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# **THE PSYCHOLOGY OF ABORTION**



**American Handbook of Psychiatry**

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# The Psychology of Abortion

## Introduction

A woman who seeks to abort a pregnancy she does not want presents us with a complex problem. The basic thesis of this chapter is that she is a human being in an acute psychological and social crisis. The definition of her situation is crucial. Some see her in moral terms; others see her in operant terms—for example, they view her as a “manipulator.” Few appear to appreciate the psychological isolation inherent in her crisis because most tend to diminish their perceptions of her in order to deal with the abstract ethical dilemma she represents. Despite the recent partial liberalization of abortion laws, medical, legal, and political recognition of the true nature of her situation still leaves much to be desired. In some measure this is so because the psychology of her problem has not been understood and articulated clearly.

At this writing the woman in question remains an ethical dilemma for psychiatry. Professionally, with few exceptions, we have maintained a distance from the woman with an unwanted pregnancy. The lack of social sanction for our engagement with the problem, coupled with the possibility of legal reprisal, has served to create our collective attitude. Our response has also been hindered by a lack of knowledge, for it is only in the past two

decades that we have started to study significant numbers of women with unwanted pregnancies. The work of Taussig, Rosen, Calderone, and Tietze has been highly important in the United States in this regard.

Despite our professional distance it is a fact that each year millions of women elect to solve the crisis of unwanted pregnancy by obtaining an abortion; they do so in every known religious group and social class in the Western world, and they do so and have done so in every known cultural and historical circumstance. Despite the emergence of so-called liberal laws, many, if not most, women still abort in social and psychological circumstances that demean them.

Proponents of further liberalization of abortion laws argue that something precious in genuine human pride is destroyed by requesting women to register, or to subject themselves to psychiatric examination, or to undergo the dehumanizing experience frequently resulting from illegal abortions. Opponents of liberal abortion laws argue that something more precious in our general moral climate is destroyed by lowering the barrier protecting the potential life of the fetus.

As noted above, the basic hypothesis of this chapter is that unwanted pregnancy should be defined fundamentally in psychological and social terms. A second major hypothesis is that regular contact with women caught up in

this intensely human crisis leads one inexorably to a position supporting abortion on demand. Most people, whatever their moral persuasion, cannot, on a face-to-face basis, regularly consign women to being demeaned, or to self-instrumentation with its attendant dangers of septicemia and death, or to referral for psychiatric resolution of their crisis when psychiatric facilities are either unacceptable, unavailable, ineffective, or nonexistent; nor can they deny a given woman access to all modern medical means to express her vision of what is moral. A corollary of this second hypothesis is that one can have an infinite set of positions with respect to the philosophical question of abortion. But the set will narrow rapidly if one will consider the real individuals involved.

The most complete expression of the abortion dilemma lies in the minor pregnant by paternal rape. Such cases, while not frequent, do occur and individually and professionally we are responsible for the alternatives in such a situation. Any serious discussion of the problem of abortion must deal with such a case; each of the options for the girl, for her family, for her potential child, and for society must be made explicit. These alternatives must be weighed in the light of modern findings that, for the large majority of women, abortion does not have negative long-term psychological effects. It is significant here to note that what is generally the best and most scholarly modern review of the question of abortion nowhere considers the question of pregnancy by rape nor does it confront the issue of pregnancy in minors. Such

omissions are inevitable when one moves from abstractions to people; therefore, the bias in this chapter is that one should create a guiding abstraction by starting from the experiences of people, not vice versa.



## Psychological Findings in Unwanted Pregnancies

Clinical experience supported by recent research strongly suggests that almost every woman with an unwanted pregnancy has a variable subset of the following symptoms: high and persisting anxiety, somatic complaints, insomnia, depressive feelings, guilt, withdrawal from her usual relationships and pursuits, decrease in self-esteem, anorexia or bulimia, and, in probably three of four such women, at least transient thoughts of suicide. These symptoms represent the mildest form of crisis seen in association with unwanted pregnancy; the greater the precrisis level of personality problems or the more disturbed the family situation, the more severe the crisis picture. While its form may vary, women with unwanted pregnancies have significant and severe psychological pain without exception. Further, this pain can have destructive effects if the woman cannot surmount it.

Ordinary defensive styles usually are employed to cope with the crisis, but, as is true in so many areas of life, those with fewest supports and poorest adaptive styles have far the worst time of it. For the Aid-to-Dependent-Children mother with six or more children, perhaps living on the ninth floor of a public housing project where she fears to use the elevator because of robbery or gang harassment, the prospect of another child usually precipitates a more severe crisis than is seen in the married suburban mother who has a stable home, fewer children, and less social and economic pressure.

The girl prone to psychotic breakdown whose pregnancy represents an unsuccessful and desperate attempt to bind an object may present a florid psychosis; hypomanic episodes also occur in relation to unwanted pregnancy. Sociopathic women may, of course, present the same kinds of cynical manipulative defensive operations that they present in any other crisis, but to define the general problem of abortion by making these few women its symbol suggests naiveté or untenable prejudice.

The most constant psychological feature of unwanted pregnancy is depression, and this is so regardless of personality style or variation in social setting. The psychology of suicide then is a matter of clinical relevance. Suicide in relation to the abortion question is sufficiently controversial to be the focus of a section below.

The presence of a psychological crisis as represented by a complex of the symptoms described above involves some response from significant others in the patient's life as well as a response from the broad society of which the woman is a part. Clinical observation will confirm that in the majority of instances the response of significant others has negative effects on the woman involved, and in almost every instance—even in states with liberal laws—the social response as evidenced in the medical and legal communities is frankly destructive. Women with unwanted pregnancies are led to feel that they are bad, inferior, criminal, inhuman, and undeserving of

the same consideration as those “genuinely” in need. It is human—particularly in time of crisis—to internalize such attitudes with the result that the crisis is usually compounded.

We have no systematic studies of the dreams of women with either wanted or unwanted pregnancies. Clinically, women seeking abortion on psychiatric grounds frequently report disturbing dreams with death and mutilation themes. This is so despite the fact that these same women deny being conscious of fantasies about the fetus within them.

Women who have been raped and have become pregnant as a consequence of the rape appear to have a uniquely difficult experience to overcome. Some such women have reported the fantasy that a residue of the brutality and viciousness of the rapist had been deposited within them, and they clearly identified the fetus with these frightening qualities. They fantasized that continuation of the pregnancy would result in the growth of these ugly potentials within them. Such fantasies, of course, form a powerful stimulus for anxiety. Many months were needed by one woman to work through such fears following an otherwise uneventful abortion.

## Solutions to the Crisis of Unwanted Pregnancy

We are particularly concerned in this chapter with the option of abortion for the woman with an unwanted pregnancy. Space does not permit an exploration of other options, such as carrying the pregnancy to term and then attempting to become the social and psychological mother, or giving the child up for adoption, or giving the child to its grandparents for raising. All these options are apparently not grossly destructive from a psychological point of view for those who can choose them. There is no question that for certain women they serve well to resolve the crisis, but we have no systematic data from which we might make fully scientific judgments in this regard.

Clinical experience would suggest that more than one out of four pregnancies brought to term are unwanted for one reason or another. Thuwe and Forssman's study suggests that the unwanted pregnancy may represent an even more consequential crisis for the fetus than for the mother, for they found that social and psychological outcomes at age 21 were poorer on all measures for unwanted children in comparison to wanted children.

The salient fact is that abortion is the option selected regularly by substantial numbers of women of every social class, intelligence level, religious, ethical, or cultural background; and, as far as can be determined, this choice represents an absolute historical continuity, for no human group

of any time or place studied to date appears to have been abortion-free. Options other than abortion are considered and rejected by perhaps a plurality of women with unwanted pregnancies; to some the thought of separation from a child to whom they have given birth is almost unthinkable, and their moral revulsion is equivalent in all respects to that of persons who equate abortion with murder.

In Scandinavian countries when abortion was first legalized, utilization of the option of legal abortion, somewhat surprisingly, was greatest by married women. The commonest motivation of such a married woman was the entirely healthy desire to raise the level of care for her living children and to improve her chances of fulfilling her potential as a person. It is a grievous error to associate such strivings with criminality; it is a grievous error to do anything other than to nurture such aspirations; collective survival may depend upon it. It appears now in the United States that single women are beginning to use legal abortion as much or more than their married cohorts.

A major effect of the legalization of abortion anywhere short of abortion on demand is the creation of a new option that large numbers of women will elect; apparently they are women who will not use illegal avenues, for the rate of illegal abortions under such conditions does not appear to decrease. Single Swedish girls, for example, go to Eastern Europe rather than face registration in their own country.

These facts suggest that there is great pressure in the female population for abortion services, and that many women, particularly the single and more youthful girl, will not use medical services that involve registration or the possibility of scrutiny by any specialists or committees not elected by or known to them. They will literally risk life—and the psychology of late adolescence lends itself particularly to such behavior—to avoid certain kinds of relationships with established medical facilities; but the evidence is incontrovertible that they will use medical services where their only relationship is with a physician of their choice and where no other parties are involved.

On clinical grounds it would appear that most women refused legal abortion in the United States use illegal channels. Scandinavian workers, however, have found that only 12 percent of women refused abortion then actually obtained illegal ones. The fact that married women predominate in Scandinavian samples needs to be borne in mind in this regard. Hook concluded from a study of 249 women refused abortion that the mental status of many suffered from the fact of refusal. Hook also noted that nearly one-third of those who went ahead and gave birth were not functioning well in their maternal role. Clinical experience suggests that the burden of unwanted pregnancies and the resulting children contribute significantly to the chronic anxiety and depression suffered by many women. This observation in no sense contradicts the finding that there are significant numbers of women

refused abortion who manage satisfactorily.

## The Role of the Psychiatrist

Laws in various states create different problems for psychiatrists and for the women who seek them out on this question. Where rigid antiabortion laws prevail, one of the few paths open to women is through psychiatry. Usually suicide, psychosis, or impending severe behavior disorders furnish grounds upon which women can obtain complete modern medical care.

Under these conditions a dilemma is created for the psychiatrist who will consent to examine such patients. He is faced with the unacceptable task of deflecting women who do not meet stringent psychiatric criteria away from legitimate medical services to the dangers of the illegal market. The situation he faces is complex and deserves careful scrutiny.

The basic fact is that the intent of abortion laws cannot be determined; for example, "to preserve the life of the mother" can be interpreted variously. I do not equate life with regular cardiovascular or respiratory function. It is also relevant to note that no psychiatrist has ever been prosecuted successfully in connection with the abortion problem.

Given the fact of legal uncertainty, it is entirely legitimate and proper for the psychiatrist to be involved on the same grounds upon which he engages with any other patient in crisis and to interpret the laws according to his best determination of their meaning. Indeed, in confused areas like this he has an



obligation to stimulate society to consider the possibility of institutionalizing his special insights. In the event of a conflict between state and patient his reference values always should be medical and psychological.

## Suicide and the Abortion Question

The most common sanction for abortion on psychiatric grounds is the judgment that a patient has some degree of risk of suicide if pregnancy is not terminated. Since such judgments are highly subjective, there is ample room for the psychiatrist who identifies with the predicament of the woman with an unwanted pregnancy to be liberal in his assessment of such risks; conversely the critics of such a psychiatrist, particularly those who equate abortion with murder, are inclined to read dishonesty into such judgments, and there is, of course, no scientific way of resolving the issue.

Sim, Sloane, and others have written that suicide is less frequent in pregnant than nonpregnant females and that suicide rates are low in the entire female population during the childbearing years, but clinical experience, supported by the recent research of Whitlock and Edwards, suggests that suicide is equally frequent in pregnant and nonpregnant females and is by no means so rare as to be irrelevant.

The concerned but inexperienced psychiatrist may need an orienting position. This need may be satisfied by considering that the prevention or reduction of relatively unlikely risks is a perfectly proper medical-psychological undertaking; general anesthesia carries a slight risk, and this risk is considered frequently in surgical decision making without inciting the least comment. A similar degree of risk in the highly emotional question of

abortion, however, generates much controversy.

As noted above, suicidal thoughts are common in women with unwanted pregnancies. Most of them do not have crystallized plans, but the psychology of suicide is prominent and must be a constant concern for the psychiatrist dealing with such patients. The acceptance of the uncertainties and risks of illegal abortion may have roots in depression and self-destructive tendencies. It is rare to encounter a woman with suicidal thoughts who needs immediate hospitalization, but such cases do occur just as successful suicides are known to every psychiatrist experienced in this area. The question of reporting false suicidal thoughts is frequently raised, usually by those without much exposure to the realities of the problem. Patt, *et al.*, found that a few patients appeared to have misrepresented their symptoms. Similarly most experienced clinicians do not feel that falsification is frequent. When it occurs it needs to be confronted. There is usually no difficulty in identifying the fact that even these women are genuinely in crisis.

## Outcome of Therapeutic Abortion

Myths to the effect that therapeutic abortion leads to sterility or to severe mental disturbance have been entirely disproved by the research carried out in the past 20 years. Ekblad's work, the largest of the early Scandinavian efforts, demonstrated that three of four women legally aborted were content with their choice of abortion and had no negative sequelae of any kind. The balance felt, for limited periods of time, some self-reproach and guilt or they suffered from mild depression, but only 1 per cent was in real difficulty and these were women who would have had major problems with or without abortion.

Subsequent Scandinavian studies and a recently growing number of American and English studies appear to confirm these early findings. As Fleck has detailed, abortion in licensed hospitals, with full medical and psychological services available, is for most women a matter of no great psychological moment; indeed, Simon, *et al.*, Levene and Rigney, Peck and Marcus, Meyerowitz, *et al.*, and Ford, *et al.*, have found in their studies that many patients were improved following abortion, and this was so despite the fact that disturbed women were overrepresented in their study samples.

The findings of improvement provides a new element in the basic philosophical debate about abortion, for now, in addition to the growing body of evidence suggesting that unwanted pregnancies are socially and

psychologically detrimental to both mother and fetus, we have the criticism that antiabortion laws prevent some women from obtaining the psychological benefit that could accrue to them if they were free to follow their moral codes.

Jansson compared rates of “psychic insufficiencies” after legal abortion, spontaneous abortions, and normal delivery and found that the respective rates were 1.92, 0.27, and 0.68. The greater rate of disorder following legal abortion no doubt reflects the fact that women predisposed to psychiatric problems were much more heavily represented in those having legal abortion than was the case in those having spontaneous abortions or normal deliveries. Psychological aspects of spontaneous abortions have not received the attention they deserve.

All workers find that single women are more prone to develop postabortion problems than married women, and there is practically universal agreement that the more psychopathology seen before abortion, the more probable the observation of psychopathology following abortion. The real question here lies in before and after comparison in the single case, not in comparison of populations. Interestingly age does not appear to contribute much to variance with respect to postabortion psychiatric symptoms.

The crisis syndrome described in the early section of this chapter usually resolves rapidly once the patient learns that her pregnancy can be

terminated legally. Anxiety decreases, depression lifts, sleep is restored, and for the married woman there may be an increase in family solidarity as the crisis is overcome.

Following the abortion itself, most women appear to suppress the entire episode and to accomplish an attenuated form of mourning without much difficulty. The fetus appears to be easier to mourn in these circumstances because these patients have inhibited the normal process of fantasy in pregnancy. Women seeking abortion regularly report that they have had no or few fantasies about the potential life within them.

In a study of the fantasies of 46 women—28 with wanted and 18 with unwanted pregnancies—I found that 16 of the 18 women with unwanted pregnancies reported no fantasies about the fetus, while none of the 28 women with wanted pregnancy reported such a complete inhibition. Confirmation of the theory of mourning advanced here is apparent in the work of Kennell, *et al.*, who observed that mourning of dead newborn infants was most difficult for mothers who were most pleased with their pregnancies.

If in the postabortion period one asks women specifically to focus on their feelings, some will experience transient anxiety or guilt, but such feelings will disappear rapidly.

As is true in other areas of psychiatry, active ego work by patients has

desirable consequences. Women with ambivalence about their pregnancies who seek psychiatric consultation during which they examine alternatives open to them and who then elect abortion will have an increase in self-esteem and no symptoms whatsoever in the postabortion period. Such an outcome is even more likely to occur if the abortion is carried out in circumstances where psychological support is readily available and where there is staff acceptance of the idea that serving such patients is fully legitimate. On the other hand, passivity and dependence carry heavy costs. The patient who will experience persisting postabortion symptoms scores high on both these traits. Usually she also has a high degree of psychopathology combined with a low degree of social support. Her pregnancy represents a new stress that overloads her defenses to the point of new symptom formation or frank breakdown, but her request to be aborted is, in parallel with that of the normal housewife, a healthy striving and it is imperative that we recognize this and support it.

Occasionally, severe psychopathology is seen in a postabortion patient, but most observers feel that one never sees such pictures in women who were not severely disturbed before the abortion. Examination of the histories of these women reveals that their pregnancies resulted from psychotic motives and once established were used, at least in part, for manipulative ends. Many psychotic women having therapeutic abortions appear to recognize with great clarity that they could not perform as mothers.

## The Question of Indications

The grounds usually cited by psychiatrists— nowhere codified in law incidentally—for therapeutic abortion are threat of suicide, psychosis, or severe personality disorder. Previous postpartum psychoses are also sometimes mentioned. The GAP report on abortion reviews such so-called indications before concluding that abortion should be removed completely from the domain of criminal law and that it should become a matter between the patient and physician with no third parties involved. Pfeiffer, who discriminates between psychiatric indication, for example, suicide, and psychiatric justification, for example, avoidable stress due to economic hardship, also feels that psychiatrists should be removed from their positions as “social decision makers” and should not have to be involved unless “hard” psychiatric indications are in question.

If one defines the unwanted pregnancy as a psychological and social crisis, the role for the psychiatrist is clear. He or she can be involved meaningfully because human crisis is a proper area for psychiatric intervention. If abortion is the option selected by the patient, we can play a proper consultative role, and we can contribute significantly to the welfare of our patients, as recent research has demonstrated. Our role vis-a-vis legal aspects of this kind of crisis should be one of advocacy for our patients.

A new problem has been created by the advances in amniocentesis.



Early diagnosis of fetal abnormality is now possible, but in states where fetal indications are not accepted, women are, of course, probing the psychiatric route to abortion. The prospect of seven to nine months of living with the knowledge of carrying a deformed fetus certainly appears to be a prepotent stress, so we as psychiatrists are being sought out and we confront another dilemma. Again it should be stressed that one should make a distinction between acting as a professional psychiatrist and acting as a concerned human being. One's bias should be made explicit. It appears to me that public morality cannot be built upon the compulsory pregnancies of psychotic minors who have been raped, or upon the suffering involved in carrying a fetus known to be deformed, or upon systematic frustration of the healthy psychological strivings of women with unwanted pregnancies.

The question of medical indications raises similar issues. Many internists take the position that any disease occurring in association with pregnancy can be managed without loss of the mother's life. Such a judgment equates life with respiration, and other definitions of life can be held that appear to be more humane. One can wonder at the morality of bringing a barely respiring mother through a complicated delivery to present her and her newborn with an extremely uncertain future. In reality women spare us such scenes, for the overwhelming majority of women with major medical problems turn to the illegal market when refused by licensed physicians and they risk their life by so doing.

## Management

The management of women seeking abortion on psychiatric grounds is in most cases an elementary exercise in crisis intervention. Significant others always should be involved. Husbands usually passively or actively agree with their wife's decisions in these matters, but in the event that they do not, resolution of the difference is imperative. One can advance no rule of thumb for decision making in this infrequent event. My practice is to attribute primacy of decision to the woman, but sustained efforts should be made to obtain consensus either for or against abortion.

Women in the crisis of unwanted pregnancy profit from learning the results of the research of the past two decades. Commonly women— even those who are highly educated—appear to feel that abortion causes grave psychological damage. Simply learning that other women appear to improve following abortion can contribute significantly to successful coping.

Not surprisingly, many women develop negative feelings about the psychiatrist involved in this question, even though they may also have a strong positive transference. Women who feel that we should have abortion on demand are more likely to have such negative feelings, and women who feel high degrees of guilt about their situation also tend to develop negative transference. Obviously ventilation and working through such feelings can be significant if it is possible. Many such patients will not permit examination of

these feelings, and they are best offered the continuous option of discussing them without pressure to do so.

Some women may use abortion to punish significant males in their lives. Again, if possible, such motives should be faced and worked through. Bernstein and Tinkham report that older married women made good use of a group exploration centered on the abortion experience, while younger and single women tended to have more difficulty in using such a therapy. If preabortion preparation has been adequate there is usually no need for postabortion psychotherapy. As noted above, most women want to suppress the experience and, as one put it, "to get back to normal as soon as I can.

## Contraindications

Abortion is contraindicated in the woman who is carrying out the wishes of someone else without engaging her ego with the problem. Commonly such women are passive and dependent and will disregard their own wishes and feelings in order to maintain masochistic ties to a husband, mother, or adviser. The psychiatrist's role here calls for gentle insistence on separating out the patient's feelings and helping her to identify them. Minors of 12 years of age are no exception here; their feelings should be identified and they should be encouraged to make an active decision; the resolution of the crisis syndrome of unwanted pregnancy may be quite dramatic when such patients become active with regard to their problems.

Some of the few severe postabortion syndromes one will encounter are clearly related to failure to resolve the intense ambivalence associated with unwanted pregnancy. Proper preparation for therapeutic abortion can prevent such complications.

## The Law and Abortion

Limitations of space preclude detailed review of the bewildering varieties of laws in various states and nations. The present differences in laws between Illinois and New York, for example, has the effect of creating discrimination against the poor and disadvantaged in Illinois. A woman with sufficient resources from this state can afford the trip to New York, but her poorer sister is restricted to the same set of options she inherited from the past.

Some socialist countries in Eastern Europe appear to have changed abortion laws according to economic needs; when low birth rates resulting from psychologically rational laws began to have economic consequences, the leaders of some of these nations reinstated repressive laws. Such experiences suggest that unless there is concerted action by all nations on the population problem, it may be that there can be no sustained advance anywhere.

In closing we should observe that legalization of abortion on demand everywhere will not make psychiatry superfluous in the abortion question. A role is assured if only to identify those patients for whom the procedure is contraindicated. If the definition of this problem as a human crisis is correct, women will continue to seek us out, regardless of legal circumstance.

We are just beginning to explore the psychology of wanted and unwanted pregnancies, and we have just started to consider the social and political implications of the little we have learned. Psychiatry, therefore, has a role in both wanted and unwanted pregnancies into the foreseeable future.

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