the fact that the onset of mental disturbance coincided with a pregnancy [p. 49]." Freeman views the woman's pregnancy as a precipitating factor in men predisposed with characteristics of hate, jealousy, and a feminine identification. Among 28 male patients hospitalized at the Veterans' Administration Hospital of Palo Alto, California, Towne and Afterman (1955) noted a "temporal relationship between the outbreak of a psychosis and a pregnancy or the birth of a child in the patient's family [p. 19]." Among these 28, 4 had attempted suicide and 7 others were "pre-occupied with self-destruction [p. 24]." Still others were openly aggressive toward the wife during and after the pregnancy and they were also careless in their handling the baby. Towne and Afterman characterized these male patients as experiencing "uncommon deprivation [p. 25]." They came from large families where parental death, sibling death, divorce, or separation were common and childhood was generally "experienced in a framework of parental quarrel and personal tragedy [p. 25]." Pregnancy apparently precipitates emotional disturbance for the male with a predisposed personality.

A study by Curtis (1955) further demonstrates a relationship between unwanted conception and emotional disturbance among predisposed males. Curtis investigated

55 expectant fathers in "an essentially peacetime military setting [p. 938]." Among the 55 men, 31 "had been expectant fathers when their presenting problems began [p. 938]." The remaining 24 men composed a control group of males who were expectant fathers but who had not been referred for psychiatric consultation. Among the group of 31 "problem" males, 17 men had problems considered serious and 14 men had problems considered minor. Of those with serious problems, two had attempted suicide, one developed severe unspecified ulcerative colitis, requiring discharge from the Army, and eight displayed "severe passive aggressive or overly defiant behavior leading to administrative separation from service [p. 949]." Fifteen of these 17 men openly rejected the expected infant.

Among the 14 men with minor problems, 11 were "ambivalent or openly rejecting in attitude toward the expected baby and toward their wives [p. 949]." These latter men were more controlled in their behavior than those with severe problems and their "transient or mild psychoneurotic or psychosomatic disorders responded to brief and realistically oriented psychotherapy [p. 949]."

Of the 24 men composing the control group and who had not been referred for psychiatric consultation, one-third had "no significant clinical problems [p. 949]," one-third had "problems similar to those [p. 950]" of the 14 men with minor problems, and the remaining one-third had problems "like those [p. 950]" but of "lesser

intensity [p. 950]" than the men experiencing minor problems.

Of special interest was the finding of Curtis that seven men with severe problems were expecting illegitimate children, while no men having minor problems and three men composing the control group expected illegitimate children. Also, among the men with severe problems and among those with minor difficulties, two men from each group conceived prior to marriage but married prior to the anticipated date of birth. These findings suggest that an illegitimate child may have particular significance upon the emotional health of an unmarried expectant father.

That the pregnancy is a precipitator of emotional disturbance among men with predisposed personalities is illustrated in the finding that among the 17 men with severe problems, 9 had a life history of impulsive behavior and 5 had schizoid personalities. Of the 14 men having minor difficulties, there were no histories of impulsive behavior but there were 5 men with schizoid personalities. Among the control group of 24 men, only 3 had histories of impulsive behavior and only 1 was a schizoid personality.

Detrimental Effects of an Unwanted
Conception Upon the Family

A child, a mother, and a father typically interact as a family, rather than existing in isolation. From the prior discussion of the adverse life of an unwanted conception and the often detrimental effects of an unwanted conception upon the mother and/or father, it follows that the family of which an unwanted conceptus is a part would experience unusual difficulties. Evidence of such family disturbance is provided by Burgess and Cottrell (1939) and Reed (1950) who found poor marital adjustment to be related to an unwanted conception. Soddy (1964) asserts that when one parent rejects a child, the other parent may attempt to compensate for this parent's rejection by giving more affection to the child. Marital friction ensues in which the child becomes a pawn. Pohlman (1969) refers to several studies which illustrate that the effects of an unwanted child may be more severe for older siblings than for the unwanted child himself. Pohlman speculates that after an unwanted conception, parental feelings of frustration and anger generalize to the whole family.

Also, fathers of unwanted conceptions may be too conflict-ridden to give their partner the emotional support which many authorities assert she needs for her emotional well-being during pregnancy and parenthood (Gordon & Gordon, 1959; Cohen, 1966; Dr. Natalie Shainess--New York psychoanalyst specializing in the problems of women--cited

by Brandt, 1968; Larsen, Brodsack, Carr, Dungey, Evans, Harmon, Hixson, Johnson, Liddane, Main, Martin, Tallent, 1968). Other fathers may desert their wives and children as a reaction to an unwanted conception. That males have left their wives during pregnancy is revealed in studies where wives report their husbands leaving them as a stress factor during pregnancy (Stott, 1957; Downs, 1964). While her husband's desertion may adversely affect the wife during pregnancy, it also exerts a more enduring destruction upon the family by often reducing its education, social, financial resources, and generally diluting the effectiveness of socialization experiences.

Illegitimacy and Its Detrimental Consequences

While the prior discussion has focused primarily upon the adverse effects of unwanted conceptions within marriage, the detrimental consequences of unwanted conceptions occurring outside of marriage will now be considered. Although having consequences similar to those of unwanted conceptions within marriage, illegitimate conceptions also pose unique problems.

A separate section devoted specifically to illegitimacy is warranted by its being a frequent and growing problem in the United States. Illegitimate births constituted an estimated 3.8 percent of all live births in 1940; in 1960, illegitimate births accounted for 5.6 percent of all live births (Martz, 1963). For the more

recent year 1968, there were an estimated 339,200 illegitimate births accounting for 9.7 percent of all live births in that year (Monthly vital statistics report, 1970a). As of December, 1961, an estimated 3,000,000 illegitimate children under the age of 18 were living in the United States (Foote, Levy, & Sander, 1966). Among the population composing the United States in 1963, Martz (1963) estimated that 7,000,000 persons were of illegitimate birth. Although some of these illegitimate conceptions may have been wanted for such unhealthy reasons as to force a marriage or to have something to possess and to provide love, a distinct majority are unwanted.

The woman experiencing illegitimate conception faces four alternatives: (1) she can marry--generally the child's father, (2) she can raise the child herself as an unwed mother, (3) she can give birth and then give the child up for adoption, or (4) she can seek an illegal abortion. Each of these alternatives entails detrimental consequences for the mother and/or the child and/or the father.

She Can Marry

Several studies suggest that at least one-fifth of first marriages occur after the conception of a child (Christensen, 1953; Gray, 1960; Pratt, 1965). Among many authorities discussing the bad effects of these forced marriages are Hepworth (1964) and Pohlman (1969). Pohlman

cites two studies (Burchinal, 1959; Geisman & La Sorte, 1963) in which poorer marital adjustment existed in forced marriages as opposed to marriages which did not result from premarital conception. Rather conclusive evidence of greater marital friction in forced marriages is the higher divorce rate among these couples. Christensen and Meissner (1953) found that among their sample of married and divorced couples more than twice as many marriages forced by premarital pregnancy ended in divorce as did marriages in which conception followed marriage. Among family physicians from three northern Minnesota counties attending a social work seminar concerning public health (Kiesler, 1962), estimates of the number of forced teenage marriages ending in divorce in these counties ranged from 50 percent to 100 percent. Most of these physicians suggested that about 80 percent of such marriages ended in divorce.

While couples experiencing forced marriage may struggle with their financial situation, educational and vocational attainment, and their personal relationship; the child may experience abuse, neglect, and destructive overprotection (as does the unwanted child, discussed earlier in this chapter). However, the unwanted child which forces a marriage seems especially likely to experience child abuse. Among 115 families having 180 children referred to a Massachusetts' child-abuse-prevention agency in 1960, "slightly less than 50% [p. 3]"

of these families experienced premarital conception (Merrill, 1962).

She Can Raise the Child Herself
as an Unwed Mother

Several studies have documented the ill-effects of a woman keeping her illegitimate child (Berkman, 1969; Glasser & Navarre, 1965; Latimer, McGuire, Startzman, & Swisshelm, 1965). These detrimental consequences of illegitimate motherhood apply to the mother, her child, succeeding generations, and ultimately society.

Investigating the living conditions of 118 unwed mothers who chose to keep their child, Latimer et al. (1965) found that 39 of the children had been passed on to at least one other mother figure and 26 had received inadequate medical care. Many of these mothers demonstrated marked apathy, using neither their intelligence nor work experience--only 34 mothers were working. These women seemed to generally have found little satisfaction in constructive activity.

Rosen (1967a) and Sarrel, Holley, and Anderson (1968) have dramatically illustrated how an unwed mother may never finish her education, spend her life doing menial labor or become dependent on welfare programs, and struggle to develop a stable family. Berkman (1969) has shown that spouseless mothers also consistently display a higher prevalence of physical and psychological

morbidity than do their married counterparts. These women, accorded the responsibility of raising a child without a spouse, were more economically deprived, displayed poorer morale (revealing less general satisfaction and happiness), were more psychologically predisposed to stress (suggesting a greater proneness to stress), and had poorer ego-strength (suggesting less ability to cope with stress).

Glasser and Navarre (1965) further elaborate upon the detrimental consequences of the "one-parent family." They assert this family is more likely than the two-parent family to experience poverty, poor social status, and poor social and emotional functioning. Glasser and Navarre claim the spouseless mother may become physically and mentally exhausted with no one to give her support or to meet her emotional needs. She doubts her personal adequacy, is restricted in social ties, and is restricted in her problem solving ability. This family structure is also prone to provide a less than adequate socialization process for the child. He receives less attention and emotional support than he would expect to receive from a two-parent family. His social skills may be impaired and his self-image, as well as his image of the adult world, may be distorted. Consequently, the child may act out destructively in the community and/or have emotional problems in school and with peers (Glasser & Navarre,

1965). Chilman and Sussman (1964) provide evidence which shows that this one-parent family structure, with its poverty and its destructive experience for each family member, tends to be passed from generation to generation.

She Can Give the Child Up
for Adoption

Rossi (1966) and Rosen (1967a) both emphasize the hurt and turmoil experienced by a single woman who gives up the infant which she has carried to term. These authors claim that such a woman senses the cruelty and sadism of those who encourage her to give up her child. Also, that her actually giving away her child after such encouragement often produces serious emotional consequences. Certainly this experience isolates her from society, temporarily or permanently disrupts her education, often marks her as a social outcast shunned by others, and diminishes her feelings of self-esteem. Her personal disparagement could severely disrupt her social and emotional functioning and grossly impair her future as a capable and productive individual. Her feelings of loss, rejection, and anger after this experience could serve to further jeopardize future relationships with males, impair her functioning as a mother to subsequent children, and foster anger toward a "generalized society who told her to deliver a child and who then took it from her."

There is also a strong probability that the child she gives up may suffer a rather dismal existence.

Humphrey (1964) refers to a Florida study of 484 private adoptions of children whose ages ranged from 9 to 15. Of these children, 70 percent had "achieved fair social and emotional adjustment on a combination of different measures [p. 13]." Among the home placements, 30 percent were "rated as definitely unfavorable [p. 13]."

Another problem of much concern is the growing discrepancy between the number of persons wanting to adopt a child and the number of adoptable children (President's letter, 1969). A nationwide survey conducted by the Child Welfare League of America found that for the period 1958-1967, the number of adoption applicants "almost doubled" while the number of available children tripled. A Committee on Psychiatry and the Law (The right to abortion, 1969) has stated that in past years many persons who wanted to adopt a child were unable to do so because the number of available children was limited. Prospective parents also had to pass lengthy and stringent qualification procedures. However, this committee points out that this has been untrue in more recent years--"in many urban areas it is currently impossible to find adequate foster parents for unwanted infants [p. 212]." Actually during 1958-1967, placement requirements were more liberal and a 36 percent rise in the ratio of placements to

applications was reported. However, the wide discrepancy between the number of placements and children available for placement persists (President's letter, 1969). These statistics also underestimate the extent of the adoption problem, particularly for nonwhite children.

The nonwhite children counted as available are only a fraction of the total who need adoptive homes since "available" refers only to those children who have been accepted for placement by an adoption agency. Agencies cannot possibly accept all children needing adoption because, with the present limited resources, finding homes for them would be quite hopeless. There are tens of thousands of children, in addition to those on agency rolls, who are "available" in the sense that adoption might be sought if adoptive homes were available (President's letter, 1969).

Foote, Levy, and Sander (1966) assert that of the estimated 3 million illegitimate children under the age of 18 living in the United States as of December, 1961, only 31 percent had been adopted. Further illustrating that the current adoption situation is most harmful to nonwhite children is the finding that of the 31 percent of these children who were adopted, only 5 percent were nonwhite.

The Adoption Resource Exchange of North America also recognizes the lack of prospective parents, asserting that

at present, uncounted thousands of children, legally free for adoption, will spend their childhood years in foster care, often in a succession of temporary homes and in crowded institutions, unless adoptive families can be found for them (Adoption Resource Exchange of North America--sponsored by the Child Welfare League of America--Brochure, 1968, p. 4).

A majority of these children are considered to be older than two years of age, or to have physical defects, or to demonstrate emotional problems, or to be of racially mixed or minority backgrounds.

Contrary to present adoption practices, it is most desirable that all adoptable children be placed at a very young age. A child who is adopted later in life is especially likely to experience social and emotional maladjustment. Concerning 2,000 children of adoptive and natural parents attending a psychiatric clinic in England, Humphrey (1964) asserts parental complaints about their adopted and their own children were similar but that "children adopted after the age of six months were more likely to give rise to a complaint of antisocial conduct [p. 14]." Humphrey related this finding to earlier studies suggesting a relationship between parental deprivation and delinquency, and also asserted that children adopted at an older age are more likely to be placed in an inadequate home. The research reviews by (Bowlby, 1966; Ainsworth, 1966; Yarrow, 1961) also demonstrate the detrimental and often irreversible effects of early maternal deprivation. Because a great number of children currently adoptable are not being adopted at an early age, if at all, the social and emotional well-being of many of these children are subject to grave impairment.

She Can Seek Illegal Abortion

The unwed pregnant woman who seeks to meet her strongly felt needs through an illegal abortion is subject to the risks of death and impaired health as discussed earlier. However, the experience of a single woman obtaining an illegal abortion may be even more detrimental for her than it is for a married woman. The unwed woman is more apt to undertake this experience alone without the support of a close relative or friend. Lacking such support, and because she is often younger and, consequently, often more emotionally immature than the married woman, she is more vulnerable to the psychological stress of knowingly violating "the law" and of having to trust her very life to some stranger. Also, she may experience more difficulty than a married woman in obtaining sufficient funds to obtain the services of a more skilled abortionist. Thus, the unwed woman is more likely to experience the hazards of the "back abortionist" or she may more frequently attempt self-abortion.

Detrimental Effects of Unwanted Conception Upon the General Public

Although unwanted conception most directly impairs personal and parental functioning, disrupts the family unit, and scars the unwanted child; it also has a powerful, destructive impact upon the functioning and development of society. The destructive influence of unwanted conception

upon total society is demonstrated through its propagating: (1) poverty, (2) a lower level of educational and vocational attainment, (3) a widening division among the social classes, (4) extensive mental health problems experienced as criminal acts as well as personal and family misery, and (5) an emotional division among individuals within society and across societies.

The more financially and educationally deprived persons (white and nonwhite) constituting the lower socio-economic classes have consistently been found to have larger families and a greater number of unwanted children than do their higher income, more educated class counterparts (Freedman, Whelpton, & Campbell, 1959; Whelpton, Campbell, & Patterson, 1966; Rainwater, 1965; Blood & Wolfe, 1960). The lower class parent with his limited finances and large family becomes burdened with just providing his family with the essentials of daily living. He does not have the money nor the attitude to provide his children with educational and job skills which would lift them out of their family's poverty. Instead, these children without adequate education and with poor job training, eventually marry and fine themselves--as their parents before them--raising large families with unwanted children who also will be poorly educated and lack job skills. Vicious circles of poverty and emotional deprivation are established which escalate geometrically over generations.

In addition to comparative economic deprivation, these poorer and larger families become progressively more socially and psychologically isolated from higher social class families. With their larger income and their greater educational attainment, the wealthier form a unique and separate world of interests, a world of thoughts and actions inaccessible to the economically and educationally deprived. The lower socio-economic classes similarly develop a unique system of socialization and mores often very different from those of the higher income classes. The more expansive growth of unwanted persons among the poorer classes compared to that among the wealthy upper classes would appear to foster unique class environments and to enlarge the resultant social and psychological chasm between the classes. Consequently, society continues to become emotionally fragmented, reducing mutual interaction, self-satisfaction, and productivity among all members of society. The resulting social fragmentation, propelled by the effects of unwanted conception, could ultimately find "class identities" in such sharp conflict as to disrupt any resemblance of what could have been a unified, mutually productive and satisfied society.

Beisdes the institutionalization of poverty, lower levels of education, and the social-psychological gap between classes; the unwanted frequently experience personal emotional turmoil which becomes destructively manifest and propagated within their families, within

society, and across societies. A child develops his self-concept, concept of others, and emotional stability, primarily through interaction with his parents. Personal feelings of worth, adequacy, empathy, trust in others, and the ability to interact with his environment in a mutually constructive manner largely depend on the form of this parent-child interaction. The unwanted children of hostile, rejecting (direct or indirect) parents generally do not develop feelings and a concept of themselves or of others which would enable them to function harmoniously within themselves or within society or across societies. Dramatic supporting evidence is often found in the family backgrounds of multiple murderers, including the Boston Strangler (Frank, 1966) who was charged with the sex-related slayings of 13 women and the Texas sniper (Megargee, 1969) who killed 14 persons and wounded 31 others in a shooting spree at the University of Texas.

As was discussed earlier, many of these unwanted persons who experience rejecting parents come to the attention of mental health clinics as children, unsocialized and aggressive; overinhibited and fearful; or withdrawn and schizoid. As adults they manifest sociopathic, neurotic, or psychotic disturbances. The unsocialized aggressive child and later sociopathic adult, with his hatred and rejection of others and his frequent participation in criminal acts, poses a direct threat to those

around him. Similarly, the rejected child who becomes an adult neurotic or psychotic--while miserable within himself--can disrupt the functioning of his family and others with whom he comes into contact.

Just as poverty is affected by unwanted children and propagated in geometric fashion, so is poor mental health with its detrimental effects upon the individual, family, and society. A dramatic illustration of this propagation can be found even in the very specific case of child abuse and neglect where a child himself once abused and neglected often becomes a parent to abuse or neglect his children (Morris, Gould, & Matthews, 1964). The unwanted person with his poor self-concept, negative view of others, and emotional instability fosters similar deficiencies in his children who in turn transmit these to their offspring. Such deficiencies are passed on to children through a child's learning from (modeling and imitation) and identifying with his parents who as a result of their experiences as unwanted children are not able to provide their children with appropriate learning situations, controls, structure, attention, and affection. These parents present themselves to their children as inadequate, insecure, emotionally distant, and as having poor concepts of themselves, as well as distorted concepts of others.

Of distinct importance is the unwanted person's displacement and projection onto others of his mistrust and the intense anger originally experienced toward his hostile, rejecting parents. These feelings are often directed toward and attributed to persons who are in some way different from the unwanted person, such as minority groups and other societies. This manner of dealing with such feelings fosters prejudice, fear, and hatred among people within society, sometimes leading to open conflict. Across societies such feelings often contribute to wars. Similar stark societal implications of unwanted conception have been stressed by Menninger (1967).

Aside from the educational, social, and emotional costs fostered upon the general public by unwanted conception, there also exists a social-economic cost--billions of dollars being spent in futile attempts to cope with the disastrous effects of unwantedness which otherwise could be spent to better the educational, social, and mental well-being of a "wanted society." As of March 31, 1967, 772,200 children were being served by public and voluntary child welfare agencies (Child welfare statistics, 1968). Toward the support of these children, many of whom were unwanted, more than 450,000,000 dollars were provided by federal, state, and local funds (Child welfare statistics, 1968). Additional billions of dollars are poured into the funding of a wide variety of mental health clinics and institutions and into the maintenance of penal and

related inservices. Additionally, to receive the services of an illegal abortionist, women spend a yearly estimate of 350,000,000 dollars (Lowe, 1966)--money which otherwise might well be spent toward personal, family, and societal enrichment.

In summary, restrictive abortion laws do not meet the needs of individuals and society. Quite the contrary, such laws seem plainly detrimental to individuals, families, and society. Many women experience physical and/or mental anguish in their defiance of these laws. Individuals, families, society, and societies suffer from the disastrous consequences of many unwanted conceptions whose number has been enhanced by restrictive abortion laws. To more appropriately meet their needs, the general public has advocated the revision of restrictive abortion laws. The form of abortion laws desired by the people--their wants being as critical as are their needs in the determination of the law's content--is discussed in the following section.

The Peoples' Wants

Among the earlier opinion polls, people desired abortion laws which would permit a legal abortion if a pregnancy resulted from rape or incest, presented a risk to maternal physical or emotional health, and demonstrated probable fetal defects. Chapter VI provides a detailed

discussion of the attitude polls conducted among the general public. Initially only a small number of persons openly favored legalized abortion for socio-economic reasons (poverty, unwed woman, getting a divorce, reaching end of reproductive period, considered unfit mother, child unwanted and treated as such). However, their number has progressively grown so that currently "at least" a significant minority of persons favor the legalization of abortion for socio-economic reasons. One recent national survey found that 64 percent of the respondents thought abortion should be the decision of the parents and their physician--not a matter of law (Changing morality, 1969).

Recommendations

Based upon the needs of the people, the wants of the people, and the necessity for efficient, effective, public supported laws to provide for the harmonious expression of diverse ethics held by significant minorities, it is to the benefit of individuals, families, society, and societies that abortion statutes permit a woman to obtain a legal, medically performed abortion whenever she so desires.

If the laws were revised so as to permit abortion only for reasons of rape, incest, fetal defects, and risk to maternal health--as they have been revised in several states--they would have little, if any, effect on the present tragedy of unwanted conception. Such laws would

do little to reduce the great incidence of unwanted conception which adversely affects individuals, families, and society. Only a small percentage of the women who seek illegal abortion do so for reasons pertinent to rape, incest, fetal defects, or health. The great majority of illegal abortions are sought for social and/or economic reasons. Permitting abortion for reasons of rape, incest, fetal defects, and maternal health--but not for social and economic concerns--has been projected to reduce the current number of illegal abortions by estimates which range from less than 1 percent (Neuhaus, 1967) to 15 percent (Abortion gets first thorough U.S. airing, quoting Bayless Manning, Dean of the Stanford University Law School, 1967, p. 13). This former figure would appear, however, to be a gross overexaggeration. Support for this view comes from public health authorities who estimate that if all states were to pass such "liberal legislation," the current 10,000 annual legal abortions would be increased by only 3 to 5 percent (Kerby, 1967). Such a 3 to 5 percent increase in the number of legal abortions would correspond to a reduction of less than 1 percent of the illegal abortions.

While continuing to result in countless numbers of unwanted individuals and in many women subjecting themselves to hazards of illegal abortion, the application of laws permitting abortion only for rape, incest, fetal

defects, and maternal health would also continue to foster discrimination between the wealthy and the poor and between single and married women. To obtain an abortion for any one of these limited reasons, a woman generally is required to have the consent of one or more physicians or psychiatrists. Low income persons cannot afford these pre-evaluation measures or the exorbitant operative costs. Monroe (1969) reports that a California survey found doctor and hospital fees for a legal abortion to average from 600 to 700 dollars. Illustrating that the cost of a legal abortion can be even greater, Monroe cites the case of a 15-year-old who paid a total of 1,800 dollars to her doctor, psychiatrist, and hospital. Physicians have also been reported to charge excessive fees just to submit an abortion request to a hospital abortion committee. Dr. Overstreet of the University of California asserts that, "A number of psychiatrists are charging 100 dollars for a single consultation with a letter of recommendation for therapeutic abortion [in Monroe, 1969, p. 271]." Not only do financial considerations prevent the poor woman from seeking psychiatric consultation for a legal abortion, equally relevant is her lack of sophistication about approaching a private psychiatrist and her fear of feeling uncomfortable and inadequate in front of a person of much higher social status.

Furthermore, the wording of laws which permit abortion only for rape, incest, fetal defects, and maternal health is often so vague so as to foster fear of prosecution among physicians and hospitals which permit abortion. Divergent practices would continue to exist among physicians and hospitals. Rape is difficult to prove; fetal defects remain at the level of statistical probability; and, risk to maternal health, particularly mental health, is subject to wide interpretation.

When legally permitting a woman to abort when she so desires, no one needs to consent to the operation other than the woman and her physician. The only legitimate concern of the physician is that the operation not pose a serious threat to the woman's physical health. While the decision to abort would hopefully emanate from agreement between the woman and her partner, the woman's decision must be given priority. She is the one who must carry the child in utero, deliver it, nurse it, and spend the most time as well as physical and emotional energy caring for it, and who will probably receive custody of the child in the case of divorce.

The physician has no special qualifications for deciding what social, economic, ethical, or humanitarian reasons should permit an abortion. His expertise is restricted to determining the physical condition of the woman, assessing possible hazards of the operation to her

physical health, and performing the operation. He can best assess the woman's physical status, the period of gestation,* and the most suitable method of abortion. The woman can best decide when abortion is indicated for her and give suitable weights to social, economic, ethical, and humanitarian reasons in terms of her own wants and needs.

Permitting a woman to obtain a medically performed abortion upon her request allows the tolerable expression of beliefs among persons with diverse moral codes. Such a policy would not require a woman to have, nor a physician to perform, an abortion if that constitutes a violation of their personal moral code. The decision to have or not have an abortion should best be a personal and private decision consistent with one's personal beliefs, needs, and wants.

This liberal abortion policy should legally stipulate that abortion can be performed only by medically trained and qualified individuals. It should levy penalties upon untrained persons attempting to perform an abortion. Such provisions are necessary to safeguard the woman's health.

*Unless a woman displays physical contraindications, an abortion is considered safe if performed during the first three months of pregnancy. An abortion can be performed after three months of pregnancy and until the time of delivery, but the operation becomes progressively more risky to the woman's health as the pregnancy extends beyond three months.

Desirable health safeguards would result from readily accessible consulting services where a woman (and her partner) considering an abortion could see a qualified counselor (psychologist, social worker, psychiatrist, etc.) to more fully explore her feelings about abortion and to assist her in arriving at her decision. It is strongly emphasized that the purpose of such consultation services should be to explore the woman's feelings so that she can arrive at a decision most pertinent to her needs. The counselor should in no way allow his personal morals or beliefs to influence this decision. If the woman decides to abort, these services should also be available to her after the operation so that she may discuss any possible concerns. Such clinical services would provide a preventive mental health function with a beneficial impact upon the woman, her family, and, ultimately, society. In some cases, such consultation may result in referrals for more extensive psychological treatment which may ultimately foster a more adjusted life for the woman (and/or her husband) and an improved family situation. Although a woman may decide to abort a current unwanted conception, she may deliver future wanted children because of the resolution of temporarily detrimental conditions to a child's development, her life, and the family's functioning.

These consultation services should be supported by federal and state funds and, like abortion itself, made

available on an "ability to pay" fee schedule. In collaboration with existent community mental health clinics, these abortion consultation services could be located in the clinic setting or, if a woman is physically unable to come to the clinic, available through home visits. Adjusted to financial ability to pay and well-publicized, such services would enable more indigent women to benefit than if such services were offered only by professionals in private practice. For indigent women, welfare services should also be able to pay the cost of the operation which, if billed realistically, should normally be modest. Providing for the cost of the operation would ultimately be far less costly even in dollars --let alone in human misery--than providing for the detrimental social and emotional cost of numerous unwanted offspring. Also, federal, state, and local monies which otherwise would be spent for the maintenance of unwanted persons would more than cover these public health costs.

Although abortion law revision seems much needed and strongly desired, abortion certainly cannot be reasonably viewed as the "most desirable" way of preventing unwantedness. Ideally all fertile individuals who engage in sexual activity would practice effective contraception so that abortion would be an unnecessary method of preventing unwantedness and its consequences. However, such contraceptive idealism is not consistent with reality and abortion is needed to prevent the adverse

accompaniments of unwantedness. Many persons do not use contraception. Even among those persons who do practice contraception, the method used may be less than completely effective or the method may be misapplied. Several studies may be cited to illustrate this current ineffective use or disuse of contraceptives. Among women participating in a study by Larsen et al. (1968), 46.6 percent reported that their current pregnancy was unplanned. Pohlman (1969) reviews literature demonstrating the failure of current contraceptive techniques. Also, among 282 women who obtained an illegal abortion, 72 percent stated they were practicing some method of birth control when conception occurred (Lader, 1969).

Concomitant with the liberal abortion policy required to reduce unwantedness fostered by the ineffective use of contraception, strong efforts should be made to establish: (1) the widespread use of contraception, (2) educational programs which facilitate a realistic perspective upon the emotionally charged topics of contraception, sexuality, and parenthood, and (3) the development of safer and more effective contraceptive techniques.* The fruit of such efforts would be a reduction of the incidence and disaster of unwanted conception, enhanced mental health among offspring and parents, and reduction

*A discussion of these suggested programs is provided in Appendix M.

of the number of needed and desired abortions. Liberal abortion policies seem presently required, however, to meet current needs and would still be needed even if the contraceptive programs suggested above could be effectively implemented. For years to come, many people will not use contraception, will be physically unable to use the most effective techniques, or will incorrectly use contraception. Consequently, unwantedness and its related misery will continue to exist and demand the creation and implementation of liberal abortion policies for its alleviation.

Because it has been clearly documented that abortion services are less available to the poorer element of the population, even though their needs for such services are greatest, the financial issue must be squarely faced. To effectively reduce the varied human miseries associated with unwanted pregnancies no appreciable economic barrier can be tolerated between the abortion-seeker and the physician. Yet, in New York, the state with the most liberal current abortion statute, a September 15, 1970, release from the Abortion Information Agency, Inc. of New York City (Abortion counseling, 1970) describes the total cost of abortions for non-residents as ranging from \$300 to \$1100. Low-cost abortions appear to be available only to indigent New York City residents who are treated in municipal hospitals where the quality of medical care is frequently dubious. Thus, even in New

York, the financial barrier seems to remain. Until public policy makes high quality medical care generally available without financial hardship to the abortion-seeker, abortion reform statutes will remain largely an empty gesture. Until national health insurance covers all citizens, it seems essential that states which enact more liberal abortion laws accompany such laws with directives to their public health departments to assure the general availability of low cost but high quality abortion services.

Conclusion

In conclusion, the public's need for liberal abortion laws is demonstrated by the disastrous consequences of unwanted conception upon individuals, families, and society at large. Furthermore, the people have expressed and will continue to express their desires for more liberal abortion policies. Their wants find expression through massive violations of current restrictive abortion laws, their response to opinion surveys, and their widespread use of the media. The general public is now asking the legislator and the court to fulfill their responsibility as the peoples' representatives by responding to the public's needs and wants with liberal abortion policies. To appropriately respond to these clearly expressed needs of the people, legislators and judicial officials may have to oppose a powerfully and politically organized Catholic minority. They may also have to

insightfully differentiate between their personal morals and those held by a majority or significant minority of society. However, legislators and judicial officials as the peoples' representatives have the delegated responsibility of enacting the peoples' needs and wants rather than implementing the legislator's or judicial official's personal needs. If legislators and judges act in ways which result in the maintenance of current restrictive abortion statutes, they will be responding to their personal wants while ignoring the wants and needs of their constituents. Such officials will be encouraging the tragedy of unwanted conception and many related human miseries. If legislators and judges are to conscientiously respond to their constituents, they must enact more liberal abortion policies. In this way, they will assist all of society in taking a notable step toward the fruits of a responsible and wanted society, increased freedom of choice, and the enhanced human dignity which only freedom can permit.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Abortaria. Time, October 19, 1936, 28, 70-71.
- Abortion and mental health. America, 1967, 116, 239.
- Abortion and the courts. Scientific American, January 1970, 50+.
- Abortion and the law. American Medical Woman's Association Journal, 1966, 21, 232.
- Abortion and the sick mind. America, 1965, 113, 37-38.
- Abortion comes out of the shadows. Life, February 27, 1970, 20B+.
- Abortion counseling information and referral services.
A division of the Abortion Information Agency, Inc., New York, September 15, 1970. (Information release)
- Abortion gets its first thorough U.S. airing. Science Newsletter, September 23, 1967, 92, 297-298.
- Abortion law voided; New test cases seen? American Medical News, November 24, 1969.
- Abortion legislation. The AMA News, March 31, 1969.
- Abortion 'quota' system described. American Medical Association News, April 7, 1969.
- Abortion refused, parents of deformed baby win suit. The Detroit Free Press, Detroit, Michigan, 1968.
- Abortion resolution approved by the American Baptists at its Boston convention, May 31, 1968.
- Abortion: The doctor's dilemma. Modern Medicine, April 24, 1967, 12-14+.

Abortionist convicted. Time, March 6, 1944, 43, 60+.

Adam, J. (Ed.) The republic of Plato. Cambridge: Cambridge University Press, 1938.

Adoption resource exchange of North America. Sponsored by the Child Welfare League of America, 1968. (Brochure)

Ainsworth, M. D. The effects of maternal deprivation: A review of findings and controversy in the context of research strategy. In Deprivation of maternal care. New York: Schocken Books, 1966. Pp. 289-357.

AMA policy on therapeutic abortion, Committee on Human Reproduction. Journal of the American Medical Association, 201 (2), 1967, 544.

Arén, P. Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1958, 37 (Suppl. 1).

Aristotle. History of animals. (Translated by R. Crasswell), London: George Bell & Sons, 1887.

ASA survey of public opinion on abortion in New York. ASA Association for the Study of Abortion, Newsletter, 1968, 3 (1), 2-3.

Baldwin, A. L., Kalhorn, J., & Breese, F. H. Patterns of parent behavior. Psychological Monographs, 1945, 58, No. 3 (Whole No. 268).

Barno, A. Obstetric infection deaths in Minnesota--Part II. Minnesota Medicine, 1964, 47 (2), 1139-1142.

Barno, A. Criminal abortion deaths, illegitimate pregnancy deaths, and suicides in pregnancy: Minnesota, 1950-1965. American Journal of Obstetrics and Gynecology, 1967, 98, 356-367.

Bass, B. 1927. Cited by S. Stamer, Partial and total atresia of the uterus after excochleation. Acta Obstetricia et Gynecologica Scandinavica, 1946, 26, 263-297.

Bates, J. E., & Zawadzki, E. S. Criminal abortion. Springfield, Ill.: Charles C. Thomas, 1964.

- Bengtsson, L. Graviditet och sjalvmord, Svenska akartidningen 44: 1469, 1947. Cited by M. Ekblad, Induced abortion on psychiatric grounds. (Translated by D. Burton), Acta Psychiatrica et Neurologica Scandinavica, 1955 (Suppl. 99).
- Berelson, B. American attitudes on population policy. Studies in Family Planning, The Population Council, January 1966, No. 9, 5-8.
- Berkman, P. L. Spouseless motherhood, psychological stress, and physical morbidity. Journal of Health and Social Behavior, 1969, 10, 323-334.
- Berthelsen, H. G., & Ostergaard, E. Komplikationer og mortalitet ved legal abortus provocatus. Ugeskr laeg, July 31, 1958, 120, 1005-1009. Cited by C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154.
- Blood, R. O., & Wolfe, D. M. Husbands and wives: The dynamics of married living. New York: Free Press of Glencoe, 1960. Cited by E. Pohlman, The psychology of birth planning. Cambridge: Schenkman, 1969. P. 204.
- Bolter, S. The psychiatrist's role in therapeutic abortion: The unwitting accomplice. American Journal of Psychiatry, 1962, 119, 312-316.
- Bovin, E. Vad lara oss verkningarna av den ryska abortlagsstiftningen? Sv. Lak. tidn. 1934, 31: 877. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- Bowlby, J. Maternal care and mental health. New York: Schocken Books, 1966.
- Brecker, E. M. We are all our mothers' daughters: What sex research reveals about unhappy wives. Redbook, November 1969, 134, 1, 71+.
- Brekke, B. In M. Calderone (Ed.), Abortion in the United States. New York: Paul B. Hoeber, Inc., 1958.
- Brew, M. F., & Seidenberg, R. Psychotic reactions associated with pregnancy and childbirth. Journal of Nervous and Mental Disease, 1950, 111, 408-423.

- Brunner, E. K. The outcome of 1556 conceptions: A medical sociological study. Human Biology, 1941, 13, 159-176.
- Brunner, E. K., & Newton, L. Abortions in relation to viable births in 10,609 pregnancies. American Journal of Obstetrics and Gynecology, 1939, 38, 82-90.
- Burchinal, L. G. Comparisons of factors related to adjustment in pregnancy-provoked and non-pregnancy-provoked youthful marriages. The Midwest Sociologist, 1959, 21, 92-96.
- Burgess, E. W., & Cottrell, L. S. Predicting success or failure in marriage. New York: Prentice-Hall, Inc., 1939.
- Calderone, M. S. (Ed.) Abortion in the United States. New York: Hoeber-Harper, 1958.
- Calderone, M. S. Illegal abortion as a public health problem. American Journal of Public Health, 1960, 50 (2), 948-954.
- Campaign to make legal abortion easier. Good Housekeeping, March 1967, 164, 191-193.
- Campbell, A. A. The "growth of American families" studies. Welfare in Review, 1965, 3, 10, 17-22.
- Canavan, F. History repeats itself. America, May 21, 1966, 114, 738-742.
- Cernoch, A. Experiences in Czechoslovakia with the effects and consequences of legalized artificial termination of pregnancy. Unpublished paper delivered at U.N. World Population Conference, Belgrade, August 30-September 10, 1965. Cited by L. Lader, Abortion. Boston: Beacon Press, 1966.
- Changing morality: The two Americas. Time, June 6, 1969, 26-27.
- Child welfare statistics 1967. U.S. Department of Health, Education, and Welfare, Children's Bureau Statistical Series, 92, 1968.
- Chilman, C., & Sussman, M. Poverty in the United States. Journal of Marriage and the Family, 1964, 26, 391-395.

- Christensen, H. T. Studies in child spacing: I--Premarital pregnancy as measured by the spacing of the first birth from marriage. American Sociological Review, 1953, 18, 53-59.
- Christensen, H. T., & Meissner, H. H. Studies in child spacing: III--Premarital unwanted pregnancy as a factor in divorce. American Sociological Review, 1953, 18, 641-644.
- Cohen, A. E. A Jewish view toward therapeutic abortion and the related problems of artificial insemination and contraception. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 166-174.
- Cohen, M. B. Personal identity and sexual identity. Psychiatry, 1966, 29, 1-14.
- Colorado abortion reform assessed. The New York Times, December 8, 1969, 1+.
- The Columbia-Viking desk encyclopedia. New York: Dell, 1964.
- Connolly, V. Death before birth. Reader's Digest, April 1944, 44, 77-79.
- Constitutional rights. Time, September 19, 1969, 66.
- Cook, L. Abortion reform in U.S. is spreading rapidly. The Flint Journal, Flint, Michigan, March 23, 1970, 8.
- Cooke, R. E., Hellegers, A. E., Hoyt, R. G., & Richardson, H. W. (Eds.) The terrible choice: The abortion dilemma. New York: Bantam Books, 1968.
- Curran, F. J. Religious implications. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 153-165.
- Curtis, J. L. A psychiatric study of 55 expectant fathers. United States Armed Forces Medical Journal, 1955, 6 (7), 937-950.
- Darby, P. Legal abortion. New Society, August 13, 1964, 98 (4), 16-18.

- David, L. The truth about one million abortions a year. Coronet, June 1958, 44, 78-86.
- Davis, M. Have your baby. Good Housekeeping, June 1944, 118, 45.
- De Frances, V. Child abuse: Preview of a nationwide survey. Denver: Children's Division, American Humane Association, 1963. Cited by E. Pohlman, The psychology of birth planning. Cambridge: Schenkman, 1969. P. 315.
- Decker, D. G. Medical indications for therapeutic abortion. Minnesota Medicine, January 1967, 50 (1), 29-32.
- Decrease in births. EMKO Newsletter, October 1969, 2.
- Despres, M. A. Favorable and unfavorable attitudes toward pregnancy in primiparae. Unpublished doctoral dissertation, University of Chicago, 1946. Cited by P. Wallin & R. P. Riley, Reactions of mothers to pregnancy and adjustment of offspring in infancy. American Journal of Orthopsychiatry, 1950, 20, 617.
- Devereux, G. A study of abortion in primitive societies. New York: The Julian Press, Inc., 1955.
- Directory of medical specialists. Vol. 12. Chicago: Marquis--Who's Who, Inc., 1965.
- The doctor's fears. Newsweek, October 25, 1954, 44, 98.
- Downs, F. S. Maternal stress in primigravidas as a factor in the production of neonatal pathology. Nursing Science, 1964, 2, 348-367.
- Drinan, R. F. The inviolability of the right to be born. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 107-123. (a)
- Drinan, R. F. Contemporary Protestant thinking. America, 1967, 117, 713-715. (b)
- Easing abortion rules. Newsweek, July 3, 1967, 70 (1), 51.
- Easton, S. C. The western heritage. New York: Holt, Rinehart, and Winston, Inc., 1966.

- Ehrlich, E. Fundamental principles of the sociology of law. New York: Russell & Russell, Inc., 1962.
- Ekblad, M. Induced abortion on psychiatric grounds. (Translated by D. Burton), Acta Psychiatrica et Neurologica Scandinavica, 1955 (Suppl. 99).
- English, O. S., Katz, M., Scheflen, A. E. Danzig, E. R., & Speiser, J. B. Preparedness of high school and college seniors for parenthood. A.M.A. Archives of Neurology and Psychiatry, 1959, 81, 469-479.
- Ethics of abortion. Time, July 15, 1957, 70, 93.
- Feniger, R., & Wetterdal, P. Om risker vid legalt avbrytande av havandeskap. Nord. Med. 1947, 35: 1528. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- Ferreira, A. J. The pregnant woman's emotional attitude and its reflection on the newborn. American Journal of Orthopsychiatry, 1960, 30, 553-561.
- Fisher, R. S. Criminal abortion. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 3-11. (a)
- Fisher, R. S. Personal communication with H. Rosen. Cited by H. Rosen, A case study in social hypocrisy. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. P. 304. (b)
- Foote, C., Levy, R. J., & Sander, R. E. A. Cases and materials on family law. Boston: Little, Brown & Co., 1966.
- Forssman, H., & Thuwe, I. One hundred and twenty children born after application for therapeutic abortion refused. Acta Psychiatrica Scandinavica, 1966, 42, 71-88.
- Frandsen, E., Mosbech, J., & Molgaard, B. Abortus provocatus i Danmark i 1955 og 1957. Ugeskar laeg, October 1, 1959, 121, 1538-1543. Cited by C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154.

- Frank, G. The Boston strangler. New York: The New American Library, Inc., 1966.
- Freedman, R., Whelpton, P. K., & Campbell, A. A. Family planning, sterility, and population growth. New York: McGraw-Hill, 1959.
- Freeman, T. Pregnancy as a precipitant of mental illness in men. British Journal of Medical Psychology, 1951, 24, 49-54.
- Friedan, B. The feminine mystique. New York: Dell, 1963.
- Friedmann, W. Legal theory. New York: Columbia University Press, 1967.
- Gains for birth control. Newsweek, December 13, 1965, 66, 94.
- Geisman, L. L., & La Sorte, M. A. Factors associated with family disorganization. Marriage and Family Living, 1963, 25, 479-481.
- George, B. J., Jr. Current abortion laws: Proposals and movements for reform. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 1-36. (a)
- George B. J., Jr. Current abortion laws. Illinois Medical Journal, 1967, 131, 696-700. (b)
- The GH poll: Should abortion laws be eased? Good Housekeeping, October 1967, 165, 12+.
- Glasser, P., & Navarre, E. Structural problems of the one-parent family. Journal of Social Issues, 1965, 21, 1, 98-109.
- Glueck, S., & Glueck, E. Unraveling juvenile delinquency. Cambridge: Harvard University Press, 1950.
- Gold, E. Cited by D. Lowe, Abortion & the law. New York: Pocket Books, 1966. Pp. 8-9.
- Gold, E. M., Erhardt, C. L., Jacobziner, H., & Nelson, F. G. Therapeutic abortion in New York City: A 20-year review. American Journal of Public Health, 1965, 55 (2), 964-972.
- Good, F. L., & Kelly, O. Marriage, morals and medical ethics. New York: P. J. Kenedy and Sons, 1951.

- Gordon, L. V. SRA Manual for Survey of Interpersonal Values. (Preliminary ed.) Chicago: Science Research Associates, Inc., August 1960.
- Gordon, L. V. Gordon Personal Profile. (Manual) New York: Harcourt, Brace & World, Inc., 1963.
(a)
- Gordon, L. V. Gordon Personal Inventory. (Manual) New York: Harcourt, Brace & World, Inc., 1963.
(b)
- Gordon, R. E., & Gordon, K. K. Some social-psychiatric aspects of pregnancy and childbearing. The Journal of the Medical Society of New Jersey, 1957, 54, 569-572.
- Gordon, R. E., & Gordon, K. K. Social factors in the prediction and treatment of emotional disorders of pregnancy. American Journal of Obstetrics and Gynecology, 1959, 77, 1074-1083.
- Gray, H. Marriage and premarital conception. Journal of Psychology, 1960, 50, 383-397.
- Greep, R. O. (Ed.) Human fertility and population problems. Cambridge: Schenkman, 1963.
- Grimm, E. R., & Venet, W. R. The relationship of emotional adjustment and attitudes to the course and outcome of pregnancy. Psychosomatic Medicine, 1966, 28, 34-49.
- Grounds for abortion. Science News Letter, August 3, 1963, 84, 75.
- Guttmacher, A. F. Babies by choice or chance. New York: Doubleday and Company, 1959. Cited by J. E. Bates & E. S. Zawadzki, Criminal abortion. Springfield, Ill.: Charles C. Thomas, 1964.
- Guttmacher, A. Techniques of therapeutic abortion. Clinical Obstetrics and Gynecology, 1964, 100, 105. Cited by K. R. Niswander, Medical abortion practices in the United States. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 37-59.
- Guttmacher, A. F. (Ed.) The case for legalized abortion now. Berkeley: Diablo Press, 1967.

- Hall, R. E. Therapeutic abortion, sterilization, and contraception. American Journal of Obstetrics and Gynecology, 1965, 91, 518-532. (a)
- Hall, R. E. New York abortion law survey. American Journal of Obstetrics and Gynecology, 1965, 93, 1182-1183. (b)
- Hall, R. E. Cited by The abortion epidemic. Newsweek, November 14, 1966, 68, 92.
- Hall, R. E. His birth without permission. Saturday Review, December 7, 1968, 78-79.
- Hamilton, G. V. A research in marriage. New York: Albert & Charles Boni, Inc., 1929.
- Harter, C. L., & Beasley, J. D. A survey concerning induced abortions in New Orleans. American Journal of Public Health, November 1967, Vol. 57, No. 11, 1937-1947.
- Hartman, R. R. Medical implications of the current abortion law in Illinois (ISMS symposium). Illinois Medical Journal, May 1967, 131, 666-695.
- Hays, W. L. Statistics for psychologists. New York: Holt, Rinehart and Winston, 1963.
- Hefnawi, F., Fuchs, A., & Laurence, K. A. Control of fertility by temporary occlusion of the oviduct. American Journal of Obstetrics and Gynecology, 1967, 99, 421-427.
- Hellman, L. M. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Helpren, M. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Hepworth, D. H. The clinical implications of perceptual distortions in forced marriages. Social Casework, December 1964, 45, 10, 579-585.
- Hetzel, B. S., Bruer, B., & Poidevin, L. O. S. A survey of the relation between certain common antenatal complications in primiparas and stressful life situations during pregnancy. Journal of Psychosomatic Research, 1961, 5, 175-182.

- Hirschler, I. Die abortfrage in ungarn. Paper presented at the International Conference on Abortion Problems and Abortion Control, Rostock-Warnemunde, May 5-7, 1960. Cited by C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154. (a)
- Hirschler, I. Personal communication with C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154. (b)
- Hollingshead, A. B. Two factor index of social position. New Haven, Connecticut: 1965 Yale Station, 1957.
- Holtz, F. 1939. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- Holtz, F. Primar och senresultaten vid havandeskapsavbrott. Forh. v. Nord. For. Obst. & Gynek. 1950, p. 77. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- The Holy Bible. (Revised standard version) New York: Thomas Nelson & Sons, 1952.
- Hooper, T. J. Sexology, July 1967.
- Humphrey, M. Adoption hopes and hazards. New Society, October 1964, 108, 13-15.
- Hutcherson, W. P. In A. Barno, Criminal abortion deaths, illegitimate pregnancy deaths, and suicides in pregnancy: Minnesota, 1950-1965. American Journal of Obstetrics and Gynecology, 1967, 98, 356-367.
- Inrikesdepartamentet. Abortfragan: Betankande aviget av 1950 ars abortutredning, Stockholm, 1953, Table 50, p. 221. Cited by C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154.
- Jakobovits, I. Jewish views on abortion. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 124-143.

- Janovski, N. A., Weiner, L., & Ober, W. B. Soap intoxication following criminal abortion. New York State Journal of Medicine, 1963, 63 (1), 1463-1487.
- Jenkins, R. L. The significance of maternal rejection of pregnancy for future development of the child. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 269-275.
- Kantner, J. F., & Allingham, J. D. American attitudes on population policy: Recent trends. Studies in Family Planning, The Population Council, May 1968, No. 30, 1-7.
- Kerby, P. Abortion: Laws and attitudes. Nation, June 12, 1967, 204, 754-756.
- Ketcham, O. Cited by Disease of unwanted pregnancy. Time, September 15, 1967, 90, 84.
- Kiesler, F. Programing for prevention in a rural area. In Public health concepts in social work education. Proceedings of a seminar held at Princeton University, Princeton, New Jersey, March 4-9, 1962, Council on Social Work Education, New York, 1962. Pp. 116-131.
- Kinsey, A. C. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Kinsolving, L. What about therapeutic abortion? The Christian Century, May 13, 1964, 81, 632-635.
- Kolonja, S., & Ulm, R. Unsere Erfahrungen mit der vaginalen Sektio. Geburtsh. u. Frauenheilk. 1952, 12:149. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- Kolstad, P. Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- Kopp, M. E. Birth control in practice. New York: Robert M. McBride & Co., 1934. Cited by J. E. Bates & E. S. Zawadzki, Criminal abortion. Springfield, Ill.: 1964.
- Kretzschmar, R. M., & Norris, A. S. Psychiatric implications of therapeutic abortion. American Journal of Obstetrics and Gynecology, 1967, 98, 368-373.

Kummer, J. M. Post-abortion psychiatric illness--a myth? American Journal of Psychiatry, April 1963, 119, 980-983.

Kummer, J. M., & Leavy, Z. Therapeutic abortion law confusion. Journal of the American Medical Association, 1966, 195 (1), 96-100.

Kvaraceus, W. C. Juvenile delinquency and the school. Yonkers-on-Hudson, New York: World Book Co., 1945.

Lader, L. Abortion. Boston: Beacon Press, 1966. (a)

Lader, L. Let's speak out on abortion. Reader's Digest, May 1966, 88, 82-85+. (b)

Lader, L. First exclusive survey of non-hospital abortions. Look, January 21, 1969, 33 (2), 63-65.

Lader, L. A national guide to legal abortion. Ladies' Home Journal, August 1970, 73.

Laidlaw, R. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.

Larsen, V. L., Brodsack, J. M., Carr, D., Dungey, L., Evans, T., Harmon, J., Hixson, A., Johnson, H., Liddane, M. J., Main, D., Martin, L., & Tallent, D. Prediction and improvement of post-partum adjustment. Division of Research, Fort Steilacoom, Washington, 1968.

Latimer, R., McGuire, K., Startzman, F., & Swisshelm, M. Unmarried mothers who keep their babies. Journal of Human Relations, 1965, 13, 1, 49-61.

Lecky, W. E. H. History of European morals. Vol. II. New York: D. Appleton and Co., 1929.

Legal abortion mortality low in East Europe. Medical Tribune, May 5, 1969.

Legal abortions argued at state senate hearing. The Detroit News, Detroit, Michigan, April 16, 1969.

Letters run 10-1 in support of fight for abortion bill. The Flint Journal, Flint, Michigan, June 19, 1969.

Liberalized abortion. America, November 12, 1960, 104, 201.

- Lidz, T. Reflections of a psychiatrist. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 276-283.
- Lindahl, J. Somatic complications following legal abortion. Stockholm: Scandinavian University Books, 1959. Cited by L. Lader, Abortion. Boston: Beacon Press, 1966.
- Lindberg, B. J. Vad gor den abortsokande kvinnan, nar psykiatern sagt nej?, Svenska lakartidningen, 45: 1381, 1948. Cited by M. Ekblad, Induced abortion on psychiatric grounds. (Translated by D. Burton), Acta Psychiatrica et Neurologica Scandinavica, 1955 (Suppl. 99).
- Linnér, B. Sexual morality and sexual reality--The Scandinavian approach. American Journal of Orthopsychiatry, 1966, 36, 4, 686-693.
- Little reason for therapeutic abortion. Science Digest, September 1955, 38, 51.
- Lochridge, P. Abortion is an ugly word. Reader's Digest, June 1947, 50, 31-32.
- Los Angeles clergymen organize abortion counseling service. ASA Association for the Study of Abortion, Newsletter, 1968, 3 (1), 5.
- Loth, M. F., & Hasseltine, H. C. Therapeutic abortion at the Chicago lying in hospital. American Journal of Obstetrics and Gynecology, 1956, 72, 304-311.
- Lowe, D. Abortion & the law. New York: Pocket Books, 1966.
- Malmfors, K. Den abortsokande kvinnas problem. Sv. Lakartidn., 1951, 48, 2445. Cited by B. Brække in M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Marley, F. Legal abortion safer. Science News Letter, March 2, 1963, 134, 83.
- Marley, F. Abortion: Unchangeable social custom. Science News, June 3, 1967, 91, 526-527.
- Martin, J. B. Abortion. Saturday Evening Post, May 20, 1961, 234 (3), 19-21+. (a)

Martin, J. B. Abortion. Saturday Evening Post, May 27, 1961, 234 (3), 20-21+. (b)

Martz. 1963. Cited by E. Pohlman, The psychology of birth planning. Cambridge: Schenkman, 1969. P. 338.

Mayer, A. Erfahrungen mit der Freigabe der Schwangerschaftsunterbrechungen in der Sovjet-Republik. Ferdinand Enke Verlag, Stuttgart, 1953, 244 p. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).

McCary, J. L. Human sexuality: Physiological and psychological factors of sexual behavior. Princeton: D. Van Nostrand Company, Inc., 1967.

McCormick, R. A. Aspects of the moral question. America, 1967, 117, 716-719.

MD gets 1-day probation for abortion. The AMA news, May 12, 1969.

MDs urge changes in abortion law. Illinois State Register, Springfield, Illinois, 1968.

Medicinalstyrelsen. Allman halso-och sjukvard 1957, Stockholm, 1959, p. 66. Cited by C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154.

Megargee, E. I. Ruminations on parenticide and the dynamics of aggression. Unpublished manuscript, 1969.

Mehlan, K.-H. Family planning in the Eastern European socialist countries. Family planning programs--Proceedings of an international conference, August 1965, Illinois: University of Chicago Press, 1966. Cited by L. Lader, Abortion. Boston: Beacon Press, 1966.

Menninger, K. Psychiatric aspects of contraception. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 247-253.

Meredith, H. M. Reporting of child abuse cases called best preventive weapon. Midland Daily News, Midland, Michigan, September 11, 1968.

- Merrill, E. J. Physical abuse of children--An agency study. In Protecting the battered child. Denver: Children's Division, The American Humane Association, 1962. Pp. 1-15.
- Method for the sterilization of males--not permanent. United States Patent Office, Patented January 21, 1969, #3, 422, 813.
- Michelman, D. K. Abortion attitude inventory and abortion questionnaire. Unpublished M.A. thesis, Michigan State University, East Lansing, Michigan, 1969.
- \$500,000 mill. Time, September 15, 1947, 50, 49-50.
- Moissides, M. Contribution a l'Etude de l'Avortment dans l'Antiquite Grecque. Janus, Paris, 1922, 26, 129-145. Cited by J. E. Bates & E. S. Zawadzki, Criminal abortion. Springfield, Ill.: Charles C. Thomas, 1964. Pp. 16-17.
- Mojic, A. Abortion is a method of family planning. Paper presented at the IPPF regional conference, Warsaw, 1962. Cited by R. O. Greep (Ed.), Human fertility and population problems. Cambridge: Schenkman, 1963.
- Monroe, K. A new abortion system that miscarried. Medical Economics, June 9, 1969, 254+.
- Monthly vital statistics report. Advance report final natality statistics, 1968, National Center for Health Statistics, U.S. Department of Health, Education, and Welfare, January 30, 1970, 18, No. 11 (Suppl.). (a)
- Monthly vital statistics report. U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, Washington, D.C., March 12, 1970, 18, No. 12 (Suppl.). (b)
- More abortions: The reasons why. Time, September 17, 1965, 86, 82.
- Morris, M. G., Gould, R. W., & Matthews, P. J. Toward prevention of child abuse. Children, March-April 1964, 55-60.
- Mumford, R. S. An interdisciplinary study of four wives who had induced abortions. American Journal of Obstetrics and Gynecology, 1963, 87, 865-876.

- Munson, H. B. Abortion in modern times: Thoughts and comments. South Dakota Journal of Medicine and Pharmacy, April 1966, 19, 23-30.
- Munson, H. B. Personal communication on September 18, 1968.
- Murdock, G. P. Our primitive contemporaries. New York: The MacMillan Co., 1936.
- Myers, H. J. The problem of sterilization: Sociologic, eugenic, and individual considerations. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 87-94.
- Need new abortion laws. Science News Letter, December 19, 1964, 86, 397.
- Nelson, R. B. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Neuhaus, R. J. The dangerous assumptions. Commonweal, June 30, 1967, 86, 408-413.
- New grounds for abortion: Colorado statute authorizes abortion. Time, May 5, 1967, 89, 69.
- New Hampshire, House, Permitting abortion in certain cases. HB 77, Journal of the House, 1969, Vol. I, 333-337.
- Niswander, K. R. Medical abortion practices in the United States. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 37-59.
- Niswander, K. R., Klein, M., & Randall, C. L. Changing attitudes toward therapeutic abortion. Journal of the American Medical Association, 1966, 196 (2), 1140-1143.
- Noonan, J. T., Jr. Contraception. Cambridge: Harvard University Press, 1965.

Olki, M. Zur Abortfrage in Finnland (Data for 1951-1957). Paper presented at the International Conference on Abortion Problems and Abortion Control, Rostock-Warnemunde, May 5-7, 1960. Cited by C. Tietze & H. Lehfeldt, Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154.

One doctor's choice. Time, March 12, 1956, 67, 46+.

Oster, & Tovell. Cited by Grandmothers beware! EMKO Newsletter, June 1969, p. 3.

Overstreet, E. W. Cited by K. Monroe, A new abortion system that miscarried. Medical Economics, June 9, 1969. P. 271.

Packer, H. L., & Gampell, R. J. Therapeutic abortion: A problem in law and medicine. Stanford Law Review, 1959, 11, 417-455.

Plans to lower voting age defeated in most states. The New York Times, New York, New York, November 5, 1970, 38.

Plass, E. D. Personal report on questionnaire of Iowa physicians regarding incidence of abortion in a rural area. Personal communication with F. J. Taussig, 1931. Cited by J. E. Bates & E. S. Zawadzki, Criminal Abortion. Springfield, Ill.: Charles C. Thomas, 1964.

Pohlman, E. The psychology of birth planning. Cambridge: Schenkman, 1969.

Pratt, W. F. Premarital pregnancy and age at marriage in a metropolitan community. Population Index, 1965, 31, 250. (Abstract)

President's Letter. Child Welfare League of America, fall, 1969.

Public favors abortion operation where health is at stake. American Institute of Public Opinion, Gallup Poll Reports, January 21, 1966.

Pugh, T. F., Jerath, B. K., Schmidt, W. M., & Reed, R. B. Rates of mental disease related to child bearing. New England Journal of Medicine, 1963, 268, 1224-1228.

Rainwater, L. Family design: Marital sexuality, family size, and contraception. Chicago: Aldine, 1965.

Rakshit, B. Experiments on tubal blocking for sterilization without laparotomy. The Journal of Obstetrics and Gynecology of India, 1968, 18, 2, 1-5.

Recommendation of the Ad Hoc Committee to study the abortion law. Maryland State Medical Journal, 1967, 16 (2), 12.

Reed, R. B. The interrelationship of marital adjustment, fertility control, and size of family. In P. K. Whelpton & C. V. Kiser (Eds.), Social and psychological factors affecting fertility. New York: Milbank Memorial Fund, 1950, 2. Pp. 259-301.

Revised abortion laws reflect new attitudes. American Medical News, May 4, 1970, 9.

The right to abortion: A psychiatric view. Formulated by the Committee on Psychiatry and Law, Group for the Advancement of Psychiatry. G.A.P. Report, October 1969, 7, No. 75, 203-225.

The rights & wrongs of abortion. Time, February 10, 1967, 89, 47.

Roemer, R. Due process and organized health services. Public Health Reports, August 1964. Cited by L. Lader, Abortion. Boston: Beacon Press, 1966. P. 3.

Rongy, A. J. Abortion: Legal or illegal? New York: Vanguard Press, 1933. Cited by J. E. Bates & E. S. Zawadzki, Criminal abortion. Springfield, Ill.: Charles C. Thomas, 1964. P. 18.

Rongy, A. J. Abortion: The \$100,000,000 racket. American Mercury, February 1937, 40, 145-150.

Rosen, H. Cited by Abortion. Today's Health, April 1965, 43, 24-25+.

Rosen, H. A case study in social hypocrisy. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 299-321. (a)

Rosen, H. Psychiatric implications of abortion: A case study in social hypocrisy. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 72-106. (b)

- Rosen, H. Introduction: Anno domini 1967: The year of the state abortion bill. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. (c)
- Rosen, H. The hysterectomized patient and the abortion problem. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 47-56. (d)
- Rosen, H. The emotionally sick pregnant patient: Psychiatric indications and counterindications to the interruption of pregnancy. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 219-243. (e)
- Rosenberg, A. J., & Silver, E. Suicide, psychiatrists and therapeutic abortion. California Medicine, 1965, 102, 407-411.
- Ross, S., & Kupferberg, H. Clergymen who help women to get abortions. Parade, August 17, 1969, 22+.
- Rossi, A. S. Abortion laws and their victims. Transaction, September-October 1966, 3, 7-12.
- Rossi, A. S. Public views on abortion. In A. F. Guttmacher (Ed.), The case for legalized abortion now. Berkeley: Diablo Press, 1967. Pp. 26-53.
- Rothman, D. In R. M. Kretzschmar & A. S. Norris, Psychiatric implications of therapeutic abortion. American Journal of Obstetrics and Gynecology, 1967, 98, 368-373.
- Rovinsky, J. J., & Gusberg, S. B. Current trends in therapeutic termination of pregnancy. American Journal of Obstetrics and Gynecology, 1967, 98, 11-17.
- Russell, K. P. Changing indications for therapeutic abortion. Journal of the American Medical Association, 1953, 151 (1), 108-111.
- Ryan, K. J. Humane abortion laws and the health needs of society. In D. T. Smith (Ed.), Abortion and the law. Cleveland: The Press of Western Reserve University, 1967. Pp. 60-71.
- Sarrel, P. M., Holley, M., & Anderson, G. The young unwed mother: The role of the obstetrician in a comprehensive care program. Obstetrics and Gynecology, 1968, 32, 6, 741-747.

- Scheffé, H. The analysis of variance. New York: Wiley, 1959. Cited by W. L. Hays, Statistics for psychologists. New York: Holt, Rinehart and Winston, 1963. P. 484.
- Schoeneck, F. J. Fatalities associated with abortions. New York State Journal of Medicine, 1964, 64, 1216-1221.
- Schur, E. M. Abortion racket. Nation, March 5, 1955, 180, 199-201.
- Seager, C. P. A controlled study of post-partum mental illness. Journal of Mental Science, 1960, 106, 214-230.
- Senators defeat abortion bill. The Flint Journal, Flint, Michigan, June 13, 1969.
- Sex education U.S.A.--a community approach. Guidance Associates/Harcourt, Brace & World/SIECUS, 1968.
- Shainess, N. Cited by Y. K. Brandt, What doctors now know about depressed young mothers. Redbook, March 1968. Pp. 164-165.
- Shajaa, K. Imotegaelse av Harald Natvigs brosjyre Fosterdrap. Tidskr. N. Leagef. 1936, 56:548. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).
- Sheriff, H. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Shubeck, F. Use of polymerizing plastics in pregnancy prevention. Preliminary report. Obstetrics and Gynecology, 1965, 25, 5, 724-728.
- Shur, E. M. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958. P. 33.
- Siegel, E., & Dillehay, R. Paper presented at 93rd Annual Meeting, American Public Health Association, Chicago, October 1965. Cited by Currents in Public Health, March 1966, 6, 3, 2-3.

- Simon, A. Psychiatric indications for therapeutic abortions and sterilization. In E. W. Overstreet (Ed.), Clinical Obstetrics and Gynecology. New York: Harper & Row, 1964. Cited by A. Barno, Criminal abortion deaths, illegitimate pregnancy deaths, and suicides in pregnancy. American Journal of Obstetrics and Gynecology, 1967, 98, 356-367.
- Simons, J. H. Statistical analysis of one thousand abortions. American Journal of Obstetrics and Gynecology, 1939, 37 (5), 840-849.
- "Sin no more!" Time, July 28, 1941, 38, 60.
- Smalldon, J. L. A survey of mental illness associated with pregnancy and childbirth. American Journal of Psychiatry, 1940, 97, 1, 80-101.
- Smith, H. H. Wasting women's lives. New Republic, March 28, 1934, 78, 178-180.
- Soddy, K. The unwanted child. The Journal of Family Welfare, 1964, 11, 2, 39-52.
- Southermer, M. Important facts about abortion. Reader's Digest, February 1956, 68, 53-56.
- Stamer, S. Partial and total atresia of the uterus after excochliation. Acta Obstetricia et Gynecologica Scandinavica, 1946, 26, 263-297.
- Star, J. The growing tragedy of illegal abortion. Look, October 19, 1965, 149+.
- Statement by the Committee on Public Health of the New York Academy of Science: Bulletin. New York Academy of Medicine, 1965, 41, 410.
- Stevenson, C. S. In A. Barno, Criminal abortion deaths, illegitimate pregnancy deaths, and suicides in pregnancy. American Journal of Obstetrics and Gynecology, 1967, 98, 356-367.
- Stevenson, L. B. In A. Barno, Criminal abortion deaths, illegitimate pregnancy deaths, and suicides in pregnancy. American Journal of Obstetrics and Gynecology, 1967, 98, 356-367. (a)

Stevenson, L. B. Maternal death and abortion, Michigan 1955-1964. Michigan Medicine, 1967, 66 (1), 287-291. (b)

Stix, R. A study of pregnancy wastage. The Milbank Memorial Fund Quarterly, October 1935, 13 (4), 362. Cited by J. E. Bates & E. S. Zawadzki, Criminal abortion. Springfield, Ill.: Charles C. Thomas, 1964.

Stott, D. H. Physical and mental handicaps following a disturbed pregnancy. Lancet, 1957, 272, 1006-1011.

Stott, D. H. Some psychosomatic aspects of casuality in reproduction. Journal of Psychosomatic Research, 1958, 3, 42-55.

Sumner, W. G. Folkways. Boston: Ginn, 1906.

Supreme Court of Michigan, Office of the Court Administrator, 1968 annual report including judicial statistics.

Suspected child abuse referrals (1-1-69 thru 12-31-69). Statistical report obtained in personal communication with the Michigan Department of Social Services, January 13, 1970.

Svanberg, N. Senkomplikationer efter legal abortprovokation. Nord. Med. 1949, 42:1264. Cited by P. Kolstad, Therapeutic abortion. Acta Obstetricia et Gynecologica Scandinavica, 1957, 36 (Suppl. 6).

Szabady, E. Magyarorszag nepesdesi helyzete; a családtervezes gazdasagi, tarsadelmi es egeszsegugyi vonatkozasai. Demografia, 1962, 5, 325-332. Cited by R. O. Greep (Ed.), Human fertility and population problems. Cambridge: Schenkman, 1963.

Tanton. Cited by A. Hodge, Two abortion critics seek repeal of outdated law. Michigan State News, East Lansing, Michigan, February 11, 1970. P. 15.

Taussig, F. J. Abortion spontaneous and induced: Medical and social aspects. St. Louis: C. V. Mosby, 1936. Cited by J. E. Bates & E. S. Zawadzki, Criminal abortion. Springfield, Ill.: Charles C. Thomas, 1964.

- Tetlow, C. Psychoses of childbearing. Journal of Mental Science, 1955, 101, 629-639.
- Therapeutic abortion--a very timely topic. Maryland State Medical Society, 1967, 16 (2), 7-10.
- Tietze, C. Abortion as a cause of death. American Journal of Public Health, 1948, 38, 1434-1441.
- Tietze, C. Report on a series of abortions induced by physicians. Human Biology, 1949, 21, 60-64.
- Tietze, C. Therapeutic abortions in New York City, 1943-1947. American Journal of Obstetrics and Gynecology, 1950, 60, 146-152.
- Tietze, C., & Lehfeldt, H. Legal abortion in Eastern Europe. Journal of the American Medical Association, April 1, 1961, 175, 1149-1154.
- Tietze, C., & Lewit, S. Abortion. Scientific American, January 1969, 220 (1), 21-27.
- Tietze, C., & Martin, C. E. Foetal deaths, spontaneous and induced in the urban white population of the United States. Population Studies, November 1957, 11 (2), 170-176.
- Timanus, G. L. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958.
- Tobin, S. M. Emotional depression during pregnancy. Obstetrics and Gynecology, 1957, 10, 677-681.
- Tolnai, B. B. Abortions and the law. Nation, April 15, 1939, 148, 424-427.
- Towne, R. D., & Afterman, J. Psychosis in males related to parenthood. Menninger Clinic Bulletin, 1955, 19, 19-26.
- Trends in illegitimacy: United States--1940-1965. Vital and health statistics, Data from the National Vital Statistics System, U.S. Department of Health, Education, and Welfare, Washington, D.C., Public Health Service Publication No. 1000-Series 21, No. 15, February 1968.
- Trinkhaus, W. Cited by D. Lowe, Abortion & the law. New York: Pocket Books, 1966. P. 89.

- Turner, E. K. The syndrome in the infant resulting from maternal emotional tension during pregnancy. Medical Journal of Australia, 1956, 1, 221-222.
- United States Bureau of the Census, Statistical abstract of the United States. (89th ed.) Washington, D.C., 1968.
- Vojta, M. Private communication with R. O. Greep (Ed.), Human fertility and population problems. Cambridge: Schenkman, 1963.
- Ward, J. Don't have an abortion. Reader's Digest, August 1941, 39, 17-21.
- Wassmer, T. A. The crucial question about abortion. Catholic World, November 1967, 206, 57-61.
- Wed and unwed. Newsweek, April 7, 1958, 51, 92.
- Westermarck, E. Origin and development of moral ideas. London: MacMillan & Co., 1924.
- Westoff, C. F. Cited by Unwanted births high. EMKO Newsletter, February 1970.
- Westoff, C. F., Moore, E. C., & Ryder, N. B. The structure of attitudes toward abortion. Milbank Memorial Fund Quarterly, January 1969, Vol. XLVII, No. 1, Part 1, 11-37.
- Westoff, C. F., Potter, R. G., & Sagi, P. C. The third child. Princeton, New Jersey: Princeton University Press, 1963.
- Whelpton, P. K., Campbell, A. A., & Patterson, J. Fertility and family planning in the United States. Princeton, New Jersey: Princeton University Press, 1966.
- Whelpton, & Kiser. Milbank Memorial Fund Quarterly, 1948, 26, 182. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958. P. 179.
- When abortion is made easier--. U.S. News & World Report, June 8, 1970, 83.
- Where is the abortion battle taking us? Medical World News, May 23, 1969, 38-39.

- White, M. A., Prout, C. T., Fixsen, C., & Foundeur, M. Obstetrician's role in postpartum mental illness. Journal of the American Medical Association, 1957, 165, 138-143.
- Wiehl, & Berry. Milbank Memorial Fund Quarterly, 1937, 15, 229. Cited by M. S. Calderone (Ed.), Abortion in the United States. New York: Hoeber-Harper, 1958. P. 179.
- Wilson, D. C. The abortion problem in the general hospital. In H. Rosen (Ed.), Abortion in America. Boston: Beacon Press, 1967. Pp. 189-197.
- Women flock to London seeking abortions under liberal law. Medical World News, March 28, 1969, 24-27.
- Yarrow, L. J. Maternal deprivation: Toward an empirical and conceptual re-evaluation. Psychological Bulletin, 1961, 58, 459-490.
- Zemlick, M. J., & Watson, R. I. Maternal attitudes of acceptance and rejection during and after pregnancy. American Journal of Orthopsychiatry, 1953, 23, 570-584.
- Zilboorg, G. Depressive reactions related to parenthood. American Journal of Psychiatry, 1931, 10, 6, 927-962.

APPENDICES

APPENDIX A

INFORMATION FACE SHEET

APPENDIX A

INFORMATION FACE SHEET

Age _____ Sex _____ Marital Status (circle) (a) Single
(b) Married
(c) Divorced
(d) Separated
(e) Widowed

Religious Preference (circle) (a) Protestantism
(b) Catholicism
(c) Judaism
(d) Agnosticism
(e) Atheism
(f) Other (specify) _____

Occupation of husband, or if you are a student, of your
father;
husband: _____ father: _____

Highest Level of Education Attained (circle)
(a) Graduate Professional Training
(b) Standard College or University Training
(c) Partial College Training
(d) High School Graduation
(e) Partial High School (completed tenth or eleventh
grade)
(f) Junior High School (completed seventh, eighth, or
ninth grade)
(g) Completed less than seventh grade.

APPENDIX B

ABORTION ATTITUDE INVENTORY

APPENDIX B

ABORTION ATTITUDE INVENTORY

The following statements are to be judged by you to indicate how well they agree or disagree with your own opinion. The statements themselves are both agreed and disagreed with by many people, so there are no "right" or "wrong" answers. Please read each statement, then show your opinion by circling the letters which best represent your own view.

	<u>Strongly Agree</u>	<u>Tend to Agree</u>	<u>Neutral</u>	<u>Tend to Disagree</u>	<u>Strongly Disagree</u>
1. Abortion should be permissible in cases of pregnancy following rape.	SA	a	N	d	SD
2. A woman judged by the courts to be an unfit mother should not be granted an abortion.	SA	a	N	d	SD
3. After a woman has had an abortion, misfortune will probably follow.	SA	a	N	d	SD
4. An abortion should be allowed if a woman is pregnant but unmarried.	SA	a	N	d	SD
5. Abortions should not be granted when there exists a strong possibility the baby would be malformed.	SA	a	N	d	SD
6. An abortion should be granted to any woman requesting one.	SA	a	N	d	SD

	<u>Strongly Agree</u>	<u>Tend to Agree</u>	<u>Neutral</u>	<u>Tend to Disagree</u>	<u>Strongly Disagree</u>
7. The wife from a poverty stricken home (yearly income less than \$3,000) should be granted an abortion.	SA	a	N	d	SD
8. A woman 45 years of age or older should be granted an abortion on request.	SA	a	N	d	SD
9. A woman judged to be psychologically incapable of being an adequate mother should be allowed an abortion.	SA	a	N	d	SD
10. An abortion should not be allowed if a woman is pregnant and is obtaining a divorce from her husband.	SA	a	N	d	SD
11. A woman who loves children would never consider an abortion for herself.	SA	a	N	d	SD
12. An abortion should never be permitted.	SA	a	N	d	SD
13. (If female) There are circumstances under which I would consider having an abortion. (If male) There are circumstances under which I would approve of my wife's or girlfriend's having an abortion.	SA	a	N	d	SD
14. Probably most women requesting an abortion are irresponsible.	SA	a	N	d	SD
15. If a woman's life is endangered by the delivery of a baby, an abortion should be performed.	SA	a	N	d	SD

	<u>Strongly Agree</u>	<u>Tend to Agree</u>	<u>Neutral</u>	<u>Tend to Disagree</u>	<u>Strongly Disagree</u>
16. After an abortion a woman could feel satisfied and comfortable with her decision and its results.	SA	a	N	d	SD
17. In a family where a child is unwanted and would be treated as such the wife should be granted an abortion.	SA	a	N	d	SD

APPENDIX C

ABORTION QUESTIONNAIRE

APPENDIX C

ABORTION QUESTIONNAIRE

The following questions concern the topic of abortion. Circle the choice which in your opinion, best answers the question. Please do not omit any items; "guess" at the best answer when in doubt.*

1. Approximately how many abortions do you believe occur each year in the United States: (a) 50,000, (b) 200,000, (c) 500,000, (d) 700,000, (e) 1,500,000.
2. Approximately how many legal abortions do you believe occur each year in the United States: (a) 300,000, (b) 100,000, (c) 40,000, (d) 10,000, (e) 1,000.
3. Most abortions are performed on: (a) unmarried women, (b) married women with children, (c) married women without children, (d) divorcees.
4. Medical authorities view abortion as a distinctly more difficult procedure after pregnancy has progressed through the: (a) fifth week, (b) seventh week, (c) ninth week, (d) eleventh week, (e) thirteenth week.
5. Which of the following countries has the most permissive abortion laws: (a) U.S.S.R., (b) Japan, (c) Sweden, (d) Norway, (e) India.
6. Scientific studies of the consequences of medically performed abortion indicate that the percentage of women who experience serious physiological impairment from the experience is nearest to: (a) 80%, (b) 60%, (c) 40%, (d) 20%, (e) 5%.
7. The number of women in the United States who die annually as a consequence of our restrictive abortion laws is approximately: (a) 50, (b) 500, (c) 1,000, (d) 10,000, (e) 50,000.

*The correct response is underlined. Recent legal changes and new information necessitate revision of certain items for contemporary use.

8. The cost of a legal abortion in the Eastern European Communist countries today is approximately: (a) \$1,000, (b) \$600, (c) \$300, (d) \$50, (e) \$2.
9. In the United States today, the approximate ratio of abortions to births is estimated by competent authorities to approximate: (a) 1:3, (b) 1:5, (c) 1:7, (d) 1:10, (e) 1:15.
10. United States authorities estimate that the percentage of self-induced abortion is approximately: (a) 5%, (b) 10%, (c) 25%, (d) 40%, (e) 60%.
11. Authorities estimate that the amount of money spent on illegal abortions each year is approximately: (a) \$1,000,000, (b) \$25,000,000, (c) \$100,000,000, (d) \$225,000,000, (e) \$350,000,000.
12. Of all criminal abortions, the percentage performed to terminate pregnancies in married women is estimated to be: (a) 80%, (b) 60%, (c) 40%, (d) 25%, (e) 10%.
13. In all 50 states, the abortion laws generally take the stance that an abortion can be granted: (a) under no circumstances, (b) only if the woman's life is jeopardized by the course of pregnancy, (c) if the woman's life is jeopardized by the course of pregnancy and/or she has been a victim of rape or incest, (d) if the woman's life is jeopardized by the course of pregnancy and/or she is mentally incapable of raising the child, (e) if the woman's life is jeopardized by the course of pregnancy and/or she has been a victim of rape or incest and/or she is mentally incapable of raising the child.
14. In the perspective of all major illegal rackets in the U.S., criminal abortions are: (a) first, (b) third, (c) fifth, (d) seventh, (e) ninth.
15. If the abortion laws of most states were strictly enforced, the number of persons--abortionists and patients--which would be prosecuted every year is estimated to be: (a) 50,000, (b) 500,000, (c) 1,000,000, (d) 2,000,000, (e) 3,000,000.
16. In performing a therapeutic abortion most physicians choose the method of: (a) cervical dilatation and curettage, (b) special drugs, (c) introduction of a caustic substance into the womb, (d) insertion of a tapering instrument into the womb, (e) physical exertion in the early stages of pregnancy.

17. Among separated, divorced and widowed women of all ages, the percentage of all conceptions terminating in abortion is estimated to be: (a) 10%, (b) 25%, (c) 40%, (d) 60%, (e) 80%.
18. In a survey of 60 leading hospitals across the country, the ratio of the number of abortions for private patients versus the number of abortions for ward patients was: (a) 2:1, (b) 4:1, (c) 6:1, (d) 8:1, (e) 10:1.
19. The percentage of single U.S. women who terminate premarital pregnancy by abortion is estimated to be about: (a) 10%, (b) 25%, (c) 40%, (d) 60%, (e) 80%.
20. Of hospital abortions performed in New York City during 1960-1962, the ratio of the number of abortions performed on whites to the number of abortions performed on nonwhites was: (a) 3:1, (b) 5:1, (c) 7:1, (d) 9:1, (e) 11:1.
21. The ratio of abortion deaths among white women versus the number of abortion deaths among nonwhite women is estimated to be: (a) 1:4, (b) 1:2, (c) 1:1, (d) 2:1, (e) 4:1.
22. Of the total number of U.S. abortions, the percentage of abortions performed on Catholics (who constitute about 25% of the total United States population) is estimated to be: (a) 10%, (b) 15%, (c) 20%, (d) 25%, (e) 30%.
23. The number of hospital abortions performed annually today in contrast to the number performed 25 years ago has: (a) decreased by 40,000, (b) decreased by 20,000, (c) remained approximately the same, (d) increased by 20,000, (e) increased by 40,000.
24. A recent authoritative survey of obstetricians and gynecologists throughout the country found that the percentage of responding physicians who admitted they referred patients to abortionists was about: (a) 5%, (b) 10%, (c) 15%, (d) 20%, (e) 25%.

APPENDIX D

PERSONALITY TRAITS DEFINED

APPENDIX D

PERSONALITY TRAITS DEFINED

Gordon Personal Profile

The Gordon Personal Profile (Gordon, 1963a) investigates the personality traits of Ascendancy, Responsibility, Emotional Stability, and Sociability. These traits are defined by Gordon (on page 3 of the manual) as follows:

Ascendancy. Those individuals who are verbally ascendent, who adopt an active role in the group, who are self-assured and assertive in relationships with others, and who tend to make independent decisions, score high on this Scale. Those who play a passive role in the group, who listen rather than talk, who lack self-confidence, who let others take the lead, and who tend to be overly dependent on others for advice, normally make low scores.

Responsibility. Individuals who are able to stick to any job assigned them, who are persevering and determined, and who can be relied on, score high on this Scale. Individuals who are unable to stick to tasks that do not interest them, and who tend to be flightily or irresponsible, usually make low scores.

Emotional Stability. High scores on this Scale are generally made by individuals who are well-balanced, emotionally stable, and relatively free from anxieties and nervous tension. Low scores are associated with excessive anxiety, hypersensitivity, nervousness, and low frustration tolerance. Generally, a very low score reflects poor emotional balance.

Sociability. High scores are made by individuals who like to be with and work with people, and who are gregarious and sociable. Low scores reflect a lack of gregariousness, a general restriction in social contacts, and, in the extreme, an actual avoidance of social relationships.*

Gordon Personal Inventory

The Gordon Personal Inventory (Gordon, 1963b)

determines the following defined traits (page 3 of the manual):

Cautiousness. Individuals who are highly cautious, who consider matters very carefully before making decisions, and do not like to take chances or run risks, score high on this Scale. Those who are impulsive, act on the spur of the moment, make hurried or snap decisions, enjoy taking chances, and seek excitement, score low on this Scale.

Original Thinking. High scoring individuals like to work on difficult problems, are intellectually curious, enjoy thought-provoking questions and discussions, and like to think about new ideas. Low scoring individuals dislike working on difficult or complicated problems, do not care about acquiring knowledge, and are not interested in thought-provoking questions or discussions.

Personal Relations. High scores are made by those individuals who have great faith and trust in people, and are tolerant, patient, and understanding. Low scores reflect a lack of trust or confidence in people, and a tendency to be critical of others and to become annoyed or irritated by what others do.

Vigor. High scores on this Scale characterize individuals who are vigorous and energetic, who like to work and move rapidly, and who are able to accomplish more than the average person. Low scores are associated with low vitality or energy level, a preference for setting a slow pace, and a tendency to tire easily and be below average in terms of sheer output or productivity.*

*Quoted from Gordon Personal Profile and Gordon Personal Inventory Tests, copyright 1953-1963 by Harcourt Brace Jovanovich, Inc. Quoted by special permission of the publisher.

Survey of Interpersonal Values

The scales of the Survey of Interpersonal Values (Gordon, 1960) are defined by what high scoring individuals value. Low scoring individuals simply do not value what is defined by that particular scale. This instrument assesses the traits of (page 3 of this manual):

Support. Being treated with understanding, receiving encouragement from other people, being treated with kindness and consideration.

Conformity. Doing what is socially correct, following regulations closely, doing what is accepted and proper, being a conformist.

Recognition. Being looked up to and admired, being considered important, attracting favorable notice, achieving recognition.

Independence. Having the right to do whatever one wants to do, being free to make one's own decisions, being able to do things in one's own way.

Benevolence. Doing things for other people, sharing with others, helping the unfortunate, being generous.

Leadership. Being in charge of other people, having authority over others, being in a position of leadership or power.*

*From SRA Manual For SURVEY OF INTERPERSONAL VALUES by Leonard V. Gordon. Copyright 1960, Science Research Associates, Inc. Reprinted by permission of the publisher.

APPENDIX E

INTRODUCTORY FORM LETTER

,

APPENDIX E

INTRODUCTORY FORM LETTER

MICHIGAN STATE UNIVERSITY - East Lansing, Michigan 48823

Department of Psychology - Olds Hall

Dear Sir:

As an informed and influential person in our community, you are probably aware that abortion laws have become an important social issue. At the present time, approximately 30 states have pending legislation to modify old abortion laws. As part of a research study, I am seeking information concerning your views of abortion. Such information is essential for the development of a sound public policy on abortion laws.

The two brief questionnaires enclosed are being circulated to religious leaders, legislators, physicians, and business leaders. The first questionnaire concerns feelings toward abortion and the second deals with information about abortion. Your cooperation in completing and returning these as soon as possible would be much appreciated. Instructions are given at the top of the first page of each questionnaire. Together they will require not more than 5 to 15 minutes to complete.

In some instances, additional data about your professional specialization is requested. Although it is unnecessary for you to give your name, if you wish to know about the outcome of this project, I will be pleased to forward a summary of my findings as soon as they become available. A postcard identifying a suitable return address, or if you prefer, writing your address on the enclosures, will facilitate this repayment for your assistance.

Your cooperation is vital to the success of this effort to gain a better understanding of this thorny but important social problem.

Sincerely,

John R. Hurley
Professor

APPENDIX F

**SCORABLE RETURNS FROM SPECIFIED
RELIGIOUS DENOMINATIONS**

APPENDIX F

SCORABLE RETURNS FROM SPECIFIED RELIGIOUS DENOMINATIONS

TABLE F1

RELIGIOUS DENOMINATIONS RETURNING
SCORABLE AAI's

Denomination	No. of Returns
Baptist Bodies	1
Brethren	11
Christian Reformed	1
Church of Christ	1
Church of God	2
Church of the Living God	1
Church of the Nazarene	2
Congregational	1
Episcopal	4
Free Methodist	2
Friends	1
Greek Orthodox	2
Jewish Congregation	1
Lutheran Bodies	9
Methodist Bodies	15
Presbyterian Bodies	5
Reformed Church Bodies	1
Roman Catholic	3
Seventh-Day Adventists	1
The Salvation Army	1
United Church of Christ	3
United Missionary	1
Unitarian-Universalist	1
Independent or Non-Denominational	3
Total	73

APPENDIX G

**GENERAL SAMPLE'S SPECIFIC ATTITUDES
TOWARD ABORTION**

APPENDIX G

GENERAL SAMPLE'S SPECIFIC ATTITUDES TOWARD ABORTION

In Table G1, (and in the tables of Appendices H and L) ratings of 1 indicate that the individual has a strongly favorable attitude toward permissive abortion in circumstances implied in the AAI item. Whether the statement is positively or negatively worded is irrelevant. A score of 1 always indicates the individual is strongly favorable toward abortion in the situation the item implies. Similarly, a score of 5 always indicates the individual is strongly unfavorable toward abortion in the situation implied in the item.

EXAMPLE:

To item #5, "Abortions should not be granted when there exists a strong possibility the baby would be malformed," the responses of 60 persons are scored as 1 and the responses of 17 persons are scored as 5. Consequently, 60 people strongly favor and 17 people strongly disfavor the granting of an abortion if there were a strong possibility the child would be malformed.

A score of 1 always indicates a strongly favorable attitude; 2, a "tend to favor" attitude; 3, a neutral attitude; 4, a "tend to disfavor" attitude, and; 5, a strongly disfavorable attitude.

TABLE G1

PERCENTAGE OF GENERAL SAMPLE ($N = 131$) GIVING SPECIFIC
ATTITUDE RATING TO EACH AAI ITEM*

Items*	Response Rating (Percentage)					Combined Response Ratings (Percentage)	
	Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree	Strongly Agree & Tend to Agree	Tend to Disagree & Strongly Disagree
	1	2	3	4	5	1 & 2	4 & 5
1. "pregnancy following rape"	64	23	02	04	07	89	11
2. "court judged unfit mother"	28	33	10	18	11	68	32
3. "misfortune after abortion"	49	28	13	08	02	89	11
4. "woman pregnant but unmarried"	13	28	12	22	24	47	53
5. "strong possibility of malformed child"	46	25	05	11	13	75	25
6. "any woman requesting an abortion"	07	15	07	22	49	23	77
7. "wife from a poverty stricken home"	11	24	13	19	33	40	60
8. "woman 45 years of age or older"	13	21	15	22	28	41	59

TABLE G1--continued

	Response Rating (Percentage)					Combined Response Ratings (Percentage)	
	1	2	3	4	5	1 & 2	4 & 5
9. "woman judged psychologically unfit"	21	37	07	20	15	62	38
10. "woman pregnant and obtaining a divorce"	17	21	21	16	26	47	53
11. "woman who loves children would never consider an abortion"	22	40	12	11	15	70	30
12. "abortion should never be permitted"	62	21	04	04	09	87	13
13. "circumstances under which I would consider abortion"	43	31	05	08	13	77	23
14. "women requesting abortion are irresponsible"	48	37	07	05	03	92	08
15. "life endangered with child-delivery"	45	27	11	11	07	80	20
16. "feel satisfied and comfortable after abortion"	17	36	24	16	08	69	31
17. "child unwanted and treated as such"	18	30	11	20	22	53	47

*Several "key words" are used to denote the item statement. Complete statements are presented in Appendix B.

APPENDIX H

**RESPONSE PERCENTAGES OF PERSONS CLASSIFIED BY
THE DEMOGRAPHIC VARIABLES OF RESIDENTIAL
STATUS, SEX, MARITAL STATUS, RELIGIOUS
PREFERENCE, SOCIO-ECONOMIC STATUS
FOR EACH AAI ITEM**

APPENDIX H

RESPONSE PERCENTAGES OF PERSONS CLASSIFIED BY THE DEMOGRAPHIC VARIABLES OF RESIDENTIAL STATUS, SEX, MARITAL STATUS, RELIGIOUS PREFERENCE, SOCIO-ECONOMIC STATUS FOR EACH AAI ITEM

In Tables H1-H5 of this appendix, ratings of 1 always indicate that the respondent has a strongly favorable attitude toward permissive abortion under circumstances implied in the item--regardless of the positive or negative wording of the item. Similarly, ratings of 5 always indicate the person is strongly unfavorable toward abortion in the situation implied in the AAI item, regardless of the item's wording. For a fuller explanation of this scoring system, see Appendix G, p. 411.

TABLE H1

PERCENTAGE OF LANSING AREA RESIDENTS ($N = 89$) AND MICHIGAN STATE UNIVERSITY STUDENTS ($N = 42$) GIVING SPECIFIC ATTITUDE RATING TO EACH AAI ITEM

Items	Residential Status	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree	Strongly Agree & Tend to Agree	1 & 2	Tend to Disagree & Strongly Disagree	4 & 5	
1. "pregnancy following rape"	Lansing Area Student	60 74	26 17	02 02	04 02	08 05	87 93	13 07			
2. "court judged unfit mother"	Lansing Area Student	30 24	28 43	11 07	18 17	12 09	66 72	34 28			
3. "misfortune after abortion"	Lansing Area Student	51 45	44 19	08 24	07 12	02 00	90 84	10 16			
4. "woman pregnant but unmarried"	Lansing Area Student	09 21	24 38	10 17	27 12	30 12	36 71	64 29			
5. "strong possibility of malformed child"	Lansing Area Student	43 52	28 19	07 02	10 12	12 14	76 73	24 27			

TABLE H1--continued

Items	Residential Status	Response Rating (Percentage)					Combined Response Ratings (Percentage)		
		1	2	3	4	5	1 & 2	4 & 5	
6. "any woman requesting an abortion"	Lansing Area Student	07 07	09 26	03 17	25 17	56 33	16 40	84 60	
7. "wife from a poverty stricken home"	Lansing Area Student	12 10	17 38	10 19	21 14	39 19	33 59	67 41	
8. "woman 45 years of age or older"	Lansing Area Student	12 14	17 30	12 21	25 17	34 17	33 58	67 42	
9. "woman judged psychologically unfit"	Lansing Area Student	22 17	31 50	07 07	24 12	16 14	58 72	42 28	
10. "woman pregnant and obtaining a divorce"	Lansing Area Student	17 17	18 26	18 26	18 12	29 19	42 58	58 42	
11. "woman who loves children would never consider an abortion"	Lansing Area Student	24 19	36 48	16 05	10 12	15 17	71 70	29 30	
12. "abortion should never be permitted"	Lansing Area Student	57 71	22 19	05 02	05 02	11 05	84 93	16 07	
13. "circumstances under which I would consider abortion"	Lansing Area Student	44 41	29 33	04 07	07 12	16 07	76 79	24 21	

TABLE H1--continued

Items	Residential Status	Response Rating (Percentage)					Combined Response Ratings (Percentage)	
		1	2	3	4	5	1 & 2	4 & 5
14. "women requesting abortion are irresponsible"	Lansing Area Student	49 45	37 38	05 12	05 05	05 00	91 95	09 05
15. "life endangered with child-delivery"	Lansing Area Student	42 52	27 26	10 12	11 10	10 00	76 89	24 11
16. "feel satisfied and comfortable after abortion"	Lansing Area Student	15 21	37 33	26 19	13 21	09 05	70 68	30 32
17. "child unwanted and treated as such"	Lansing Area Student	17 19	25 40	12 07	21 17	25 17	47 64	53 36

TABLE H2
 PERCENTAGE OF FEMALES ($\bar{N} = 71$) AND MALES ($\bar{N} = 60$) GIVING SPECIFIC ATTITUDE
 RATING TO EACH AAI ITEM

Items	Sex	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree	Strongly Agree & Tend to Agree	1 & 2	3	4	5
1. "pregnancy following rape"	Female	63	24	01	01	10	89	89	11		
	Male	65	22	03	07	03	90	90	10		
2. "court judged unfit mother"	Female	30	25	14	18	13	64	64	36		
	Male	27	42	05	13	10	72	72	28		
3. "misfortune after abortion"	Female	49	25	15	10	00	88	88	12		
	Male	48	32	10	07	03	89	89	11		
4. "woman pregnant but married"	Female	11	21	10	23	35	36	36	64		
	Male	15	37	15	22	12	61	61	39		
5. "strong possibility of malformed child"	Female	44	25	06	11	14	73	73	27		
	Male	48	25	05	10	12	77	77	23		

TABLE H2--continued

Items	Sex	Response Rating (Percentage)					Combined Response Ratings (Percentage)		
		1	2	3	4	5	1 & 2	4 & 5	
6. "any woman requesting an abortion"	Female	08	10	06	17	59	19	81	
	Male	05	20	10	28	37	28	72	
7. "wife from a poverty stricken home"	Female	13	21	11	13	42	38	62	
	Male	10	27	15	27	22	43	57	
8. "woman 45 years of age or older"	Female	15	17	11	18	38	37	63	420
	Male	10	27	20	27	17	46	54	
9. "woman judged psychologically unfit"	Female	20	31	10	18	21	56	44	
	Male	22	45	03	22	08	69	31	
10. "woman pregnant and obtaining a divorce"	Female	21	17	18	14	30	47	53	
	Male	12	25	23	18	22	48	52	
11. "woman who loves children would never consider abortion"	Female	21	35	15	11	17	67	33	
	Male	23	45	08	10	13	75	25	
12. "abortion should never be permitted"	Female	58	23	06	01	13	85	15	
	Male	67	20	02	07	05	88	12	

TABLE H2--continued

Items	Sex	Response Rating (Percentage)					Combined Response Ratings (Percentage)	
		1	2	3	4	5	1 & 2	4 & 5
13. "circumstances under which I would consider an abortion"	Female	39	30	03	10	18	71	29
	Male	47	32	08	07	07	85	15
14. "women requesting abortion are irresponsible"	Female	49	32	07	08	03	88	12
	Male	47	43	07	00	03	96	04
15. "life endangered with child-delivery"	Female	46	21	13	11	08	77	23
	Male	43	33	08	10	05	84	16
16. "feel satisfied and comfortable after abortion"	Female	20	28	25	18	08	64	36
	Male	13	45	22	13	07	74	26
17. "child unwanted and treated as such"	Female	17	27	06	21	30	46	54
	Male	18	33	17	18	13	62	38

TABLE H3

PERCENTAGE OF MARRIED ($N = 83$) AND SINGLE ($N = 43$) PERSONS GIVING
SPECIFIC ATTITUDE RATING TO EACH AAI ITEM

Items	Marital Status	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree	Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree
		1	2	3	4	5	1	2	3	4	5
1. "pregnancy following rape"	Married Single	58 74	28 16	02 02	05 02	07 05	88 93			12 07	
2. "court judged unfit mother"	Married Single	29 26	27 44	12 07	20 14	12 09	63 75			37 25	
3. "misfortune after abortion"	Married Single	53 42	34 21	07 26	04 12	02 00	94 84			06 16	
4. "woman pregnant but unmarried"	Married Single	10 21	24 35	11 16	28 14	28 14	38 67			62 33	
5. "strong possibility of malformed child"	Married Single	45 49	28 21	07 02	08 12	12 16	78 71			22 29	

TABLE H3--continued

Items	Marital Status	Response Rating (Percentage)					Combined Response Ratings (Percentage)		
		1	2	3	4	5	1 & 2	4 & 5	
6. "any woman requesting an abortion"	Married Single	07 07	08 26	05 14	25 16	54 37	16 38	84 62	
7. "wife from a poverty stricken home"	Married Single	13 09	18 35	10 19	23 14	36 23	35 54	65 46	
8. "woman 45 years of age or older"	Married Single	13 14	17 30	13 19	27 16	30 21	35 54	65 46	
9. "woman judged psychologically unfit"	Married Single	22 16	31 51	08 05	23 14	16 14	58 71	42 29	
10. "woman pregnant and obtaining a divorce"	Married Single	16 16	17 26	19 26	19 09	29 23	40 56	60 44	
11. "woman who loves children would never consider abortion"	Married Single	24 19	39 44	14 07	08 14	14 16	73 68	27 32	
12. "abortion should never be permitted"	Married Single	57 72	23 19	05 02	05 02	11 05	84 93	16 07	

TABLE H3--continued

Items	Marital Status	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	4 & 5		
13. "circumstances under which I would consider an abortion"	Married Single	43 44	30 30	05 07	06 12	16 07	77 80		23 20	
14. "women requesting abortion are irresponsible"	Married Single	52 42	36 40	04 14	05 05	04 00	91 95		09 05	
15. "life endangered with child-delivery"	Married Single	41 51	27 28	11 12	12 09	10 00	76 89		24 11	
16. "feel satisfied and comfortable after abortion"	Married Single	17 19	37 33	24 21	14 21	07 07	71 65		29 35	
17. "child unwanted and treated as such"	Married Single	17 16	24 44	13 07	23 16	23 16	47 65		53 35	

TABLE H4

PERCENTAGE OF INDIVIDUALS AMONG CATHOLIC ($\bar{N} = 32$), PROTESTANT ($\bar{N} = 82$), JEWISH ($\bar{N} = 7$), AGNOSTIC ($\bar{N} = 5$), AND UNCLASSIFIED ($\bar{N} = 5$) RELIGIOUS CLASSIFICATIONS GIVING SPECIFIC ATTITUDE RATING TO EACH AAI ITEM

Items	Religion	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		Strongly Agree	1	Tend to Agree	2	Neutral	3	4	Tend to Disagree	5	Strongly Disagree
1. "pregnancy following rape"	Catholicism	25	38	03	09	25	31	65	35		
	Protestantism	72	22	02	02	01	04	96	04		
	Judaism	100	00	00	00	00	00	100	00		
	Agnosticism	100	00	00	00	00	00	100	00		
	Unclassified	100	00	00	00	00	00	100	00		
2. "court judged unfit mother"	Catholicism	09	25	09	25	31	62	38	62		
	Protestantism	29	35	12	18	05	26	74	26		
	Judaism	71	14	00	00	00	00	100	00		
	Agnosticism	60	40	00	00	00	00	100	00		
	Unclassified	40	60	00	00	00	00	100	00		

TABLE H4--continued

Items	Religion	Response Rating (Percentage)					Combined Response Ratings (Percentage)		
		1	2	3	4	5	1 & 2	4 & 5	
3. "misfortune after abortion"	Catholicism	50	19	13	16	03	79	21	
	Protestantism	46	34	12	06	01	92	08	
	Judaism	71	14	14	00	00	100	00	
	Agnosticism	60	00	20	20	00	75	25	
	Unclassified	40	40	20	00	00	100	00	
4. "woman pregnant but unmarried"	Catholicism	06	16	13	25	41	25	75	
	Protestantism	07	33	13	24	22	46	54	
	Judaism	57	14	00	14	14	71	29	
	Agnosticism	60	40	00	00	00	100	00	
	Unclassified	40	40	20	00	00	100	00	
5. "strong possibility of malformed child"	Catholicism	16	22	09	19	34	41	59	
	Protestantism	49	29	05	10	07	82	18	
	Judaism	86	14	00	00	00	100	00	
	Agnosticism	100	00	00	00	00	100	00	
	Unclassified	80	20	00	00	00	100	00	
6. "any woman requesting an abortion"	Catholicism	06	06	09	13	66	14	86	
	Protestantism	04	13	07	28	48	18	82	
	Judaism	43	29	00	00	29	71	29	
	Agnosticism	20	60	00	20	00	80	20	
	Unclassified	00	20	20	20	40	25	75	

TABLE H4--continued

Items	Religion	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	2	4 & 5	
7. "wife from a poverty stricken home"	Catholicism	03	19	13	16	50	25		75	
	Protestantism	09	23	13	23	32	37		63	
	Judaism	57	14	14	00	14	83		17	
	Agnosticism	60	40	00	00	00	100		00	
	Unclassified	00	60	20	20	00	75		25	
8. "woman 45 years of age or older"	Catholicism	03	19	09	22	47	24		76	
	Protestantism	11	20	20	26	24	38		62	
	Judaism	71	14	00	00	14	86		14	
	Agnosticism	40	60	00	00	00	100		00	
	Unclassified	00	40	20	20	20	50		50	
9. "woman judged psycho-logically unfit"	Catholicism	06	26	09	25	34	34		66	
	Protestantism	20	43	07	21	10	67		33	
	Judaism	71	14	00	00	14	86		14	
	Agnosticism	80	20	00	00	00	100		00	
	Unclassified	00	80	00	20	00	80		20	
10. "woman pregnant and obtaining a divorce"	Catholicism	16	06	19	25	34	27		73	
	Protestantism	09	26	24	15	27	45		55	
	Judaism	71	14	00	14	00	86		14	
	Agnosticism	60	40	00	00	00	100		00	
	Unclassified	40	20	20	00	20	75		25	

TABLE H4--continued

Items	Religion	Response Rating (Percentage)					Combined Response Ratings (Percentage)		
		1	2	3	4	5	1 & 2	4 & 5	
11. "woman who loves children would never consider abortion"	Catholicism	19	19	13	16	34	43	57	
	Protestantism	22	45	12	11	10	76	24	
	Judaism	29	57	00	00	14	86	14	
	Agnosticism	60	40	00	00	00	100	00	
	Unclassified	00	60	40	00	00	100	00	
12. "abortion should never be permitted"	Catholicism	22	31	13	06	28	61	39	
	Protestantism	72	20	01	04	04	93	07	
	Judaism	86	14	00	00	00	100	00	
	Agnosticism	100	00	00	00	00	100	00	
	Unclassified	80	20	00	00	00	100	00	
13. "circumstances under which I would con- sider an abortion"	Catholicism	19	13	06	25	38	33	67	
	Protestantism	46	39	06	02	06	91	09	
	Judaism	86	14	00	00	00	100	00	
	Agnosticism	80	20	00	00	00	100	00	
	Unclassified	40	40	00	20	00	80	20	
14. "women requesting abortion are irresponsible"	Catholicism	41	28	13	09	09	79	21	
	Protestantism	48	43	06	02	01	96	04	
	Judaism	71	14	00	14	00	86	14	
	Agnosticism	60	40	00	00	00	100	00	
	Unclassified	60	40	00	00	00	100	00	

TABLE H4--continued

Items	Religion	Response Rating (Percentage)					Combined Response Ratings (Percentage)	
		1	2	3	4	5	1 & 2	4 & 5
15. "life endangered with child-delivery"	Catholicism	13	22	22	25	19	44	56
	Protestantism	51	30	09	06	04	89	11
	Judaism	86	14	00	00	00	100	00
	Agnosticism	80	20	00	00	00	100	00
	Unclassified	60	20	00	20	00	80	20
16. "feel satisfied and comfortable after abortion"	Catholicism	09	22	19	28	22	38	62
	Protestantism	13	41	30	11	04	79	21
	Judaism	57	29	00	14	00	86	14
	Agnosticism	60	40	00	00	00	100	00
	Unclassified	20	40	00	40	00	60	40
17. "child unwanted and treated as such"	Catholicism	06	31	00	16	47	38	62
	Protestantism	15	32	16	23	15	55	45
	Judaism	71	00	14	00	14	83	17
	Agnosticism	60	40	00	00	00	100	00
	Unclassified	20	20	00	40	20	40	60

TABLE H5

PERCENTAGE OF INDIVIDUALS AMONG SOCIO-ECONOMIC CLASSES I ($\bar{N} = 32$), II ($\bar{N} = 36$), III ($\bar{N} = 23$), IV ($\bar{N} = 33$), AND V ($\bar{N} = 7$) GIVING SPECIFIC ATTITUDE RATING TO EACH AAI ITEM

Items	Class	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree	Strongly Agree	Tend to Agree	Tend to Disagree	Strongly Disagree	n
1. "pregnancy following rape"	Class I	69	22	03	00	06	94	06	06	06	
	Class II	64	22	00	11	03	86	14	14	14	
	Class III	70	22	00	00	09	91	09	09	09	
	Class IV	61	24	03	03	09	88	12	12	12	
	Class V	43	29	14	00	14	83	17	17	17	
2. "court judged unfit mother"	Class I	34	34	06	13	13	73	27	27	27	
	Class II	25	31	14	22	08	65	35	35	35	
	Class III	35	22	09	17	17	62	38	38	38	
	Class IV	24	39	12	18	06	72	28	28	28	
	Class V	14	43	00	14	29	57	43	43	43	

TABLE H5--continued

Items	Class	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	4 & 5		
3. "misfortune after abortion"	Class I	66	19	06	09	00	90	10		
	Class II	50	19	19	11	00	86	14		
	Class III	48	22	22	09	00	89	11		
	Class IV	33	58	06	03	00	97	03		
	Class V	43	00	14	14	29	50	50		
4. "woman pregnant but "unmarried"	Class I	22	31	09	22	16	59	41		
	Class II	14	25	17	31	14	47	53		
	Class III	09	30	13	13	35	45	55		
	Class IV	06	33	06	21	33	42	58		
	Class V	14	00	29	14	43	20	80		
5. "strong possibility of malformed child"	Class I	59	13	09	06	13	79	21		
	Class II	44	28	08	19	00	79	21		
	Class III	52	17	04	04	22	73	27		
	Class IV	33	39	00	09	18	73	27		
	Class V	29	29	00	14	29	57	43		
6. "any woman requesting an abortion"	Class I	13	19	09	19	41	34	66		
	Class II	03	11	08	28	50	15	85		
	Class III	09	13	09	09	61	24	76		
	Class IV	03	18	06	21	52	23	77		
	Class V	14	00	00	57	29	14	86		

TABLE H5---continued

Items	Class	Response Rating (Percentage)					Combined Response Ratings (Percentage)	
		1	2	3	4	5	1 & 2	4 & 5
7. "wife from a poverty stricken home"	Class I	16	28	22	16	19	56	44
	Class II	06	19	14	33	28	29	71
	Class III	22	13	13	09	43	40	60
	Class IV	09	33	06	09	42	45	55
	Class V	00	14	00	43	43	14	86
8. "woman 45 years of age or older"	Class I	19	22	19	22	19	50	50
	Class II	08	19	14	31	28	32	68
	Class III	17	09	13	26	35	30	70
	Class IV	12	24	18	12	33	44	56
	Class V	00	57	00	14	29	57	43
9. "woman judged psycho-logically unfit"	Class I	28	50	06	06	09	83	17
	Class II	14	28	06	36	17	44	56
	Class III	30	22	13	09	26	60	40
	Class IV	15	42	06	24	12	61	39
	Class V	14	57	00	14	14	71	29
10. "woman pregnant and obtaining a divorce"	Class I	19	28	22	13	19	60	40
	Class II	14	22	11	28	25	41	59
	Class III	17	09	22	13	39	33	67
	Class IV	15	21	30	06	27	52	48
	Class V	29	14	14	29	14	50	50

TABLE H5--continued

Items	Class	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	4 & 5		
11. "woman who loves children would never consider abortion"	Class I	38	34	13	06	09	82	18		
	Class II	25	44	14	08	08	81	19		
	Class III	22	43	09	13	13	71	29		
	Class IV	06	39	15	12	27	54	46		
	Class V	14	29	00	29	29	43	57		
12. "abortion should never be permitted"	Class I	69	19	03	03	06	90	10		
	Class II	58	31	08	00	03	97	03		
	Class III	65	26	00	00	09	91	09		
	Class IV	61	12	03	09	15	75	25		
	Class V	43	14	00	14	29	57	43		
13. "circumstances under which I would consider an abortion"	Class I	59	25	00	03	13	84	16		
	Class II	33	39	08	11	08	79	21		
	Class III	48	26	04	13	09	77	23		
	Class IV	36	30	03	09	21	69	31		
	Class V	29	29	29	00	14	80	20		
14. "women requesting abortion are irresponsible"	Class I	56	38	03	03	00	97	03		
	Class II	44	47	08	00	00	100	00		
	Class III	43	26	13	13	04	80	20		
	Class IV	52	33	06	06	03	90	10		
	Class V	29	43	00	00	29	71	29		

TABLE H5--continued

Items	Class	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	4 & 5		
15. "life endangered with child-delivery"	Class I	41	41	06	06	06	87	13		
	Class II	44	22	14	17	03	77	23		
	Class III	57	17	13	09	04	85	15		
	Class IV	45	24	09	09	12	77	23		
	Class V	29	29	14	14	14	67	33		
16. "feel satisfied and comfortable after abortion"	Class I	22	47	22	09	00	88	12		
	Class II	19	42	22	11	06	79	21		
	Class III	17	35	17	17	13	63	37		
	Class IV	09	27	33	21	09	55	45		
	Class V	14	00	14	43	29	17	83		
17. "child unwanted and treated as such"	Class I	22	31	16	16	16	63	37		
	Class II	11	22	14	28	25	39	61		
	Class III	30	35	00	13	22	65	35		
	Class IV	15	36	06	21	21	55	45		
	Class V	00	14	29	14	43	20	80		

APPENDIX I

KNOWLEDGE OF ABORTION AND DEMOGRAPHIC VARIABLES

APPENDIX I

KNOWLEDGE OF ABORTION AND DEMOGRAPHIC VARIABLES

Residential Status

Although the between group t (1.77; two-tailed) did not reach the level of statistical significance, there was a trend ($p < .10$) for Lansing area residents to possess more factual knowledge of abortion than undergraduate students attending Michigan State University. For 89 Lansing area residents, the $\overline{AQ} = 5.8$ (SD = 2.0); for 42 students, the $\overline{AQ} = 5.1$ (SD = 2.4).

The $\overline{AQ}$ score did not differ significantly from that expected by chance for students ($z = .159$) or for Lansing area residents ($z = .524$).

Sex

There was no significant difference ($t = 0.029$; two-tailed) between males and females with respect to their knowledge of abortion. For the 60 males, the $\overline{AQ} = 5.6$ (SD = 2.2); for the 71 females, the $\overline{AQ} = 5.6$ (SD = 2.1).

Neither the $\overline{AQ}$ for males nor females differed significantly from that expected by chance ($z = .415$).

Marital Status

There was no statistically significant difference ($t = 1.950$) between married persons and single persons with respect to their knowledge of abortion. However, a trend ($p < .10$) was demonstrated that married individuals are more knowledgeable about abortion than are single persons. For the 83 marrieds, $\overline{AQ} = 5.9$ ($SD = 1.9$); for the 43 singles, $\overline{AQ} = 5.1$ ($SD = 2.4$). The two divorced persons and the three widowed individuals among the 131 people constituting the general sample were excluded from this analysis.

The $\overline{AQ}$ score did not differ significantly from that expected by chance for marrieds ($z = .537$) or singles ($z = .146$).

Religious Preference

Knowledge of abortion was found to differ significantly ($p < .02$) among individuals expressing a religious preference categorized as Protestantism, Catholicism, Judaism, Agnosticism, and Unclassified, see Table II.

As determined from Scheffé's method of analysis, no significant difference in knowledge of abortion was found for any of the possible comparisons of individuals expressing a different religious preference. The only trend toward difference ($p < .10$) was for Jews to be more

TABLE 11

ONE-WAY ANALYSIS OF VARIANCE OF KNOWLEDGE OF ABORTION
AMONG INDIVIDUALS WITH DIFFERENT
RELIGIOUS PREFERENCES

Source of Variance	df	MS	<u>F</u>	<u>p</u>
Between categories	4	14.3	3.39	0.011
Within categories	126	4.2		
Total	130			

knowledgeable about abortion than Catholics. The pertinent data for the five religious categories are presented in Table I2.

TABLE 12

KNOWLEDGE OF ABORTION AMONG INDIVIDUALS WITH
DIFFERENT RELIGIOUS PREFERENCES

Preference	<u>N</u>	Mean	Standard Deviation
Agnosticism	5	7.60	0.55
Judaism	7	7.57	2.23
Protestantism	82	5.56	1.99
Catholicism	32	5.09	2.28
Unclassified	5	5.00	2.24

For no religious group did the $\overline{AQ}$ differ significantly from that expected by chance--Agnosticism, $z = 1.427$; Judaism, $z = 1.402$; Protestantism, $z = .390$; Catholicism, $z = .146$; Unclassified, $z = .098$.

Socio-economic Status

A significant difference ($p < .04$) in knowledge of abortion was found to exist among individuals of the five socio-economic classes, see Table I3.

TABLE I3

ONE-WAY ANALYSIS OF VARIANCE OF KNOWLEDGE OF ABORTION AMONG SOCIO-ECONOMIC CLASSES

Source of Variance	df	MS	$\underline{F}$	$\underline{p}$
Between categories	4	11.6	2.68	0.034
Within categories	126	4.3		
Total	130			

However, using Scheffé's method of analysis, no significant difference nor trend toward difference in knowledge of abortion was found between any possible comparison among the socio-economic classes. The pertinent data for each of the five socio-economic classes are presented in Table I4.

TABLE I4
KNOWLEDGE OF ABORTION AMONG
SOCIO-ECONOMIC CLASSES

Class	<u>N</u>	Mean	Standard Deviation
I	32	6.59	2.06
II	36	5.50	2.02
III	23	5.22	2.09
IV	33	5.27	2.11
V	7	4.57	2.23

For no socio-economic class did the $\overline{AQ}$ differ significantly from that expected by chance--class I, $\underline{z} = .915$; class II, $\underline{z} = .354$; class III, $\underline{z} = .207$; class IV, $\underline{z} = .244$; class V, $\underline{z} = -.122$.

APPENDIX J

MULTIPLE REGRESSION AND FACTOR ANALYSIS OF
PERSONALITY TRAITS WITH ATTITUDE
TOWARD ABORTION

APPENDIX J

MULTIPLE REGRESSION AND FACTOR ANALYSIS OF PERSONALITY TRAITS WITH ATTITUDE TOWARD ABORTION

Multiple Regression of Personality Traits

A multiple regression analysis was done to determine the extent to which the personality traits measured by the GPP, GPI, and SIV account for variance in attitude toward abortion. All traits together were found to account for 32 per cent ($R = .57$; $p < .001$) of the variance in attitude, see Table J1.

TABLE J1

MULTIPLE REGRESSION OF PERSONALITY TRAITS WITH ATTITUDE TOWARD ABORTION--ANALYSIS OF VARIANCE FOR OVERALL REGRESSION

	df	MS	<u>F</u>	<u>p</u>
Regression (about $\bar{X}$)	14	706.8	3.92	0.001
Error	116	180.2		
Total	130			

The traits which add the most unique information are Original Thinking, Support, Conformity, Independence, and Leadership (see Table J2).

As revealed in Table J2, when the remaining 13 traits are partialled out, the correlations of both Original Thinking and Independence with attitude demonstrate the same significant relationship (higher trait score, more permissive attitude) as when the remaining traits were not partialled out (see Table 15, Chapter VIII). Similarly, Leadership with the removal of other traits maintains its trend for higher scores to be associated with a more permissive stance. However, the traits of Benevolence and Ascendancy correlated with attitude when the remaining 13 traits have been partialled out, do not maintain their significant association with abortion attitude evidenced prior to the removal of the effects of the other traits. Similarly, the trend for higher scores of Sociability to be associated with a favorable abortion attitude was not demonstrated with the effects of the remaining traits removed. Higher Support scores, in contrast to a nonsignificant relationship with attitude prior to the removal of other trait effects, tend ($p < .07$) to be related to a more permissive position toward abortion. Higher Conformity scores prior to the removal of other trait effects, was significantly associated with a less permissive attitude. However,

TABLE J2
MULTIPLE REGRESSION OF PERSONALITY TRAITS WITH ATTITUDE TOWARD ABORTION

Traits	Regres. Coef.	Std. Errors Coef.	Beta Wts.	Std. Error Betas	TB	FB	p	Part. Corr. Coef.
<u>GPP</u>								
Ascendancy	-0.03	0.07	-0.06	0.14	-0.42	0.18	0.674	-0.04
Responsibility	0.09	0.06	0.17	0.11	1.57	2.45	0.120	0.14
Emotional Stability	0.01	0.06	0.01	0.12	0.09	0.01	0.925	0.01
Sociability	-0.06	0.07	-0.12	0.12	-0.94	0.89	0.347	-0.09
<u>GPI</u>								
Cautiousness	-0.02	0.06	-0.04	0.11	-0.32	0.10	0.752	-0.03
Original Thinking	-0.18	0.06	-0.34	0.11	-3.19	10.19	0.002	-0.28
Personal Relations	-0.01	0.05	-0.03	0.11	-0.25	0.06	0.800	-0.02
Vigor	-0.05	0.05	-0.10	0.10	-1.02	1.04	0.311	-0.09
<u>SIV</u>								
Support	-0.19	0.10	-0.35	0.19	-1.86	3.45	0.066	-0.17
Conformity	-0.23	0.12	-0.45	0.24	-1.90	3.61	0.060	-0.17
Recognition	-0.02	0.10	-0.04	0.17	-0.23	0.05	0.821	-0.02
Independence	-0.30	0.12	-0.52	0.20	-2.56	6.55	0.012	-0.23
Benevolence	0.05	0.11	-0.09	0.21	0.45	0.20	0.653	0.04
Leadership	-0.21	0.13	-0.41	0.24	-1.67	2.81	0.097	-0.15

with the effects of the remaining traits removed, higher Conformity scores tended ($p < .06$) to be associated with a more permissive attitude.

The multiple regression analysis (Table J2) and the correlation of traits with attitude without the removal of possible interaction effects among traits (Table 15, Chapter VIII) suggest that the traits of Original Thinking and Independence significantly and uniquely relate to attitude toward abortion. Similarly, the trait of Leadership consistent with and without the other 13 traits partialled out in its tendency to relate to attitude, appears uniquely associated with attitude. Sociability tends to relate, and, Ascendancy, Benevolence, Conformity significantly relate, to attitude, not uniquely but in unknown interaction with other personality traits.

Considering that human beings are most often characterized by dynamic, interacting processes where the removal of "one process" may result in a "different animal," the relationship between personality traits and attitude without the removal of possible trait interaction effects is most psychologically meaningful. While the meaning of the partial correlation coefficients may be of academic interest, "unpartialled" correlation coefficients appear to be of more psychological interest.

Factor Analysis of Personality Traits

A factor analysis of the 14 personality traits assessed by the GPP, GPI, and SIV using the technique of quartermax rotation demonstrates that the traits most appropriately cluster into four factors which together account for 66 percent of the variance ($r = .81$).

Factor I consists of the traits Responsibility, Emotional Stability, Personal Relations, Cautiousness, and Original Thinking; and may be described as a dimension of General Adjustment.

Factor II is bipolar with Ascendancy, Sociability, Leadership, Vigor, and Original Thinking constituting one pole and Cautiousness, Support, and Conformity the other. This factor is described as a dimension of Extroversion-Introversion.

Factor III, a dimension of Self-Other Need Orientation, is bipolar with the traits Recognition and Support located at one pole and Benevolence situated at the other.

Factor IV is comprised of two "opposed" traits Independence and Conformity and is described as a dimension of Independence-Conformity.

The pertinent data of the factor analysis are presented in Table J3. The intercorrelation matrix of the personality traits is presented in Table J4.

TABLE J3
FACTOR ANALYSIS OF PERSONALITY TRAITS

Traits	Communality	Factor I	Factor II	Factor III	Factor IV
<u>GPP</u>					
Ascendancy	.73	.06	-.85	.11	.05
Responsibility	.72	.81	.07	-.11	-.21
Emotional Stability	.73	.80	-.08	-.02	.28
Sociability	.50	-.09	-.70	.00	-.02
<u>GPI</u>					
Cautiousness	.67	.61	.41	.23	-.27
Original Thinking	.53	.52	-.49	.11	.10
Personal Relations	.61	.71	-.13	.28	-.03
Vigor	.50	.27	-.51	.26	-.32
<u>SIV</u>					
Support	.49	-.10	.44	-.54	.05
Conformity	.73	.09	.58	.35	-.51
Recognition	.82	-.09	-.17	-.86	-.21
Independence	.90	-.02	.08	.02	.94
Benevolence	.73	.09	-.06	.83	-.18
Leadership	.60	.01	-.76	-.11	-.07
Proportions of Variance		.18	.22	.15	.11

TABLE J4
INTERCORRELATION MATRIX OF PERSONALITY TRAITS

	Ascendancy	Responsi- bility	Emotional stability	Sociability	Cautious- ness	Original Thinking	Personal Relations	Vigor	Support	Conformity	Recognition	Independence	Benevolence
Responsibility	-.03												
Emotional Stability	.17	.54											
Sociability	.70	-.05	-.02										
Cautiousness	-.25	.45	.27	-.32									
Original Thinking	.39	.27	.29	.12	.18								
Personal Relations	.19	.40	.54	.14	.40	.36							
Vigor	.34	.24	.14	.25	.02	.42	.21						
Support	-.36	-.06	-.17	-.09	.03	-.25	-.17	-.27					
Conformity	-.35	.23	-.06	-.32	.42	-.28	.08	-.06	-.10				
Recognition	.01	.02	-.06	.09	-.29	-.06	-.27	-.09	.27	-.32			
Independence	-.02	-.13	.19	-.04	-.21	.05	-.12	-.22	.02	-.37	-.22		
Benevolence	.10	.01	.03	.06	.24	.16	.31	.34	-.37	.17	-.55	-.21	
Leadership	.51	-.04	.03	.29	-.21	.33	.04	.26	-.48	-.47	.13	-.16	-.16

APPENDIX K

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY ATTRIBUTES AND ATTITUDE TOWARD ABORTION BY DEMOGRAPHIC CLASSIFICATIONS

APPENDIX K

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY ATTRIBUTES AND ATTITUDE TOWARD ABORTION BY DEMOGRAPHIC CLASSIFICATIONS

Residential Status

Among Michigan State University undergraduates enrolled in an introductory psychology course only Original Thinking correlated significantly ($p < .05$) with attitude toward abortion. A higher score on this measure related to a more permissive attitude toward abortion. Higher scores on the trait measures of Ascendancy ($p < .14$) and Independence ($p < .14$) tended to relate to a more permissive attitude.

For the Lansing area residents, higher scores on Original Thinking ($p < .005$) and Independence ($p < .01$) were significantly associated with a favorable stance toward abortion while higher scores on Ascendancy ($p < .07$) and Sociability ($p < .11$) tended to be so associated. Higher Benevolence scores were related ($p < .05$) to a more unfavorable attitude toward abortion. The pertinent correlation data for students and Lansing area residents

are presented in Table K1. For Table K1, and all the tables of this appendix, negative correlations show that a more permissive attitude toward abortion was associated with higher scores on the personality measures. Positive correlations show that higher scores on the personality variables were associated with a less permissive stance.

Sex

For the males, higher scores on Independence ($p < .01$) and Ascendancy ($p < .05$) measures were related to a more permissive attitude toward abortion. Although not reaching the level of significance, higher scores on the Original Thinking measure were also related to a more permissive attitude. On the other hand, higher scores of Benevolence ($p < .05$) were associated with a more unfavorable attitude; higher Cautiousness scores tended to be similarly associated ($p < .11$).

For the females, a more favorable stance toward abortion was associated with higher scores on measures of Original Thinking ($p < .005$) and Independence ($p < .01$) and tended to be associated with higher scores of Leadership ($p < .07$). Although no correlation attained significance, an attitude more opposed to permissive abortion tended to relate to higher scores on indexes of Recognition ($p < .06$), Benevolence ($p < .09$), and Conformity ($p < .10$). All relevant correlation data for attributes and attitude among males and females are presented in Table K2.

TABLE K1

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY
ATTRIBUTES AND ATTITUDE TOWARD ABORTION AMONG
LANSING AREA RESIDENTS ($N = 89$) AND
MICHIGAN STATE UNIVERSITY
STUDENTS ($N = 42$)

Attributes	Lansing Area Resident	Student
	<u>r</u>	<u>r</u>
<u>GPP</u>		
Ascendancy	-.20	-.24
Responsibility	-.05	.15
Emotional Stability	-.04	-.07
Sociability	-.17	-.01
<u>GPI</u>		
Cautiousness	.04	-.10
Original Thinking	-.31***	-.33*
Personal Relations	-.06	-.06
Vigor	-.05	-.23
<u>SIV</u>		
Support	.01	-.05
Conformity	.09	.21
Recognition	.05	.21
Independence	-.28**	-.24
Benevolence	.27*	.05
Leadership	-.14	-.19

* $p < .05$; two-tailed
 ** $p < .01$; two-tailed
 *** $p < .005$; two-tailed

TABLE K2

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY
ATTRIBUTES AND ATTITUDE TOWARD ABORTION AMONG
MALES ($N = 60$) AND FEMALES ($N = 71$)

Attributes	Males	Females
	<u>r</u>	<u>r</u>
<u>GPP</u>		
Ascendancy	-.28*	-.13
Responsibility	-.02	.12
Emotional Stability	-.16	.05
Sociability	-.17	-.11
<u>GPI</u>		
Cautiousness	.21	-.04
Original Thinking	-.21	-.37***
Personal Relations	.11	-.12
Vigor	-.12	-.04
<u>SIV</u>		
Support	.07	-.12
Conformity	.16	.20
Recognition	-.10	.22
Independence	-.33**	-.30**
Benevolence	.27*	.21
Leadership	-.06	-.22

* $p < .05$; two-tailed

** $p < .01$; two-tailed

*** $p < .005$; two-tailed

Marital Status

Among married persons, higher scores on measures of Original Thinking ($p < .01$) and Independence ($p < .05$) were related with a more permissive attitude toward abortion. Higher scores on Ascendancy ($p < .07$), Leadership ($p < .11$), and Sociability ($p < .13$) tended to be associated with a more positive stance toward permissive abortion. Benevolence was the only trait measure for which higher scores were associated with a more unfavorable position toward abortion ($p < .01$).

For single persons, higher scores of Original Thinking ($p < .05$) were related to a more permissive position on abortion and higher scores of Independence ($p < .10$), Vigor ($p < .12$), and Leadership ($p < .15$) tended to be so related. No correlation reached nor tended the level of significance in which a higher trait score would have been related to a more unfavorable attitude. The pertinent correlation data for marrieds and singles are presented in Table K3.

Religious Preference

Among Protestants higher scores on the Ascendancy measure ($p < .05$) were related to a more permissive attitude toward abortion. A similar relationship tended to exist for the attributes of Vigor ($p < .06$), Original Thinking ($p < .08$), Leadership ($p < .11$), and Independence

TABLE K3

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY
ATTRIBUTES AND ATTITUDE TOWARD ABORTION AMONG
MARRIEDS ($N = 83$) AND SINGLE
PERSONS ($N = 43$)

Attributes	Married	Single
	$\bar{r}$	$\bar{r}$
<u>GPP</u>		
Ascendancy	-.21	-.22
Responsibility	-.06	.15
Emotional Stability	-.04	-.10
Sociability	-.17	-.01
<u>GPI</u>		
Cautiousness	.07	-.09
Original Thinking	-.29**	-.36*
Personal Relations	.00	-.10
Vigor	-.07	-.25
<u>SIV</u>		
Support	.02	-.02
Conformity	.10	.22
Recognition	-.01	.19
Independence	-.24*	-.26
Benevolence	.30**	.09
Leadership	-.18	-.22

* $p < .05$; two-tailed

** $p < .01$; two-tailed

($p < .12$). Only for the measure of Benevolence ($p < .05$) were higher scores associated with a more unfavorable position toward permissive abortion.

For those who stated Catholicism as their preference, higher scores on the measure of Independence ($p < .005$) were related to a more favorable abortion attitude; higher scores on the measure of Emotional Stability ($p < .07$) tended to be associated with a more approving position. Higher scores associated with a less permissive stance were found for the measures of Conformity ($p < .05$) and Benevolence ($p < .05$) and tended toward a significant association for the trait of Vigor ($p < .09$).

Within the sample of persons professing Judaism, higher scores on Independence ($p < .05$) were significantly related to a more approving stance toward abortion while higher scores on Responsibility ($p < .06$) and Conformity ($p < .11$) measures tended to be associated with a less approving position.

Among Agnostics only one correlation reached the level of significance. Higher scores of Support ($p < .05$) were associated with a more favorable attitude toward permissive abortion. The pertinent correlation data for each religious category are presented in Table K4.

TABLE K4

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY ATTRIBUTES AND ATTITUDE TOWARD ABORTION AMONG INDIVIDUALS STATING A PREFERENCE FOR PROTESTANTISM ($N = 82$), CATHOLICISM ($N = 32$), JUDAISM ($N = 7$) OR AGNOSTICISM ($N = 5$)

Attributes	Protestantism	Catholicism	Judaism	Agnosticism
	$\bar{r}$	$\bar{r}$	$\bar{r}$	$\bar{r}$
<u>GPP</u>				
Ascendancy	-.22*	-.07	-.17	-.47
Responsibility	-.10	-.16	.74	.44
Emotional Stability	-.13	-.33	.56	.65
Sociability	-.14	-.20	-.20	-.56
<u>GPI</u>				
Cautiousness	.09	-.05	.66	.65
Original Thinking	-.20	-.19	.02	.02
Personal Relations	-.08	-.08	.50	-.26
Vigor	-.21	.31	-.25	-.20
<u>SIV</u>				
Support	.02	.01	.12	-.90*
Conformity	.00	.38*	.66	.21
Recognition	.15	.02	.07	.38
Independence	-.18	-.50**	-.87*	-.27
Benevolence	.23*	.37*	.01	-.11
Leadership	-.18	-.15	-.51	.61

* $\bar{p} < .05$; two-tailed

** $\bar{p} < .005$; two-tailed

Socio-economic Status

For persons of class I status, higher scores of Original Thinking ($p < .005$) were related to a more permissive abortion attitude; higher scores of Independence ($p < .08$) tended to be similarly related. Although for no trait measured were higher scores significantly related to a more restrictive stance toward abortion, the attribute of Conformity ($p < .07$) tended to be so related.

Among class II, higher scores on Sociability ($p < .06$) and Ascendancy ($p < .12$) measures tended to be associated to a more liberal attitude toward abortion. To the contrary, higher scores on the measure of Responsibility ($p < .05$) were significantly related to a less permissive stance.

For class III higher scores of Original Thinking ($p < .05$) were significantly associated with a more permissive position toward abortion. Higher scores on Independence ($p < .06$), Leadership ($p < .07$), and Ascendancy ($p < .13$) measures tended toward such a relationship. A more unfavorable attitude toward permissive abortion tended to relate to higher Benevolence scores ($p < .09$).

Among individuals of class IV, higher scores of Independence ($p < .15$) tended to be associated with a more favorable attitude toward abortion while higher scores of

Benevolence ($p < .05$) were significantly associated with a less favorable attitude.

For class V, the only trait measure which reached or tended toward statistical significance was Personal Relations. Higher scores on this attribute measure were related ($p < .05$) to a less permissive stance toward abortion. The pertinent data for attributes and attitude within social class are presented in Table K5.

TABLE K5

PRODUCT-MOMENT CORRELATIONS BETWEEN PERSONALITY ATTRIBUTES AND ATTITUDE TOWARD
ABORTION AMONG SOCIO-ECONOMIC CLASSES I ($\bar{N} = 32$), II ($\bar{N} = 36$),
III ($\bar{N} = 23$), IV ($\bar{N} = 33$), and V ($\bar{N} = 7$)

Attributes	Class I	Class II	Class III	Class IV	Class V
	$\bar{r}$	$\bar{r}$	$\bar{r}$	$\bar{r}$	$\bar{r}$
<u>GPP</u>					
Ascendancy	-.03	-.27	-.33	-.26	.24
Responsibility	.08	.33*	-.06	-.05	.58
Emotional Stability	.20	-.02	-.12	-.23	.34
Sociability	-.04	-.32	-.31	-.04	.15
<u>GPI</u>					
Cautiousness	.08	.06	.25	-.07	.28
Original Thinking	-.47**	-.13	-.49*	-.13	.40
Personal Relations	-.06	-.04	.19	-.14	.79*
Vigor	.11	-.10	-.30	-.06	.52
<u>SIV</u>					
Support	-.05	-.08	.08	.10	-.45
Conformity	.33	.16	.21	-.10	.30
Recognition	.09	-.11	-.07	.14	.37
Independence	-.32	-.15	-.40	-.26	-.58
Benevolence	.21	-.03	.37	.35*	.34
Leadership	-.21	.10	-.39	-.24	.06

* $\bar{p} < .05$; two-tailed

** $\bar{p} < .005$; two-tailed

APPENDIX L

PROFESSIONALS' RESPONSES TO AAI ITEMS

APPENDIX L

PROFESSIONALS' RESPONSES TO AAI ITEMS

Businessmen, legislators, physicians, and religious leaders generally differed greatly in their approving or disapproving of abortion under various specified circumstances. The responses of these professionals to each AAI item are presented in Table L1. Response ratings of 1 always indicate that the respondent has a strongly favorable attitude toward permissive abortion under circumstances implied in the item--regardless of the positive or negative wording of the item. Similarly, ratings of 5 always indicate the person is strongly unfavorable toward abortion in the situation implied in the AAI item, regardless of the item's wording. For a fuller explanation of this scoring system, see Appendix G, p. 411.

TABLE L1

PERCENTAGE OF INDIVIDUALS WITHIN PROFESSIONAL GROUPS OF BUSINESSMEN ($\bar{N} = 79$),
LEGISLATORS ($\bar{N} = 39$), PHYSICIANS ($\bar{N} = 98$), AND RELIGIOUS LEADERS ($\bar{N} = 73$)
GIVING SPECIFIC ATTITUDE RATING TO EACH AAI ITEM

Items	Group	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		Strongly Agree	Tend to Agree	Neutral	Tend to Disagree	Strongly Disagree	Strongly Agree & Tend to Agree	Tend to Disagree & Strongly Disagree	1 & 2	4 & 5	
1. "pregnancy following rape"	Businessmen	86	08	00	03	04	94	06			
	Legislators	69	23	03	00	05	95	05			
	Physicians	65	19	01	05	09	86	14			
	Religious Lds.	52	29	04	10	05	84	16			
2. "court judged unfit mother"	Businessmen	51	19	10	11	09	77	23			
	Legislators	31	26	18	21	05	69	31			
	Physicians	32	28	11	14	15	67	33			
	Religious Lds.	14	27	08	27	23	45	55			
3. "misfortune after abortion"	Businessmen	57	29	13	01	00	99	01			
	Legislators	38	36	18	08	00	91	09			
	Physicians	57	28	13	01	01	98	02			
	Religious Lds.	38	30	18	11	03	83	17			

TABLE L1--continued

Items	Group	Response Rating (Percentage)					Combined Response Ratings (Percentage)				
		1	2	3	4	5	1 & 2	2	4 & 5		
4. "woman pregnant but unmarried"	Businessmen Legislators Physicians Religious Lds.	25 15 06 01	20 15 20 08	20 08 12 08	20 33 26 33	14 28 36 49	57 33 30 10		43 67 70 90		
5. "strong possibility of malformed child"	Businessmen Legislators Physicians Religious Lds.	71 51 62 29	16 33 16 32	03 05 01 07	05 03 08 19	05 08 12 14	90 89 79 65		10 11 21 35		
6. "any woman requesting an abortion"	Businessmen Legislators Physicians Religious Lds.	14 13 06 01	23 15 12 00	06 05 09 03	18 18 17 15	39 49 55 81	39 30 20 01		61 70 80 99		
7. "wife from a poverty stricken home"	Businessmen Legislators Physicians Religious Lds.	24 10 10 03	27 21 20 08	15 10 15 12	14 23 18 33	20 36 36 44	60 34 36 13		40 66 64 87		
8. "woman 45 years of age or older"	Businessmen Legislators Physicians Religious Lds.	30 18 15 07	24 26 21 14	19 08 07 12	08 18 22 18	19 31 34 49	67 47 40 23		33 53 60 77		

TABLE L1--continued

Items	Group	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	2	4 & 5	
9. "woman judged psycho-logically unfit"	Businessmen Legislators Physicians Religious Lds.	51 18 20 12	29 36 40 36	01 15 05 10	11 21 17 22	08 10 17 21	81 64 63 53		19 36 37 47	
10. "woman pregnant and obtaining a divorce"	Businessmen Legislators Physicians Religious Lds.	19 13 14 08	28 21 22 12	15 08 14 12	10 26 22 27	28 33 27 40	55 36 43 23		45 64 57 77	
11. "woman who loves children would never consider an abortion"	Businessmen Legislators Physicians Religious Lds.	29 31 36 23	38 36 29 34	14 18 15 16	10 13 13 14	09 03 07 12	78 81 76 69		22 19 24 31	
12. "abortion should never be permitted"	Businessmen Legislators Physicians Religious Lds.	76 74 81 56	14 10 08 23	05 10 01 04	03 00 04 08	03 05 06 08	95 94 90 83		05 06 10 17	
13. "circumstances under which I would consider abortion"	Businessmen Legislators Physicians Religious Lds.	54 44 48 27	35 36 34 41	06 18 02 07	03 00 06 07	01 03 10 18	96 97 83 74		04 03 17 26	

TABLE L1--continued

Items	Group	Response Rating (Percentage)					Combined Response Ratings (Percentage)			
		1	2	3	4	5	1 & 2	4 & 5		
14. "women requesting abortion are irresponsible"	Businessmen Legislators Physicians Religious Lds.	57 56 55 36	29 23 36 41	05 13 03 15	06 05 02 04	03 03 04 04	91 91 94 90	09 09 06 10		
15. "life endangered with child-delivery"	Businessmen Legislators Physicians Religious Lds.	67 44 53 34	25 38 26 37	04 08 03 12	01 05 10 10	03 05 08 07	96 89 81 81	04 11 19 19		
16. "feel satisfied and comfortable after abortion"	Businessmen Legislators Physicians Religious Lds.	20 21 30 12	44 38 42 38	23 26 15 25	11 13 09 19	01 03 04 05	84 79 84 67	16 21 16 33		
17. "child unwanted and treated as such"	Businessmen Legislators Physicians Religious Lds.	34 10 13 04	29 21 21 15	10 13 17 21	16 33 26 32	10 23 22 29	70 35 42 24	30 65 58 76		

APPENDIX M

**CONTRACEPTIVE AND EDUCATIONAL PROGRAMS
TO PREVENT UNWANTED CONCEPTIONS**

APPENDIX M

CONTRACEPTIVE AND EDUCATIONAL PROGRAMS TO PREVENT UNWANTED CONCEPTIONS

The purpose of this section is to contribute to the enhancement of mental health through the reduction of unwanted conceptions. Its central concerns are: (1) contraceptive programs which would foster the widespread use of effective contraception, and (2) education programs which would foster a realistic and responsible understanding of sexuality, marriage, and parenthood. Perhaps some of these ideas are currently being applied in certain locations. However, the increased implementation of these and other presented ideas may further serve to reduce unwantedness.

Liberal abortion laws seem required in the foreseeable future to reduce the incidence of unwanted children. For the various reasons identified on page 465 of this appendix, it is clear that many persons will continue to engage in sexual intercourse without practicing contraception. Others will use contraception incorrectly. Still others will use less effective contraceptive techniques. These restrictions upon the use of contraception,

in addition to the limited effectiveness of many commonly used techniques, will continue to produce many unwanted conceptions. While a liberal abortion policy can be expected to reduce the incidence of unwantedness, obviously this policy would be much more effective in the context of concomitant efforts to increase a person's consistent, effective use of contraception and education programs designed to enhance a realistic and responsible understanding of sexuality, marriage, and parenthood. Also, effective contraceptive programs and education programs pertinent to sexuality, marriage, and parenthood would be expected to reduce, although they will certainly not eliminate, the need for abortion. Furthermore, these programs hold much promise of enhancing the current and future mental health of the participants and their desired offspring.

Contraceptive Programs

Minimizing unwanted pregnancies appears to be in the public interest in view of mounting national and international anxieties about the population explosion. It is assumed that sex education programs will realistically present an adequate picture of the psychological and emotional costs and benefits of having and rearing children in addition to their providing contraceptive information. It is further suggested that contraceptive information and supplies should be available whenever

persons: (1) visit a physician, particularly to receive their premarital examination; (2) apply for a marriage license; (3) deliver a child; (4) have an abortion. Contraceptive advice and supplies should also be available in clinic settings at minimal cost to the indigent. These settings would also provide information pertinent to prenatal, infant, and child care; child spacing; and healthy as opposed to neurotic reasons for having children.

Much more than the ready availability of contraceptive information is needed. In the four circumstances specified above, people would be directly offered contraceptive services without their having to initiate a request for such assistance. The need for such a policy was dramatically illustrated in a study by Siegel and Dillehay (1965) presented in Currents in Public Health. These authors found that medically indigent women stated they would be too shy or embarrassed to request contraceptive information. Nonetheless, 84.6 percent of these women believed that doctors and nurses should provide them with this knowledge and without their asking for it. Professionals capable of supplying these services have erroneously tended to wait for direct or indirect requests for family planning information. Direct offers of contraceptive services would bridge such communication gaps and respond to contraceptive needs hidden by fears of embarrassment and status differences.

Contraceptive programs clearly need to include:

(1) discussion of all available techniques, (2) demonstrations of the correct way to use these techniques, (3) research programs which will periodically evaluate the effectiveness of widely used contraceptives. Such programs should also include discussions of the purpose of contraception and related physiological and psychological functions. Such discussions might importantly alleviate many of the irrational concerns and fears which often prevent people from using contraceptives even when they are available. Many of the topics of concern for discussion in a contraceptive program might be those cited by Pohlman (1969) in his search of the literature to find hypotheses as to why people may fail to use contraception, use it ineffectively, or use a less effective technique. Among the hypotheses Pohlman cites were:

- (1) reluctance to plan, control, or interfere with nature;
- (2) religious assertions that birth control is sinful;
- (3) fear of a reduced population among minority groups;
- (4) unavailability of techniques;
- (5) uncertainty of how the technique works;
- (6) fears of being drugged, poisoned, sterilized, or castrated;
- (7) provision of more control for the wife;
- (8) male's concerns of his wife's engaging in extra-marital relations without the fear of a telling pregnancy;
- (9) expense of the technique;
- (10) interference with ongoing sexual activity;
- (11) fear of an embarrassing exposure of sexual motives when purchasing the technique.

Pohlman also noted that parental ambivalence was frequently cited as leading to a vacillating ineffectiveness in the usage of contraceptives. It was speculated that such contraceptive usage was an attempt to avoid a personal decision of wanting or not wanting a child and leaving the possibility of conception to chance.

Campbell (1965) asserts that the less educated persons require more than cheap, convenient, available, and effective contraceptives to prevent unwanted conceptions. He suggests that contraceptive programs should emphasize the need to use and accept contraception as a habit and as a normal process of married life. The couple needs to use contraception early in marriage in addition to using it consistently after they have achieved their desired number of children.

Contraceptive Advice When Obtaining the
Premarital Physical Examination and
the Marriage License

The premarital physical examination required in most states is a mechanism which might be used to guarantee that every married person receives at least minimal contraceptive information. Perhaps given by a nurse or physician's assistant, this should include knowledge of available techniques, demonstrated applications, discussions to alleviate irrational contraceptive fears, and an appraisal of these devices for each individual's personal use. Similar information might again be offered verbally

or in written form to every couple at the time they receive their marriage license. Offering contraceptive advice for a second time when the marriage license is granted would: (1) encompass some persons who may have earlier felt less need for this knowledge, (2) provide answers to questions not asked during the physical examination, (3) enable previous information to be re-emphasized, (4) allow the couple together to ask and resolve questions upon which they may disagree. Providing both males and females with this information may result in one partner convincing the other of the need for them to practice contraception. Thus, a couple which otherwise would not be using contraceptives, because of one person's apprehension and the other's ignorance of contraceptives, may prevent an unwanted conception.

Because this contraceptive information would be provided at required stops in the route to marriage, acceptance of this information may well be greater than if they had to decide to obtain contraceptive information on their own initiative and then travel to another location to obtain such information.

By supplying this information to all couples entering marriage, all married couples will have been offered knowledge which could prevent unwanted conceptions throughout marriage and, of particular importance, at the outset of marriage. Offering premarital contraceptive advice could reduce the often disastrous "honeymoon

pregnancies" among newlyweds who often are neither psychologically nor financially ready to rear children because they have yet to know each other well enough to build a firm marital and familial foundation. The frequently harmful impact of a child born early in marriage has been well documented by Pohlman (1969).

Contraceptive Advice Following the Delivery
of a Child or an Abortion

After every delivery, contraceptive information should be offered the woman, both in the hospital setting and also in the physician's office during post-partum visits. Because many new mothers may not be able to afford post-partum appointments with the physician, particularly indigent mothers, it may prove desirable to provide home visits from trained nursing or social service professionals. While these home visits would provide a woman with contraceptive information, they may also meet related needs. Post-partum home visits could provide the new mother with emotional support, deal with concerns about her adequacy as a mother and wife, facilitate her adjustment to a new pattern of family interaction, make the husband aware of his wife's changing needs, and alleviate the maternal depression which so frequently accompanies child birth. These visits could possibly prevent a severe neurosis or psychosis precipitated by the child's birth.

Just as after delivery, contraceptive advice should also be offered after an abortion. Home visits following abortion may also be advisable to provide contraceptive advice. These visits could also serve to enhance the mental health of the woman. Home visits to women following a birth or an abortion could also be used as referral sources to mental health clinics for women who are experiencing rather severe emotional problems.

Of 37 hospitals which estimated the incidence of their providing contraceptive services to ward patients, Hall (1965a) found 13 hospitals reported no service, 19 estimated contraceptive advice was given to less than 50 percent of their ward patients, and only 5 claimed contraceptive information was provided to more than 50 percent of such patients. These findings demonstrate that many ward patients are not offered contraceptive advice. In contrast to the lack of contraceptive services provided ward patients, Hall (1965a) states that "it must be safe to assume that contraceptive advice was available to virtually all of the private patients who wanted it [p. 531]." While hospital practices are obviously such that the wealthier private patient is more likely to receive contraceptive advice than is the more needy ward patient, it appears that even many private patients may not request such information out of their fears or embarrassment.

That contraceptive advice can be effectively offered, accepted, and later used when presented to new mothers in a hospital setting is provided by the experience of Chicago's Cook County Hospital. Planned Parenthood established a bedside visiting program on the obstetrical wards and a family planning clinic in Cook County Hospital which provides the country's largest obstetrical service. These contraceptive services were credited "almost entirely [p. 2]" with the 10.7 percent decrease in births during 1968 (Decrease in births, 1969). This decline of births was reported to be continuing for 1969. Attempts to persuade the Cook County Board that the hospital needed and wanted the bedside visitation program required a 10-year struggle before the service was finally established in 1967.

Contraceptive Advice Offered in Clinic Settings

Some individuals may resist contraceptive information when obtaining their premarital physical examination, receiving the marriage license, following delivery, or after their having had an abortion. However, these persons may on later occasions use contraceptive services offered in a clinic setting. Other individuals who had earlier obtained contraceptive advice may come to contraceptive clinics with questions or in need of supplies. In addition to contraceptive advice, these clinics could offer discussions, perhaps short classes, concerning

prenatal care, post-partum care and adjustment; infant and child care; and child spacing. Such discussions also could assist a woman during current and future pregnancies to be physically and emotionally adjusted to her role as mother and wife.

Contraceptive Advice Offered to
Poor and Wealthy

Pohlman (1969) asserts that the wealthy are more apt to seek contraceptive advice from physicians. The poor are likely to seek such information from welfare agencies. Hall (1965a) has found that the indigent are less likely than the wealthy to receive contraceptive advice in the hospital setting. By directly offering contraceptive advice and supplies to all persons when they: (1) have their premarital physical, (2) obtain their marriage license, (3) give birth, (4) have an abortion, or (5) attend a "contraceptive clinic"; contraceptive services could be more equally available to all individuals, wealthy and poor. Those who are most often in need of controlling their fertility are the medically indigent. It is suggested that their contraceptive supplies be paid for from federal, state, and local funds. Providing money for contraceptive needs ultimately would be much less expensive than providing money to support many unwanted conceptions and to alleviate the detrimental consequences which accompany these unwanted conceptions.

Contraceptive Advice Offered to Married
and Single Persons

Just as married persons should receive contraceptive services in the settings discussed above, so should single persons. Obviously the single woman can become just as pregnant as the married woman. Upon request, they should receive advice and supplies from physicians or other qualified professionals when visiting a physician, a marriage license bureau, or a contraceptive clinic. Unmarried women experiencing either child birth or abortion should be offered contraceptive advice in the hospital setting, during post-partum medical appointments, and during home visits by trained professionals.

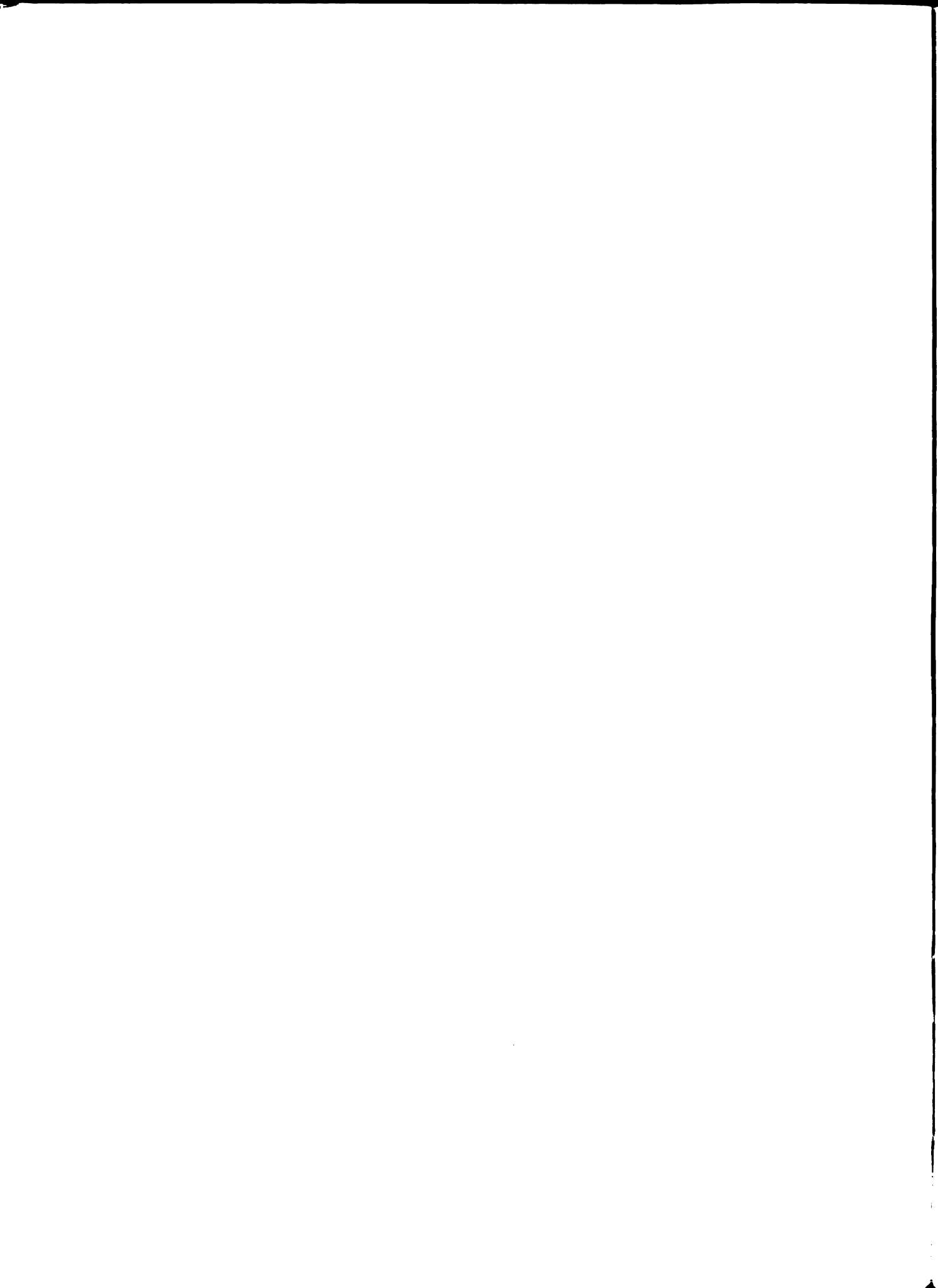
Although Puritan ethics would dictate that unmarrieds should not engage in sexual intercourse, many single persons will experience sex regardless of Puritan ethics or the absence of contraception. Because conceptions out of wedlock are especially likely to be unwanted, the single person's need for sound contraceptive information probably exceeds that of the married individual.

While it has been claimed by some that promiscuity would increase as a result of distributing contraceptive information and supplies to single individuals who desire them, Ryan (1967) has discredited this contention by drawing attention to the absence of evidence of linkages between the availability of contraceptives or abortion

and increased promiscuity. Linnér (1966) has further asserted that the liberal teaching of birth control in Scandanavian countries has not undermined their concept of family life; larger numbers of young persons have married in more recent than previous decades, the birth rate has increased, and the divorce rate is stable.

Even if the availability of contraception to single persons would result in a greater incidence of premarital sexual intercourse, such an increase must be weighed against the destructive ramifications of more than 300,000 illegitimate children born each year when contraceptives have not been openly available to unmarrieds (Monthly vital statistics report, 1970a). As earlier stated and as demonstrated in Pohlman's (1969) relevant literature review, unmarrieds who desire to have sexual relations will do so regardless of family taboos or the unavailability of contraceptives. During 1968 the fear of pregnancy did not serve to prevent premarital intercourse among more than 300,000 unwed women in the United States who delivered illegitimate children and among other unmarrieds included in the estimated one million women who illegally or spontaneously aborted unwanted conceptions.

Also, offering contraceptive information to single adult persons appears to have the support of a majority of society. Among a 1965 modified probability sample of more than 3,000 persons in the United States (Berelson,



1966), 50 percent of the respondents felt contraceptive information should be easily available to any single adult person who desires it. Seven percent of the persons were not sure of their stance. More educated persons were especially likely to be favorable. Among the Catholics, 43 percent agreed; and, among non-Catholics, 52 percent agreed.

Among more than 3,000 persons composing a 1967 follow-up survey (Kantner & Allingham, 1968), 51 percent approved of providing contraceptive information to single adults. Such a policy was favored by 46 percent of the Catholic respondents and 53 percent of the non-Catholic respondents. Thus, a majority of the United States public in 1967 continued to feel contraceptive information should be available to single adults. In view of the obvious contemporary trend toward more liberal sexual attitudes, it appears safe to predict that the percent of persons definitely favoring the availability of contraceptive information to single persons would have increased since the 1967 survey.

Educational Programs Providing Responsible
and Realistic Meaning to Contraception,
Sexuality, and Parenthood

While contraceptive programs, particularly those in clinical settings, can offer discussions which provide persons with a more responsible attitude and realistic

understanding of contraception, sexuality, and parenthood; this beneficial experience can probably be more easily and widely provided within the school setting. Guided by trained and qualified professionals, attuned to the age and emotional maturity of children, such discussions could serve to reduce the incidence of illegitimacy, unwanted conceptions, neurotically desired maladjusted children, and enhance the present and future mental well-being of the participants.

Some parents believe that they should have the sole responsibility for sexual education. It has been demonstrated, however, that parents often fail--whatever the reasons may be--to educate their children in the areas of sexuality, contraception, and parenthood (Sex education U.S.A., 1968). Because of their personal concerns about sexuality, parents often present attitudes toward sex and related areas which enhance a child's guilt about sexual behavior. This guilt does not serve to prevent premarital conception but perhaps enhances its occurrence and creates a more conflict-ridden individual (Breckner, 1969).

Prominent sex educators stress the quality of such programs and emphasize that:

giving students the facts about reproduction, menstrual hygiene, and venereal disease does not constitute adequate sex education. Rather, sex education should be taught in a total context that includes material on growth and development, personality, human behavior, masculinity and femininity, the roles the individual plays in society, marriage and the family, and some understanding of value

systems--the ethical, moral, or emotional guidelines on which we base our decisions (Sex education U.S.A., 1968, p. 6).

While these programs would serve to put sex in an appropriate psychological, social, and moral context of life, they could be further broadened to specifically include a similar approach to parenthood and contraception. Mumford (1963) has emphasized that our culture overvalues the physical fact of parenthood and undervalues the personality and attitudes needed for parenthood. English, Katz, Scheflen, Donzig, and Speiser (1959) found high school and college seniors are generally ignorant of parenthood and parent-child relationships. In discussing motivations for parenthood, rational reasons which would enhance the development of healthy parent-child relationships--as opposed to neurotic reasons which would have a destructive influence for the child and parents--could be stressed. Pohlman's (1969) review cites many neurotic and ultimately destructive needs for having children. Among these needs were having a child to: appear "normal" rather than deviant or maladjusted as they fear society would label childless couples (conforming to a perceived norm); provide parental emotional security and meet dependency needs; hopefully strengthen a failing marriage; prove one's virility, adequacy, or potency; serve as a symbol of adulthood and independence from parents; compete in family size with relatives; vicariously live

through their child; fulfill an experience of life; attain recognition; relieve boredom; be a stable possession for a rejection sensitive individual; force a marriage; provide a doubted feminine identity. Other neurotic reasons to conceive are: to be pregnant, per se, but not to have the child; or to have a child of a certain age but not wanting it at other ages.

These educational programs could further provide persons with a realistic readiness and awareness of the physical, social, and psychological changes brought about by the arrival of a child. Pohlman (1969) cites several studies demonstrating that the arrival of a child, particularly a first child, can be a crisis requiring reorganization of family interaction and patterns of adjusting for the demanding dependency needs of the child, financial pressure, and vast amounts of work leading to psychological and physical strain.

In summary, educational programs providing children and adolescents, as well as adults, with a responsible and realistic understanding of contraception, sexuality, and parenthood promise to enhance the current mental health of these individuals and their future mental well-being as parents. Their children would also experience better mental adjustment as the result of their parents' improved knowledge and adjustment. The participants of these programs should also experience a lesser incidence of unwanted

conception. Also, they would be more prepared to later function as adjusted, stable spouses and parents. The professional administrators of these programs would also be able to provide an additional preventive mental health function by directing children and adolescents (and their parents) to mental health clinics, if they should demonstrate such a need.

Research Programs to Develop Safer and More Effective Contraceptives

Much research is currently being conducted--and should continue--to develop cheaper, more convenient, safer, and more efficient contraceptive methods for males as well as for females (Method for sterilization of males --not permanent, 1969; Shubeck, 1965; Rakshit, 1968; Hefnau, Fuchs, & Lawrence, 1967). However, as Campbell (1965) has earlier emphasized: the development of such techniques is not enough. To prevent unwanted conception, the efficient application of these new techniques must be habitually established and accepted. This important goal can only be approached through a relatively comprehensive public program of education and related services.

MICHIGAN STATE UNIV. LIBRARIES



31293102324807