Humane Reproduction

Formulated by the Committee on Preventive Psychiatry

Group for the Advancement of Psychiatry
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It cannot be denied that Malthusian concerns become a necessity in married life at some time or other. Theoretically it would be one of the greatest triumphs of mankind, one of the most compassionate liberations from natural bondage to which we are subject, were it possible to raise the responsible act of procreation to a level of voluntary and intentional behavior, and to free this act from its entanglement with our indispensable satisfaction of a natural desire.
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This is the sixth in a series of publications comprising Volume VII. For a list of other recent GAP publications, please see page 516.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

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

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

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

Humane Reproduction was formulated by the Committee on Preventive Psychiatry, which acknowledges on page 392, the participation of various committee members and consultants in the preparation of this report. The current members of this committee as well as all other committees and the officers of GAP are listed below.

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INTRODUCTION

For thousands of years, the news of pregnancy and its culmination in the birth of a child have usually been a cause for joy and celebration. Until the last hundred years, however, both the process of birth itself and the health of small children have also been the source of great and realistic anxieties, because survival of either mother or child was far from assured. Since then, medical advances have helped minimize such risks. In the past a large number of children in a family was more often found to be desirable, especially in agricultural societies, than it was found burdensome. Nevertheless, some nomadic societies have attempted to conserve their finite resources by limiting family size through birth prevention or infanticide. In industrial nations also a large number of children has often proved burdensome. Today children usually survive to their adulthood only after prolonged and expensive dependency on the family and society, as compared with the earlier productive participation of children on the farm or in the early industrial settings.

Unfortunately, life-extending medical achievements have not been paralleled by comparable achievements in the quality of life. The paradoxical discrepancies between lowered death rates and higher birth and survival rates, between greater knowledge of children's needs and deficient family and community resources for child health and development, between polluted and healthful environments, between medical knowledge and actual health care for all ages—all these discrepancies
have encompassed the most crucial problems confronting post-
industrial societies and societies wishing to industrialize. Curbing
human reproduction quantitatively in favor of improving
life qualitatively thus becomes an essential ingredient in any
constructive narrowing of these discrepancies. This has been
pointed out convincingly in the report of the National Com-
mision on Population, which documents carefully the many
disadvantages of further population increases in the United
States for the nation's families, its communities, and the national
welfare. In its report the Commission considered these broad
issues at greater length than it considered the emotional factors
of sexual behavior and reproduction or the impact of contra-
ception on them.

Essentially this book addresses itself to the need for humane
reproduction in adjusting a nation to fulfillment of the capac-
ties of its citizens and their communities. Specifically, it will
address itself to the mental health aspects of controlled fertility.
To be considered are the family's psychosocial and material
resources; the impact of reproduction on the individual, on the
family, and on communal functioning; and the implications
for mental health of effective reproductive restraint, whether
for the benefit of the family itself or for the purpose of popu-
lation stabilization. We are here dealing with circularities con-
sisting of reproductive behavior and sociocultural values as they
relate to sex and the care of the young, to individual and com-
munal mental health, and, at full circle, with the impact of
reproductive restraint on all of these. We shall endeavor to
anchor these broad issues in clinical experience and research
focusing on the individual, on the family, and on social systems.
The problems involved in creating a numerically static society
will be discussed and some of the predictable consequences of
indefinite population growth described. Humane reproduction
requires reproductive behavior and policies based on compa-
sonate consideration of these issues, as well as action responsive
to the needs of the individual, the family and society beyond
mere survival.

One purpose of this report is to show that the prevention of
unwanted children is a significant factor in the promotion of
mental health and the prevention of mental disorders—what
there is hardly a single more effective tool for the prevention
of emotional disorders than the prevention of unwanted preg-
nancies and unwanted parenthood.

At the outset a distinction must be made between family
planning on the one hand and family limitation and population
control on the other. The first involves planning by the part-
ners of the size and composition of their particular family
according to their own wishes, needs and life goals. Such a plan
may or may not dovetail with their own resources, their pro-
fiency in sexual behavior, or the population policy of their
society. Population control or stabilization is an essentially
political proposition which, as a policy, would impose the
responsibility for reproductive restraint on everybody. Actually,
family limitation has been effective in achieving population
stability without any explicit policy; for example, in France for
a century and a half following the Revolution of 1789, or in
Ireland since the potato famine of the last century. In both
nations, family limitation antedates modern contraceptives, and
in Japan population stability has been achieved in recent deca-
des primarily through widespread abortion rather than by
preventing conception.

Birth control methods, including abortion and sterilization,
will be considered from the standpoint of mental health and
optimal family health care. We shall begin by examining the
essentials for healthful emotional growth and maturation in the
context of family functioning because the family is the unit
into which children are born. In almost all societies the family
assumes or has been charged with the care of the young and
their guidance into adulthood. The family must therefore be
evaluated, both as a concept and as an operational system in
which family size is reconciled with effective family functioning
and the requirements of society. We shall describe the basic
functions of the family and the nature of the essential internal
and external (communal) resources needed to assure its viability.

We shall then consider the indications for limiting reproduction and its implications for the individual; the social pressures for population growth or limitation; and the resistences to humane reproduction encountered in the individual, the family, and the community.

Finally, we shall outline services and educational principles for rational sexual behavior and family formation as essential elements in the achievement of humane reproduction and of parenthood based on choice and informed consent.

Reference


Individuals are born into families and are destined to recreate families, although family forms and composition may change over time and vary among different cultures. This institutionalized grouping is also characteristic of some animals and seems to be determined by the biological given of two genders, only one of which can insure the survival of the newborn. The family also serves to socialize children for the purpose of becoming adults who fit into a particular group or society. Societies and their cultural continuity conversely depend on the survival and enculturation of the young. It may be doubted that the family as an institution would have evolved except for the needs of the young because the regulation of sexual activity which it permits seems by comparison quite secondary to the tasks of rearing the young that it performs. A great variety in sexual mores may be observed across the cultures of man, ranging from monogamy to quite varied sexual interactions, but strict parental role assignments are to be found in all societies. Usually the biological parents are charged with primary parental responsibility, although in some few societies collateral relatives or others may be assigned this role. Our further considerations, however, will be limited mostly to Western society and thus to the monogamic nuclear family.

The decline and demise of the family as a viable institution seem to be an ever-recurring theme of historians, philosophers and various prophets of gloom and doom. It was thus in Plato's
day, in Seneca’s, in the early Christian era, and in almost every century since then. Of course, human history whether Eastern or Western can be viewed as a long chain of disasters and miseries, or it can be seen as a series of achievements in human collaboration, creativeness, and mastery over nature. In either view, it is a testimony to the essentiality of the basic family structure that it has existed for as long as we can trace human history, and universally so; and that it has so often been pointed to as the source of both good and evil.

Divorce. Currently it is the vogue to cite divorce rates as an indicator of the obsolescence of the family as an institution. Such figures, however, are often quoted misleadingly. Marriages are dissolved but families persist. At least three-fourths of all marriages in the United States remain intact, and almost half of single-parent families have resulted from the death of one parent. Moreover, as mental health professionals know only too well, the fact of no divorce does not vouch that all is healthy in a particular marriage or family, nor is divorce always undesirable for family health and welfare. When it is considered that the “average marriage lifespan” has doubled in this century, and that many of the legal, economic and sociocultural barriers to divorce have been breached if not removed, the rise in the nation’s divorce rate of one-third during the past half century is not very remarkable, related as it is to many determinants outside the family system. Although 83 per cent of all children lived in two-parent homes in 1970, some 400,000 children in the United States were affected by their parents’ divorce in 1970, or 12 per cent more than the national total for the year before.1

In the face of so many social changes, the survival of the family is all the more remarkable when we take into consideration the stresses imposed upon it by its intensified nuclearity and isolation, to say nothing of the economic liabilities currently facing parents, at least in Western and industrialized societies.

The perpetuation of the family as a social system bespeaks the essentiality of basic familial and parental functions in humanizing the newborn and the growing child, functions usually assigned to the biological parents. Single parents, adoptive parents, collateral relatives or substitute parents (other adults) can fulfill the rearing tasks that guide a child into adulthood as defined by his society. But the family pattern has the advantage of providing two adults, as partners and as parents, to accomplish these tasks and is thus one of the most satisfactory existential modes available for the purpose. The roles of partner and parent can be separated—not all societies cherish a monogamous family arrangement—but in those societies which sanction polygamy or extramarital sexual activity, the care of offspring is nevertheless strictly regulated, and progeny usually foregone in extramarital alliances.

In monogamous families the marital relationship is central to the family dynamics and is just as important for the mutual satisfaction and support of each partner by the other as it is for the tasks required in behalf of their children. We refer to this relationship as the marital coalition, which must be effected by the couple as the first important family function, ideally before reproduction takes place.

Other essential family functions warrant consideration in this report: nurturing tasks, enculturation of the young, emancipation of offspring from the family, family work and leisure activities, and crisis mastery. In many respects these tasks parallel the life cycle of the individual, and especially the personality development of the child. Many of these concepts of family functioning and task performance are related to Erikson’s eight stages of development, and to the formulations of Parsons concerning family structure and role divisions as models of social interaction among many modes and systems.2

The marital coalition

The marital coalition consists of those interactional patterns which the partners develop, at first to meet their mutual needs and satisfactions, later to erect the structure and infuse it with
the dynamics of the family. This coalition must serve the developing needs of the children while protecting an area of exclusive relationship and mutuality for the parents. A central function of the coalition is sexual activity, forbidden to children within the family in almost all societies. Sexual activity is variously tied to reproduction. In one society it may be considered proper only for reproductive purposes, but in another group or culture it may be completely divorced from parental obligations. The recent increase in life expectancy and decrease in infant mortality have freed sexual activity from its primarily reproductive purpose. When child-bearing is not desired or possible, the issues of sexual gratification and nongenerative sexual activity for mutual pleasure come to the fore.

The achievement of mutual sexual gratification presupposes a capacity to consider one’s own and one’s partner’s desires and needs and to communicate with each other about them, including any desire or need for contraception.

Nonreproductive sex is nevertheless in conflict with some traditions and religious teachings and with the needs and fantasies of many individuals. Marital discord can be precipitated when efforts are made to limit family size in the face of such beliefs. Likewise, sexual intercourse is considered an obligation or duty in marriage in some quarters, which can increase opportunities for marital disharmony on conscious as well as unconscious levels. This potential for inner and interpersonal conflict is an important variable in reproductive restraint or control and a common source of contraceptive failure even when one or both partners consciously wish not to have more children. Couples who have failed to achieve pleasurable and satisfying patterns of sexual intimacy apart from reproduction are at higher risk with regard to contraceptive failure. (Figure 1.)

Mutuality characterizes the spouses’ interactive patterns on both implicit and explicit levels, the sharing of feelings, the conveying of respect and appreciation to each other, and of each other to the children and to outsiders. The representation of one partner by the other to the children is particularly important in family life when one parent has to be absent periodically or permanently from the family. Another important function of the marital coalition is the mutual reinforcement of the spouses’ complementary sex-linked roles, so that each of them not only represents an appropriate identification model for their children, but is reinforced in his marital and parental roles by the support and approval of the other.

Another function of the marital coalition is to establish divisions and reciprocities in the conjugal roles of the partners. Men are usually the instrumentalists in most cultures, and their activities often determine the family’s social position. Women have been more responsible for the affective and emotional climate in the family. These role divisions are not absolute, and parents may find task-sharing more satisfactory than rigid division of roles on the basis of sex. Young people in particular and women of all ages are challenging traditional stereotypes. Moreover, role allocations in a marriage as well as the decision-making methods employed will vary with different socioeconomic classes in the same society. In both psychodynamic and sociodynamic terms, whatever division of family tasks the parents develop provides a foundation for formation of the
in this sense but usually “wanted” once the baby is born, even when the pregnancy occurred prematurely (as it does in at least 40 percent of teenage newlyweds).\textsuperscript{a} The fact of having a child at a certain time is no indication of proper understanding or readiness for parenthood. Some young people can adapt to the responsibilities of parenthood if the nine months of gestation can be utilized as a period of emotional growth and maturation, as in the case of those aided by special prenatal care programs for teenage mothers-to-be.\textsuperscript{b} The disadvantages of premature parenthood will be considered later on.

**Rearing of the young**

Nurturing tasks are traditionally assigned to the mother, although she can perform them best when supported tangibly and emotionally by her partner. These tasks encompass more than the providing of food and the psychological aspects of feeding. Primary among them is the establishment of basic trust. Early nurturing of the child involves helping him learn how to manage and control his body and how to observe, distinguish between and communicate about his inner and external experiences even before he speaks. It entails furnishing him appropriate stimulus experiences and learning opportunities. Parents must understand that play is the young child’s work. The importance of these latter nurturing functions in the child’s early life has been recognized clearly only in recent times. The potential damage to personality development, social adjustment, and educational capabilities when these nurturing tasks beyond feeding are not adequately fulfilled is currently a source of concern and investigation.

Weaning is also a nurturing task, but more is involved here than merely withdrawing the bottle or breast. The intense physical closeness with the mother must be loosened and in its stead an essentially nonphysical intimacy established with all family members. Moreover, the process of weaning, which is
usually the first separation experience of the child, determines his sense of separateness and his acquisition of ego boundaries.

Mastery of separation can be defined as follows: The child experiences the pain of losing the supportive closeness to a significant person (the parent) without losing faith and trust in the continuity of the relationship or in the ultimate restoration of good feeling and a sense of security. Through separation experiences the child learns and grows—he becomes better able to avoid the same impasse that confronted him the first time and less vulnerable to or threatened by subsequent separations from others. This mastery must be facilitated by the opportunity to observe, imitate, and eventually internalize the modes of other family members in coping with frustration and separation anxiety, and also in mourning the permanent loss of a relative or friend.

**Encturation**

Any clear line between nurturing and encturating tasks is arbitrary because family functions are continuous and overlap. Nevertheless, passage of the oedipal phase may be considered a turning away from the earlier nurturing experiences toward those of encturation. At this point, not only should the child have achieved body control and gender awareness, but he should have acquired verbal competence and have accepted the incest taboo in the sense of feeling comfortable in his relationship to each parent. Latency can then begin as a period of minimal sexual and erotic strivings and problems. The child is freed for instrumental learning and for increasing his capacity to invest in peer relationships. He is allowed greater distance from the family circle at the same time that he is taught within the family many of the instrumental modes of his culture in shared work and games.

Together with the child’s formal instruction, the family continues to inculcate the communicative and social skills and interactional modes of their culture, defining the norms of his relationships explicitly and by example. The style of communication and the competence of the family in communicating are crucial. Significant deviation from culturally valid patterns of interaction, symbolization and reality concepts can create disturbances within the family and handicap its members, especially the young members, in relating to the surrounding community.

**Emancipation**

In industrial societies, stepping into adulthood usually means physical and geographical separation as well as psychological and social emancipation from one’s family of origin. To be accomplished successfully, this final separation cannot be abrupt—it must be the culmination of many psychosocial differentiations between parents and child. The first steps toward independence which the family must encourage as the child moves through his developmental stages are nursery attendance or school entrance, gang identification, camp or other living-away-from-home experiences, followed by dating, jobs or college. Finally, his achievement of a social identity and self-direction culminates in readiness for marriage and parenthood. Successful completion of these steps calls for developmental resources and opportunities outside the family.

Emancipation from the family demands mutual tolerance and resilience between the generations. Adolescents need to experiment with independent behavior and often teeter between their still intense needs for dependency and guidance and their equally intense strivings for independence, at times annoyingly proclaimed. Currently, youth’s experimental independence often involves early sexual activity leading to family conflict rather than considered family discussions of responsible sexual activity and reproduction. Unfortunately, Western families have remained handicapped in communicating and guiding effectively in this area.

Emancipation may be precipitated by marriage or pregnancy.
Today this is probably always unhealthful for the young parents, as it usually foreshortens further education and preparation for a career. It often means flight from the family of origin and failure to master psychosocial independence. Certainly it is not an auspicious beginning for a new generation.

* * * *

The marital coalition is on trial because the child's experimentation with independence often involves much hostility against the older generation. Parents must meet this hostility together, and they also must prepare at this time to live again as a dyad. Emancipation thus entails the evolutionary dissolution of the family as a unit because grandparental functions are limited and are not continuous in the nuclear family of industrial societies.

Family sharing of leisure and recreation is essential in all societies, particularly industrial societies. Television, communal playgrounds, and the mobility often afforded youth today have rendered family group play and joint recreational activity with other families seemingly superfluous. Yet there is a deficiency in family functioning when family games and work projects are replaced entirely by solitary pursuit on the part of each family member of separate concerns. Joint meals become a rarity in such households. Because work, including formal schooling, has to be different for each family member, family projects, games, outings and the like are all the more crucial for family interaction and as learning models for intimate nonsexual relationships, conflict resolution, and communal give-and-take. The family is a necessary environment in which individuals can be and act with less psychological defensiveness than in the larger society. The creation of such an environment is an important family function. All adults can be masters in their own home, but only few in their work or profession. At home, children should be accorded greater tolerance for their foibles and more guidance in overcoming them than they can be afforded at school or elsewhere. The family, no matter how constituted, must provide for emotional and psychological recuperation, for recharging the batteries that power the children's and parents' participation in community life.

These, in synopsis, are the four major parental task capabilities that should be evaluated when procreation and the number of offspring are being decided. Without an understanding of these tasks, family planning is meaningless and informed consent for truly humane parenthood beyond the capabilities of the young parents-to-be.

References


* Suitable for educational programs.
The burdens on the isolated nuclear family in industrial and postindustrial societies are psychosocial, economic and ecological in nature. In an industrial society, families are usually of two generations. The father is absent during most of the young child's waking hours, and household help for the mother is uneconomical in most families. This leaves many mothers during the day with the complete responsibility for child-rearing, especially in the case of the preschool child. The full-time housewife-mother role is a recent phenomenon. But once a mother, a woman may have more and more children as a substitute for the career she was denied by her first child. In the past, women on the farm and in the city did their work while caring for their children; it was both together, not a division between "productive" work and housekeeping. Today, although men can share household burdens and many do, such sharing is limited in a basically competitive society where fulfilling one's potential often requires of the father long hours of work and application on the job, usually outside the home. A career in itself can prevent his participation, not to mention moonlighting for economic reasons. From the standpoint of mental health, consistent yet flexible division of tasks and the assumption of complementary roles are more important than any fixed assignment of chores on a quantitative basis. Task-sharing is also pleasurable. Yet the urban and suburban family group is held together more by affectional bonds and intangible sharing.
than by the need to share work and leisure that characterized rural families of the past.

Social models to relieve stress. Although special arrangements to relieve full-time mothering are relatively new in the United States, they are well established in Israel and Russia, among other countries, in the form of day care centers. Such centers are not only important for all mothers who work or pursue careers, but they can enrich the lives of children who attend them. Later on, children should have access to playground programs and eventually to camping opportunities. Regular exposure to adults other than one's parents is important in providing alternate identification models, and day care centers could be viewed as a modern part-replacement of the earlier extended family system from among whose members support figures and substitute parents were easily procured.

Current experimentation with communal living may add to the limited resources currently available for effective child care services that benefit the child while reducing parental burdens for some families. Here mothers or parents generally can spell each other in parental work assignments. Whereas communal living has some of the advantages of an extended family system, and also provides alternate adult models for children in a two-generation system, it probably has the disadvantages of an extended family in that conflicts of sibling rivalry attend the sharing of resources.

Consider the changes in national life in the last fifty years. In 1920 this nation was still half rural while now it is 80 per cent urban. Consider, too, the complex tasks and special stresses peculiar to the isolated nuclear family. In the light of these developments the family has proved remarkably adaptive as the primary institution of socialization and as the resilient buffer system between the developing child and a complex postindustrial society. Although clinicians in particular are aware of the existence of not a few disturbed families, the inadequacy of education and support for family life, combined with the high cost of untimely fertility and the frequency of ill-advised family formation, makes the success and endurance of the family as an institution all the more notable.

To be or not to be a parent

Little is known about how people, married or unmarried, make decisions for family formation—whether to have a family, how many children to have, and when to have them.1 However, we know a good deal, at least statistically, about the proportion of unplanned pregnancies, if not of unwanted children.2 It was Thackeray who reflected that "If people only made prudent marriages, what a stop to population there would be." Were the advice implicit in his comment seriously considered, especially by young people, unwanted reproduction and overpopulation might indeed be reduced. Only severe economic pressures have forced our people and those of other nations to limit procreation to a replacement figure of 2.1 children per couple. Thirty-five years ago under the impact of financial depression, the two-child family was preferred by a majority and had become modal in the United States. During the 25 years following World War II, however, the three- to four-child family was preferred. These levels have been dropping again and only recently were reported to be at 2.5 children per family,3 with only 20 per cent of adults wanting families of four or more children.

Aside from the psychosocial considerations affecting family formation, couples should take into account the more tangible factors of economics, housing, and career planning for both spouses, as well as the resources and limitations of the larger community. On the whole these are more likely to be taken into account by young couples from the middle and upper classes. Yet there is a clear need to extend career opportunities to wives from all classes lest they embark on the career of housewife and mother by default, rather than by conscious and deliberate choice. This is important not only for a sound ecology
but for the mental health of women. It is not necessary that at
the end of the child-bearing period, or the menopause, women
be left without a meaningful, satisfying life composed of more
than shopping and housekeeping for two. The shift in values
which has rejected the career of housewife as inadequate for a
lifetime is prerequisite to achievement of family size limitation
on a national scale.

Unprepared parenthood. Although Americans have practiced
reproductive restraint, as in the great depression of the thirties,
they have a poor record of personal decision-making for paren-
thood. In 1960, two-thirds of couples with children reported
using no method of birth control before arrival of the first
child. From 1961 to 1965 the average interval between marriage
and first birth was 18 months excluding fetal deaths, but one-
third of all first births were premarital conceptions and 42 per
cent of teenage mothers were delivered within eight months of
marriage.

Unplanned first pregnancies in particular usually indicate
parenthood without informed decision to become a parent.
Postponing the first pregnancy and entering parenthood with
forethought and consent would serve the goals of physical and
mental health and a sound ecology. Postponement of accidental
first pregnancies alone would increase significantly the average
parental age at first birth, and increase the number of non-
parents at all ages, while resulting in better child spacing for
the nation's families.

In 1968, the latest year for which full statistics are available,
900,000 or almost 25 per cent of the 3.5 million births in the
United States occurred to mothers under 22. A large percentage
of these births were unplanned. In view of the demands upon
parents today, postponement of motherhood to age 22 is recom-
mended. In 1968, one out of four births would have been post-
poned had this recommendation been observed. Unmarried
motherhood had increased between 1940 and 1967 as follows:
a two-and-one-half-fold increase among those aged 20 to 24 and
more than fivefold among those aged 25 or older. This repre-
sents a rise from 3.7 to 8.4 per cent of all births. Noteworthy is
the differential increment in the white population, whose ille-
gitimacy rate has risen 50 per cent since 1960, whereas the rate
for nonwhites declined 6 per cent in the same period.7 Added to
these figures should be the number of "legal" but probably un-
planned births resulting from premarital conceptions. In
the late sixties an opposite trend became noticeable—a re-
duction in the percentage of illegitimate births (but not necessarily
of out-of-wedlock pregnancies) probably due to the greater
availability of abortion.

The number of lifelong nonparents in the nation has been
small, currently about 6 per cent, compared with the highest
rate, 18 per cent of married women born from 1900 to 1910,
whose most fertile years coincided with the depression. Cur-
cently 96 per cent of people marry, half the women before age
21. Of these couples, 92 per cent have children, and a high rate
of marital vicissitude and family breakup may be inevitable.
Lifelong marriage, with or without children, can be a joyous
experience without parallel, or it can be miserable. The same
is true of parenthood. If we want to reduce the personal and
social tragedies of disturbed family life and the misery of un-
wanted children born to unprepared, unwilling parents, we
must prevent marriage and parenthood that result from ac-
cident or the mere desire to conform. The presence of 500,000
children in foster homes or institutions suggests that, in addi-
tion to the 6 per cent of nonparents in this country, a large
number of biological parents do not welcome or cannot cope
with parenthood. Many biological mothers indeed did not have
the privilege or opportunity for informed consent to parent-
hood. The recent abortion experience and the rise in age at
first marriage hold promise that people are becoming more
aware of the personal and social responsibilities of marriage
and parenthood and are making more deliberate choices. How-
ever, the option for nonparenthood is still too often foreclosed
by a combination of uterine and ideological misconceptions, with childless couples openly pitied when not made to feel guilty for their failure to reproduce.

**Adoptive parenthood.** The decision for parenthood is most clear-cut in the case of adoption. But adopted children are handicapped by a number of factors. First of all, their biological mothers usually did not want them. Probably even more important are the socially induced difficulties of adoptive parenthood. For decades adoptive parents have been taught and have taught their children that there are two kinds of parents, real and adoptive. Then came the concept of birth and real parents, attributed to Lili Peller. Giving birth may be beautiful, but it is secondary as far as the child is concerned—it is the animal part. For the child, the parents who raise him are his real parents, the human part. Indeed, the chief reason a child needs to give him a medical history containing needed genetic information; a secondary reason is that he may find out from others what he is not told by his adoptive parents. Society’s exaggerated concern with biological parenthood is reflected in the onetime recommendation by some adoption agencies that the children they placed be brought to the agency on their birthday so that they would be perfectly clear about their origin!

The adoption issue is important in another context: In a psychological Utopia, one could argue that anyone who is not ready to adopt a child is not ready for parenthood at all. To this day, however, adoption is treated as second-class parenthood. Society demands the right to screen infertile couples for their qualifications to rear children, whereas fertile couples are magically presumed to be capable of competent parenthood.

Another socially engendered disadvantage for infertile adoptive parents derives from the general attitude of pity toward childless couples. This attitude puts infertile couples under pressure to adopt, when in the absence of such pressure they might have opted for a childless marriage.

With increased family planning and recourse to abortion the number of unwanted children to be placed for adoption should be reduced to the minimum. Already there is a shortage of white children in this group, so that white childless couples are faced with a choice of doing without children or adopting non-white children. That a growing number of such real parents are doing this with courage, competence and love may profoundly affect society’s attitudes toward race as well as toward parenthood.

Until recently adoption as an alternative way to form a family was an unusual step unless dictated by necessity, that is to say, biological incapacity. Today there are couples—and individuals—who are adopting children by prior initiative or just plain love for children. In some states unmarried persons may adopt. Homosexuals may want to be parents, which would actually necessitate a change in values on the part of society at large. Yet if the state allows anybody who can get pregnant to become a parent, and takes no child away from a parent except for conspicuous neglect or severe abuse, what justification is there for denying adoption to any adult who wants to be a parent?

**Stresses on women**

The issue of women’s roles in our society is a complex and controversial one. The demand for equality of the sexes in every walk of life is not likely to abolish the unique capacity of women to bear children and nurture a family with loving care. Although femininity is largely a culturally defined characteristic, it is also embedded in biological forces. Pregnancy and suckling of the young still call for role divisions between the parents, whether or not protection from predators during these phases is a real necessity. Today breast-feeding may be psychophysically more important for mothers than it is for babies.

While regenerative cloning and even extraterrestrial fetal development can be envisioned in principle, neither is likely to become the preferred form of reproduction in the foreseeable
future. Furthermore, parenthood is not just a set of tasks, but an essential ingredient in a meaningful life providing creative opportunity to many if not most adults. While an equal division of parenting is theoretically possible, it is unfeasible in a culture that offers advancement in careers or jobs primarily to those who work full time.

**The housewife-mother career.** Housekeeping and child care as life goals are realistic now only for those women past 40 or 50 who are able and willing to continue this calling in behalf of other people’s children and families. Reciprocal family functioning must give opportunities for the personal growth and emotional health of all its members, parents as well as children. An overburdened family atmosphere may interfere with a growing relationship between the spouses that permits intimacy and sexual expression. Clinically, a common complaint of married women with children is that sexual intercourse is perfunctory and boring, however frequent. Such fatigue or ennui may also play a role in contraceptive failure (taking a chance might relieve boredom).

Women are confronted with certain choices and one of them is whether to seek motherhood at all. As noted, our society has not dealt kindly with spinsters and infertile couples, disparaging them when not making barren women feel guilty. Yet nonparenthood is compatible with mental health and a productive, satisfying life. Another choice concerns the reconciliation of motherhood with work or career. Some compromises have to be made here unless the mother is prepared to leave the care of even the very young to a substitute mother. Yet democratic industrial societies have denigrated substitute mothering and the housekeeper role to such a degree that it is rarely practical economically or possible operationally for a mother to work full time and be satisfied that her family does not suffer by her absence from the home.

A third possible choice might offer a tandem solution. Women can finish their education or achieve certain career goals before undertaking motherhood and then return to work or profession after the youngest child is ready for a day care center or kindergarten. Obviously this solution implies that the community will provide the necessary facilities for young children and appropriate work conditions for mothers. Without them a woman may see little choice but to become a full-time parent, continuing on and on with additional pregnancies, since there is no hope of escape from parental and home chores in any case. However, it must be recognized that motivations for pregnancy and for motherhood are no more identical for all women than are their capacities for either.

Thus the issue of women’s roles in our society is crucial to the formation of small families. We are just beginning to come to grips with this issue and with that of discrimination against women, rationalized up to the present time by ancient myth and prejudicial habit. It took American men 130 years to acknowledge in the Nineteenth Amendment that women are equal, at least politically. Only now, by the abolition of our restrictive abortion laws, are women being extended the right to decide for themselves whether or not and when to become mothers. Without the opportunity to obtain an abortion when she does not want motherhood a woman’s freedom to guide her own fate does not exist as it does, in this respect, in many nations we consider authoritarian and oppressive.

The abortion controversy provides a cogent illustration of our society’s hypocrisy that reveals many outmoded beliefs and attitudes about women and femininity. As we know only too well from other areas of discrimination, ingrained attitudes and prejudices do not yield readily to reason and rational education, and in consequence often bring forth aggressive and overstated demands from the oppressed. From the mental health standpoint, not to mention the cause of justice, we can ill afford to continue abridging the rights of whole groups in our society whose members thus become surly and coerced participants in the societal process. An unwilling mother who was refused an
abortion may be the outstanding example of oppressive prejudice and discrimination.

**Stresses from and on unwanted children**

There are few careful, psychologically sophisticated psychiatric case histories that do not reveal in some way the patient's sense of not having been wanted, regardless of his parents' opinion in the matter. There are also a good many patients whose family, when observed and studied carefully, shows evidence of not having wanted in some significant way the particular child who became the patient. Moreover, it is clear that the tens of thousands of children who are known to suffer physical abuse at the hands of at least one parent are only the visible tip of an iceberg of "unwantedness." We are as much concerned here with the more intangible forms of making children feel unwanted in the emotional and psychosocial areas of life as with their gross mistreatment. In either case, such children may have been wanted at birth or before.

We must distinguish between two types of unwanted children. One is the child who to begin with was not wanted by one parent or the other; or he is the child they found unsatisfactory later on for whatever reason. The other type is the child who may have been wanted by his parents and his family but is not wanted by society because the family is overburdened and cannot give him the care and training all children need. And our society at large is not prepared to provide substitute parenting, except for that minority of unwanted babies who are offered for adoption and are desirable for adoption. Nevertheless, we are first concerned with the child who is not wanted in the family into which he was born.

It takes an unwanted parent to produce an unwanted child. The harsh fact of being consciously unwilling to be a mother to a particular unborn child is signal and stark, though the reasons for this cold fact are legion. Ambivalence is no stranger to the woman who wants her baby, but this distinct, other feeling of not wanting a pregnancy is too certain to be ambivalent. It is an attitude compounded of dismay, frustration and anger, of blasted hopes and ruined plans, of lost chances and missed opportunities, of dropping out of school or rushing into a precipitous, ill-considered marriage. This attitude afflicts unwed teenage mothers, middle-aged mothers ready to turn to other things—an attitude that permeates whole families under stress of increased family size, decreased family resources, and the endless unhappy consequences of one life too many. This "unwanting" is too well grounded to be dissolved by the charm of a new baby.

Such a pregnancy—unplanned, untimely, accidental, unwelcome—makes a pregnant woman unfriendly and implacable toward this one fetus. And however much guilt or conflict these feelings may cause her, they do not compare to the hostile, resentful, condemning attitudes at their worst that are in store for this particular child. No family can contain such a malignant relationship without every member's suffering.

Baby care takes a willing heart. To the simple transaction between a "nursing couple" an infant brings utter dependency and vulnerability. Everything has to be done for him. His mother's feelings introduce him to his beginning life. The quality of his mother's care creeps into the dim light of his dawning consciousness to tinge and color a response in kind. Gentleness breeds ease and trust, impatience breeds discomfort and distrust.

The unwanted child senses his mother's anger, hostility and resentment toward him. And he does not know why she feels as she does. An infant victimized by such a damaging attitude cannot avoid his own responding feelings of anxiety and tension. He lives at the center of the conflict, the breeding place of emotional disturbance.

The fate of an unwanted child whose mother has repressed her feelings of rejection, or whose father disapproves of the mother as a mother, is equally thorny. For such a child the prize of approval seems a possibility but he feels his efforts to attain it are unsuccessful. He will blame himself for his fail-
child becomes accustomed to receiving disapproval. He then behaves in a self-fulfilling predictive manner—first at home, then in school, and finally in society. Followed far enough, this road leads to ingrained antisocial behavior. A lifelong distrust of society's ability to be fair places a person outside the laws of that society. The "outlaw" makes his own unrealistic, self-serving rules of conduct, which inevitably outrage and alienate society. This is his revenge. He is ignored, poorly nurtured, neglected, exploited and abused. These are the overt signs of unwantedness, visible to anyone. Worst of all, the hurts of being unimportant, insignificant, unloved by and unlovable to his parents are survived only at the cost of scarring his personality.

We cannot pretend that the facts are otherwise. It is not that all mental disorders or brain damage are rooted in unwantedness, but rather that the contribution of unwantedness makes to these complex conditions is preventable. Mental health specialists from every discipline should know the facts. They should know how the lives of unwanted children are blighted. They should realize that these children do not have a fair and equal opportunity to grow and prosper. Professionals should also realize that their knowledge can be translated into responsible action, that it is humane and possible for all human beings to choose to have only wanted children.

When a couple prevents a conception they are not able or willing to foster at that point in time, they are acting humanely, rationally and maturely. They are preventing an unwanted child. If conception occurs and they still feel unable or unwilling to raise this particular child, their responsibility is to have an abortion or arrange for an adoption. In either case they are preventing an unwanted child. Outraged sensibilities of others have to be put in balance with the fate of unwanted children. Everyone should know that the life of an unwanted child is enviable. The responsibility of society for a child does not begin or end with birth. A child needs parents who
are responsible enough to plan to have him when they are able to give him a fair chance to grow and prosper. In addition, he needs a community that supports his family.

**Stresses from and on society**

Although society proclaims that all children should have equal care and opportunity, the phenomenon of socially unwanted children remains ominous and documentable. The evidence points to a society unconcerned with its children, which cares little about and neglects specifically those children who become its responsibilities. At least 300,000 unwanted children are known to reside in usually unsatisfactory foster homes or institutions, awaiting disposition by adoption which is not likely to eventuate for various reasons. But community services for all children—education, and health and welfare services—are also inadequate and are the first to be curtailed still further when governmental economies are instituted. It is difficult to maintain the illusion of a society concerned with its children in which upwards of half a million children are underattended and sometimes mistreated in institutions or foster homes.

Former Justice Wise-Polier, of the New York City Family Court, recently deplored the disparity between the myth of a child-centered society and the reality of indiscriminate budget cuts affecting services for children in the courts, in institutions and in the schools. Services for delinquent youth have been equally hampered despite the intense nationwide concern with crime in the streets and the violence engendered by drug addiction. Children requiring psychiatric hospital care often have suffered from faulty or misguided rearing; but in the hospital setting they also suffer from therapeutic neglect and the squalid living conditions frequently found in public institutions. It is all of us who are behaving in this way, although we are wont to point the finger of blame at our institutions—medical care systems, school systems, the police, and so on.

A family usually assumes that when it balances its budget it is "taking care of itself" and would do better if only taxes were not so exorbitant. Yet it is our taxes which pay for our institutions, and few if any families with children pay fully for what they receive. It is estimated that it costs a family $25,000 to rear a child to legal maturity with a good education. For example, in a typical town the annual public school tuitions are calculated at $500 per child, or $6,500 over the period of a child's primary and secondary education. However, the average annual tax contribution per household to the school operation in the same town is barely half this amount, so that a family with three children would only be paying between 15 and 20 per cent of their own schooling costs during that period, exclusive of other services. Even in a purely economic sense families are often uninformed about what their children actually cost and to what extent they depend on the community and on the community's concern for children to defray these costs. When a child has to be reared outside of the home by institutional arrangements, the cost is over $100,000 by the time he is 18—usually for inadequate and inferior care. Indirectly and intangibly, society contributes a good portion of the differential between what the family of a child pays and the actual expenditures for his care.

We are not only concerned with the economics of the situation but also with the fact that next to the family, schools provide for a child's development and mental health. Currently we see considerable resistance in our society to meeting school expenses, which from the mental health standpoint intensifies the effects of inadequate and discriminatory school arrangements. One expectation in our society is for an ever-increasing school input in terms of both education and special services, many of them related to mental health, such as guidance, remedial reading and the like. Yet many school systems are forced to curtail existing operations, and those special services ("the frills") are usually the first to go. In 1971 over half the school bond referendums in the United States met majority
voter disapproval. One of the likely victims of "economy" campaigns is adequate family life and sex education in the schools, often also a source of controversy. While recent surveys show that only a minority of young people at first intercourse expect a continuing relationship, at least a third of the group used no contraception.\textsuperscript{12}

**The response of young people.** Furthermore, there is a connection between the dissatisfaction of many young people with school programs and the fact that the peak year in which single mothers produce their firstborn is 18, thereby cutting short for many of them any further education and the pursuit of desirable life goals. This is true whether their babies are wanted or not. (In fact, some youngsters use pregnancy for relationship coinage.) But pregnancy wishes must not be equated with readiness for parenthood or motivation for it.\textsuperscript{13}

It also holds true for married young parents that a birth within two years of marriage is associated with poorer marital adjustment\textsuperscript{14} and with more problems for the child than is the case when children are born after the first two years of marriage.\textsuperscript{15} Thus it can only be agreed that premature parenthood is bad for parents, for marriages, and for children—therefore it cannot be good for society.

**Family size as a source of stress**

It is hard to imagine a more important variable in preventive psychiatry than family planning. No close rival or substitute has been found for good parenting—an arduous and joyful task when undertaken willingly, an arduous and soul-destroying burden when not wanted. In general it would appear that small families do better than large ones, and that babies reasonably spaced and born to mature women develop better than others not so favored. It would also appear that, poverty aside, the stigmata of poor physical and mental health mark the large family regardless of social class.

For instance, 70 per cent of military recruits rejected for mental health reasons come from families of four children or more although they represent only 33 per cent of the nation's families. This is not an exceptional correlation because recruits who have five or more siblings represent only 11 per cent of families nationwide, but almost half of them (47 per cent) are rejected from service for the same reasons. In another group 59 per cent of inmates in one reformatory had four or more siblings. Unfortunately, the class distribution of these cohorts is not known, although doubtless poverty, with the attendant undernourishment and limited socialization, has contributed significantly to these figures.\textsuperscript{16}

Other studies have demonstrated that intelligence and educational achievement correlate inversely with a pupil's family size regardless of social class.\textsuperscript{17} The Swedes recognize a clinical syndrome in women with many pregnancies called "maternal fatigue" and have demonstrated among them increments in complications of pregnancy and delivery together with a decrease in the health and developmental status of the younger children from birth onward.\textsuperscript{18}

While small family size may not inevitably favor mental health and social adjustment, it is significant that 70 per cent of children coming from large families desire small families for themselves, whereas the reverse is not true. In a study of 400 psychiatric inpatients, Gregory found some challenging correlations concerning child spacing and sibling relationships.\textsuperscript{19} Patients born within two years of an older sibling had a disproportionate incidence of paranoid conditions; those with a younger sibling born within two years of their own birth had a disproportionate incidence of psychopathy.

Most studies in this area report nothing specific about want edness as a variable. Yet it has been observed that not only the unwanted child but the entire family suffers from his presence. One study has compared an "unwanted" birth sample (whose mothers sought but were denied abortion) with a random sample of births; the abortion seekers' children did worse with
respect to their health and social adjustment in the ensuing 21 years than did their controls. If feeling wanted is a measurable factor in mental health, we shall eventually detect it. As the population of newborns changes from mostly unplanned to mostly planned—in number and spacing—we shall eventually find improved mental health. So far, this transition has not been socioeconomically uniform. The poor, the less educated, and the very young mothers have more unplanned children than their favored counterparts, so that great social and professional effort will be required to equalize the important advantages of planned family formation.

The best indicator of success in family planning over the short run will be found in statistics on maternal and infant mortality and neonatal morbidity. In these respects the United States has lagged behind a dozen other Western countries. Pastanick and Knobil's concept of the continuum of reproductive casualty leads us to expect a decrease in birth defects, cerebral palsy, minimal brain dysfunction, and behavioral disorders as a result of better family planning and prenatal care. Women who eagerly wish to have children are more likely to take care of themselves during gestation than unhappily pregnant women, who have been known to abuse themselves in the hope of aborting the pregnancy. Unfortunately there can be little doubt since David Gil's study that more children are abused to death than are removed by courts from abusive parents. This situation is likely to improve as children become scarcer and accordingly become more valued by parents, the community, and the larger society.

Other considerations point to the desirability of small families, quite apart from population pressures. While many people want as many children "as they can afford," this affording usually has been perceived only in an economic sense. "Affording" should also refer to what people can afford in terms of their own emotional and enculturating resources and of the community support systems available for the care of their children. A couple preoccupied with child care finds little energy and time for marital intimacy and satisfaction, let alone personal growth and further adult education.

Adult education of course was of little moment when the average life expectancy was less than 50 years of age, the situation prevailing early in this century. Since then, however, life expectancy has increased by some 25 years. The health and quality of life of a couple during these last 25 years are as essential a personal and social concern as are the health and welfare of the family with dependent children. A couple whose entire attention and emotional resources for 20 to 30 years have been devoted to children are ill equipped to find equivalent satisfaction when returning to their own more restricted interactions. Nor is it likely that women who have been full-time housewives and mothers for that long can suddenly, upon finding themselves almost unemployed at home, undertake other meaningful and productive activities in a society that does not look kindly on middle-aged or elderly job seekers.

Admittedly, children in small families can be disadvantaged when poor transportation and neighborhood planning, combined with rigid age stratification in schools, tend to isolate them. Here the school systems could promote some type of age mixing, perhaps through the tutoring of younger children by older children. Or day care centers located in high schools could provide a needed service while teaching our future parents about child development. An only child would benefit from such arrangements. The one-child family is least popular, even though indications are that "only" children perform better by all the usual measures of achievement than other children. The prejudice against the one-child family is unwarranted. The prospect of preplanning the sex of a child could also contribute to the goal of small families.

The move to the commune is interesting, and doubtless valuable for some people temporarily if not permanently. Some communes could be said to be better environments for children.
than some families—which is not to herald the commune as the successor to the nuclear family. It is a minority phenomenon, not so widespread as its notoriety suggests. However, it could have the effect of raising the average age of (conventional) marriage for young people, possibly a wholesome development in view of the fact that “young” marriages fail disproportionately often. In one long-established commune pattern, the Israeli kibbutz, parents have a daily two-hour period with their children, more parental time than many children enjoy in our nuclear families.

The late 1960’s may have marked a turning point for the family in the United States, showing two reversals: a downward trend in birthrate and an upward trend in the age of marriage. These same years also witnessed an upsurge in concern about the environment and its pollution by people, with a focus on people as pollutants. Today, educated youth, at least, expresses a concern about family formation and communal living, as well as great doubt about careless reproduction. A distinction is being made between living together and making a permanent marital or family commitment, which may bespeak an attitude that “the family is dead—long live the family.” What may be dead or certainly dying is family formation by accident, or family formation for the purpose of sanctioning sexual relationships or accidental pregnancy.

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4

POPULATION PROBLEMS: TWO DISCIPLINES AGREE

As the National Commission on Population Growth and the American Future pointed out in 1972, it is late in the day to persist in our assumption that no matter how many children we produce they will somehow be taken care of and somehow flourish. Such assumptions slant history to suit our ideals, based as they are on our pride in a society that has grown enormously in size, in utilization of resources, and in material production. Yet continued production of people at recent rates can lead to disaster in this country as well as the world. In fact the increase in the number of human beings on earth has become one of the major crises facing man today.

Enhanced death control effected by the medical profession and the health sciences has shifted the age structure of populations to the point where in many regions of both developed and developing countries the large numbers of dependent young and old hinder economic development and accommodation to social and technological change. Malnourishment and famine are very much with us and are likely to spread in the near future, even as societies strive for a higher standard of living. Meanwhile, the transformation of natural resources into material goods, with the attendant pollution of air, land and water, menaces the balance of the biosphere. Ecocrisis is threatening man and his cultures. Spreading urbanization, coupled with increasing mobility and the rapid pace of social change, further aggravates the difficulties facing a burgeoning population.
Ecology and psychiatry, perhaps the earliest and most recent of the life-oriented disciplines to become concerned with the population problem, share a crisis-oriented concern and focus. Both disciplines systematically study phenomena of change—the growth and decline of certain systems—in attempting to discover the determinants and the governing forces of change and their interconnections. Caplan has defined crisis in the psychosocial field as requiring a readjustment and rebalancing of relationships. Similarly ecologists appreciate how once-stable communities and populations can adaptively rearrange their functions and relationships toward a new stability characterized by new organizational patterns.

Rarely do animal populations maintain numerical stability over many generations. Actually, low numbers of predators and an absence of disease combined with an abundance of food and favorable weather conspire to permit rapid increase in numbers until stress from territorial constraints and too-frequent social interaction, as well as unusual weather or overuse of food resources, all contribute to a rapid decline in numbers. Thus, natural populations customarily fluctuate about some intermediate density which ecologists designate as the carrying capacity of the environment. In considering this broad picture, the search is for general principles explaining the dynamics of the relationships among large numbers of individuals.

By contrast, psychiatrists as crisis managers have only recently looked beyond the individual toward those more complex processes of community ecology and evolution that contribute meaning and at times stress to the individual's life. Though overpopulation by man is patently a crisis in the making, and both ecology and psychiatry are crisis disciplines, each discipline suffers from its own historical myopia in evaluating the problem perceived by both. Without mutual correction of vision, however, these disciplines will contribute little to alleviating it.

We are indebted to Julian Huxley and Erik Erikson for a significant beginning toward fusing the philosophies of evolution and ecology on the one hand, and those of psychiatry and psychoanalysis on the other, as they bear upon the population crisis. Their essays and formulations suggest that the search for identity and the fulfillment of one's potentiality stand at the core of the human state. Such fulfillment requires satisfaction of generativity, an extension of sexuality. At its primary and basic level, duplication of the biological self through the production and rearing of children satisfies the generative drive. At a second and higher level, generativity may equally be expressed through promoting the survival of values one holds essential to one's identity, as in the transmission of tradition and in traditional education. The highest level of generativity consists of creative endeavor leading to adaptive change in former organizational patterns of self and society. Only by cultivating generativity in these two extended forms, characterized by sustaining and transmitting self values or by creating concepts that lead to new values, can sexual generativity be modified in a way compatible with a decline in the birthrate. Thus biological visible creativity must be replaced and be replaceable in terms of less tangible forms of creativity.

Though attainment of a lowered birthrate may retard the growth of world population or culminate in a slow decline, it offers no assurance of future stability unless coupled with a studied effort to promote the third level of generativity. This generativity can prove successful only in the presence of a willingness to adjust to the new values it will foster.

**Population density and individual reproduction**

Konrad Lorenz's views on aggression, although speculative, may elucidate the interplay of several forces—aggression, creativity, and value conflicts. When man lived in small closed social groups and possessed only crude weapons of hand-to-hand combat, crowding or encroachment of one group upon a neighboring group precipitated mutual aggression. Here each group served the role of outgroup for the other, and defense
related directly to tangibles—physical objects, people, or living space. As evolving social cohesion led to larger aggregations of humanity, the individual members of which knew most of their associates less well or not at all, the threat of social or physical encroachment was displaced and came to be exchanged for a threat to behavioral norms, traditions or values. And yet the individual’s involvement retained the primitive characteristics of the prehistoric tribe, almost at a prehuman level. By this, Lorenz means the shiver running down the back and limbs that “makes the hair stand on end” which our primate ancestors felt as they experienced the exhilaration of challenge, rising to full height with elbows outward and chin up in a bluffing stance, upon perception of a tangible threat. This exhilaration becomes what Lorenz terms “militant enthusiasm” when many members of a group simultaneously gratify innate aggressive drives. By implication, any threat, any set of strange objects, altered circumstances, or divergent set of values may act as the releaser of militant enthusiasm. Analogies of international wars and ghetto rumbles easily suggest themselves, blocking as they do all opportunity for higher-level generativity in the nations, in inner city populations, and in rural poverty sectors. However, such interpolations between animal and human behavior are always speculative.

Population density is not the only threat facing man should wanton reproduction continue indefinitely. High population density is found in inner cities, where we also find the highest prevalence of disease—including mental illness, crime and violence. Here, poverty, unsatisfactory conditions of life in slums, and a relative lack of opportunity often accompanied by deficient education are also potent determinants of behavior. In many European cities there is greater density of people in middle-class neighborhoods than there is in some slums, so that the indicators of illness and maladjustment correlate more with factors of social class than with density of the population.

A controlled mouse universe. A study on mouse populations may yield further insight into these problems. Four pairs of mice were introduced into an environment which was Utopian in the sense that many of the factors customarily inhibiting population growth were greatly ameliorated or eliminated entirely. No predator existed, and epidemic-producing diseases were excluded. Food, water and shelter were provided in excess of that requisite to sustain a population of 3,000 individuals. The opportunity for emigration was precluded. Thus all the major factors of hunger, predation, disease, inclement weather, shortage of resources and migration, which in the natural state require a reproductive rate sufficient to compensate for the numerical losses they occasion, were rendered essentially inoperative. As a consequence of this sharp curtailment of normal mortality, the original population enjoyed several successive doublings, with a doubling time of about 55 days, until it stood at 620 individuals. At that point a change in reproduction took place and the population doubling time increased threefold until community numbers reached 2,200 individuals.

Then another dramatic shift occurred. Production of viable young ceased with a gradually diminishing capacity to conceive, until the normal age-associated mortality eventually reduced the population to 300 postmenopausal members. This was the situation two years after the beginning of the die-off phase. Currently all indications point to a further decline until the population becomes extinct.

A population can be viewed as a system which fabricates living products, develops them, and finally makes some disposition of them. A mouse population living under natural ecological conditions produces a number of additional mice sufficient to satisfy the nutritional needs of both microscopic and macroscopic predators. Most population products so used comprise those individuals forced to wander away for lack of opportunity to incorporate themselves into the traditional system of relationships among that portion of the population residing in a habitat of favorable density. Within this system a certain number of
individuals find the opportunity for incorporation in replacement of those lost to the system through aging or predation.

Idea in the sense of information packed into sets of genes form another category of population products. Natural selection determines which of these ideas products will be developed, that is to say, will be incorporated within the gene pool of the species. Over the long run, the balance between product fabrication and product disposal permits species survival with adaptive evolution.

The experimental study of a mouse population under discussion may be examined in this perspective. Elimination of most normal avenues for product disposal culminated in a dramatic imbalance between product fabrication and product disposal. This imbalance overtaxed the capacity of the system to develop its products further and to incorporate them into functional social units. In fact, the very favorable early development of these excess products provided them with the potentiality for incorporation into an adequately functioning society, but at this stage the adults boycotted the immature. Blocking the straining of the young for participation in the basic relationships necessary for species survival inhibited their energies, except for periodic expression in violent outbursts of maladaptive aggression directed toward their peers. This violence represented the initial symptom of an imbalance between product fabrication and product disposal.

As this imbalance became more accentuated, attempts by the producers to reverse it actually led to a dissolution of their former adaptive capacities for reproduction and for guiding the development of their living products. This terminal failure consisted of an incapacity to engage in and complete those complex repertoires requisite for species survival. Interrelated repertoires of courtship, territorial defense, and maternal performance form the most complex set of behavior for this species. The demise of this population through progressive imbalance between product fabrication and product disposal was marked initially by violence, which replaced more complex behaviors required for species survival.

A psycho-ecological perspective

Examining the present human population crisis from this perspective of product fabrication, development and disposal may be useful in constructing a rational approach to its resolution. For the past 40 or 50 thousand years man has been able to fabricate two kinds of products with equal facility and in equal amounts: biochemical information in the form of genes assembled into new individuals, and intellectual information assembled into new ideas or concepts. These two products have interacted to increase the reproductive rate of both, so that the human population and the pool of conceptual information developed have expanded in such a way as to require half as much time for each successive doubling as that required by the doubling which preceded it. This acceleration has multiplied the increase a thousandfold over the past 50 millennia. The increase in the product that is man has resulted in an imbalance in the ratio of production (birth) to disposal (death) in existence for hundreds of thousands of years. Extrapcacies disposal (by predation and disease) or intraspecies disposal (by homicide and war) has never had more than a temporary retarding impact on the ascendency of births and survivals over deaths.

The foreseeable population crisis calls for drastic realignment of the fabrication, development and disposal of man and his ideas as products. This realignment may be considered a consciously introduced new epoch of evolution. The past pattern of cultural evolution and present reproductive rates, if continued, will culminate in the completion about 2010 A.D. of a worldwide information network in which individuals will serve as nodes (Huxley). Completion of that network, which may be anticipated to comprise about 8.5 billion adults, will mark termination of the present 50,000-year epoch of evolution, with the new epoch in sight. (See Table 1.)
TABLE 1

<table>
<thead>
<tr>
<th>World Population (N)</th>
<th>Year</th>
<th>Doubling Time (Years to next doubling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15,625,000</td>
<td>9429 B.C.</td>
<td>5728</td>
</tr>
<tr>
<td>31,250,000</td>
<td>3701 B.C.</td>
<td>2566</td>
</tr>
<tr>
<td>62,500,000</td>
<td>837 B.C.</td>
<td>1432</td>
</tr>
<tr>
<td>125,000,000</td>
<td>595 A.D.</td>
<td>716</td>
</tr>
<tr>
<td>250,000,000</td>
<td>1311 A.D.</td>
<td>358</td>
</tr>
<tr>
<td>500,000,000</td>
<td>1669 A.D.</td>
<td>179</td>
</tr>
<tr>
<td>1,000,000,000</td>
<td>1848 A.D.</td>
<td>89.5</td>
</tr>
<tr>
<td>2,000,000,000</td>
<td>1937 A.D.</td>
<td>45</td>
</tr>
<tr>
<td>4,000,000,000</td>
<td>1982 A.D.</td>
<td>22</td>
</tr>
<tr>
<td>8,000,000,000</td>
<td>2005 A.D.</td>
<td>11</td>
</tr>
<tr>
<td>16,000,000,000</td>
<td>2016 A.D.</td>
<td>—</td>
</tr>
</tbody>
</table>

Note.—Date and doubling time are based on the modified von Foerster equation: \( N = 1.79 \times 10^{11} \rho \), where \( \rho \) is years to the date 2026 A.D., when \( N \) goes to infinity if \( N \) continues to increase as it has between 0 A.D. and 1958 A.D. [See von Foerster et al. in Science 132(1960):1291-1295.]

From mice to men. Our formulation would indicate that only a marked reduction in biological generativity is compatible with enhancing and fulfilling human potentialities. To the extent that the two shifts in fabrication and development of human products fail to take place, mankind will be putting itself in a position similar to that of the mice in the study described. Violence could continue to escalate, followed by increasing alienation of the individual from the group characterized by an inability on the part of the individual to become involved in any complex behavior, particularly of an intellectual nature. Yet these are the behaviors requisite for the survival and continued evolution of the species. In this context the worldwide university unrest of recent years could be viewed as a symptom of excess biological reproduction, an excess of those most capable of becoming involved in the generation and development (utilization) of new concepts. But the adult segment of society, traditionally and socially well-integrated, tends to reject much of youth as well as new concepts and values. So far, any strengthening of the third level of generativity to balance the drive to fulfill the first level of generativity, or biological reproduction, has lagged behind the shortened interval from concept creation to concept application characteristic of an advanced material technology. We are thus in a dual population crisis marked by poverty of opportunity for involvement of the products that are men and the products that are ideas—including the idea of fertility reduction as an imperative to survival.

The compassionate revolution

The conceptual framework for coping with the population crisis harbors the Compassionate Revolution,[7] which should form the bridge between two epochs of evolution. The first epoch, the past 50 thousand years of cultural evolution, initiated a continuously enlarging world population that accompanied the transformation of man as a biological entity, to man become human. The second epoch must initiate a declining world population that will permit a continued expansion of individual potentiality. Compassion in Erikson's sense is a component of responsible mutuality which further the cultivation and realization of human potentiality of and by others.[8] Such other-centered action implies tolerance and a capacity to participate in the resolution of identity crises encountered by individuals, institutions and societies. The desirability of attaining such universal compassion from the mental health standpoint, let alone from that of ecological necessity, cannot be overemphasized. Fertility management and population stability are both "fallout" products of creative compassion, and are essential to its attainment.
The determination of family size and population stability involves interrelated psychological, institutional, and extramural factors. While the psychological and institutional factors are open to conscious and explicit consideration by parents, the social factors involved are more difficult to formulate and are not precisely understood. Society's behavior in these respects has varied considerably, as indicated in the Introduction to "Population, Power, and Their Social Consequences," where the leadership of Japan and China has occurred mostly without prescription by governmental or social leadership. Such prescription has been more blatant, more extensive, although not with standing effect, in those nations where increased mortality was achieved by governmental or social leadership. Such measures have included forced sterilization, contraception, and abortion, among others.

Are the only gratifications available. India, parts of Africa and South America. Nor do the religious influences, though potent, seem to be decisive in the presence of educational influences and alternative occupational opportunities for gratification. In the United States for instance, socioeconomic class correlates more significantly with family size than does denominational adherence, although it must be noted that no simple correlations are one hundred percent accurate.
cent valid over time. The significant correlation between poverty and undereducation, probably combined with restricted opportunities for gratification, have been pointed up by Rainwater and others as most importantly related to extant family size (albeit not the desired family size, which is usually smaller than that attained).

This gap between the desired number of children and the usually larger number people have presents an important opportunity for educational and remedial health service action; it is also an indictment of the deficient education and health service delivery currently available in this country. However, information and education will not do enough. High dropout rates from family planning clinics in the first two months indicate that birth control advice and prescriptions do not suffice to motivate people for the long-term task of keeping a small family small.

**Psychosocial impediments**

Westoff and others have shown that birth control is inefficiently practiced regardless of method. His data and the Indianapolis study begun before World War II showed only 6 per cent of families composed of children who were all planned in respect to number and spacing. These investigators found, as did Rainwater, that a major determinant of large family size was more often incompetence in contraception than any desire for a large family or lack of birth control information per se. As late as 1960, two-thirds of firstborns were children whose parents had not used any method of family planning. Westoff and Westoff estimate that over 30 per cent of the children born in 1970 continued to be the product of pregnancies unwanted by at least one parent — this was ten years after oral contraceptives became widely available.

There is currently a trend toward more effective application of contraceptives and toward greater freedom to abort unwanted pregnancies. In parallel one finds a greater consciousness of the responsibilities and tasks of family formation and greater social recognition of the undesirability of adding to overpopulation in a careless or unintended way. However, social pressures in this direction can also endanger individual rights. Nevertheless, at the present time it seems more important to close the gap between what people, women in particular, want and what actually happens. The tremendous need and demand for abortion already demonstrated would go far to bridge this gap, because with proper contraceptive practice, over 95 per cent of unwanted pregnancies should be preventable, closer to 99 per cent with oral contraceptives. Clearly, sex and family life education must go beyond the joys of parenthood and family life to some realistic preparation for contraception and the inculcation of a sense of social responsibility in parents.

Parenthood is the most vital task any individual can perform for any society, yet it is often assumed that everybody knows how to be a parent without having to learn anything about parenthood. Licenses are required for marriage and for driving a car. Parenthood is not so licensed: Teenagers are not even told that pregnancy is unwholesome for them and their children, nor are they helped to avoid pregnancy or abort it when indicated. But the biological drives for sexual activity and maternity are at their peak in the age bracket for which parenthood in our society is a handicap. Teenagers still face considerable hesitancy on the part of the community to provide them with contraceptives on the ground that it might abet promiscuity and immoral behavior. On the contrary, requests for contraceptives should be looked upon as an opportunity to discuss young peoples’ relationships, to consider with them whether sexual consummation really suits their needs and wants. Like college physicians, the health professions, especially those concerned with youth, must appreciate that promiscuity is not the result of prescribing contraceptives but is part of a personality pattern that will operate with or without protection against pregnancy.
Even couples well prepared in the sense of personal and social maturity and contraceptive information have unplanned pregnancies. It has been discovered since the improvement of contraceptives to nearly 100 per cent effectiveness that even those who consciously decide to practice contraception fail to do so to a significant degree. The reasons for this are found in unconscious and irrational forces within the partners and in the conflicts between the partners arising out of these forces. Apart from parenthood, fertility itself has great self-expressive and ego-supportive values. Having a child may be important in providing one with a sense of immortality. Despite our greater lifespan, the rapidity of change in technology and in social institutions and morals has enhanced our sense of the impermanency of the human condition. This may be reflected in the considerable decrease in average age at which women have their first child: In 1850 in Western Europe it was 28; in the United States now, it is 18.9 There is an urge to find out everything in a hurry, including whether or not one is fertile. Aside from the fact that emotional vicissitudes have always been channeled readily into sexual behavior—or misbehavior as defined by a particular culture—intergenerational conflict seems to have been intensified by the decreasing chronological distance between generations. The rising incidence in out-of-wedlock conception among white high school students may be seen as one expression of these feelings.

The significant incidence of contraceptive failure among married couples despite their professed desire not to add children to their families has been particularly disappointing to obstetricians. Physicians in general believed that an intelligent woman with access to an almost ideal contraceptive such as the pill or the loop would be grateful to be relieved of the fear of pregnancy. But failures occur, whether based on inefficient application of the method or on the development of side effects which are not tolerable to the user.

In considering the complexity of the total situation, it becomes clear first of all that motivation not to enlarge the family cannot be equated with motivation not to become pregnant. Nongenerative sexual activity is simply a new experience for many partners, who for whatever reasons—religious, cultural, economic, personal or interpersonal—have never considered coitus as something apart from reproduction. They may have connected the two fearfully or expectantly as the case might be, but either way, severing sex and fertility represents an incisive change for many partners and for their relationship (see Table 2 following).

The fear of another pregnancy may have been used by either partner as a shield against recognizing his or her negative attitude toward sex and in some couples the verity that sexual activity for one or the other or both of them has never been pleasurable. Or the fact of the wife's pregnancy may have given some husbands culturally accepted license to seek another sexual partner for the duration, while women who have conflicts about intercourse may have welcomed nine months of sanctioned abstinence.

The shift from a contraceptive directly connected with the act of intercourse, where decision to interfere with fertility has to be made on the spot, to an agent imposing prolonged though temporary infertility causes unexpected difficulties. The decision-making has not only been separated from the act itself but also may have been transferred from one partner to the other. Such a shift in responsibility may entail considerable alteration in other aspects of the relationship—for example, power or dominance. Some husbands fear that without the risk of pregnancy their wives may be tempted to seek or may more easily become victims of extramarital affairs. "Taking a chance" may also have been an enjoyable element in sexual intercourse between the partners.

There may be emotional reactions against taking pills or against implanting a foreign body in one's womb. It is noteworthy that the alleged symptoms and side effects of either
TABLE 2
Sources of Conflict in Contraceptive Failures

<table>
<thead>
<tr>
<th>Complaints</th>
<th>Personal Conflict</th>
<th>Interpersonal Conflict</th>
<th>Societal Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood changes</td>
<td></td>
<td></td>
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<tr>
<td>Nervousness</td>
<td></td>
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<tr>
<td>Guilt</td>
<td></td>
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<tr>
<td>Feeling empty</td>
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<td></td>
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<tr>
<td>Breast discomfort</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased libido</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WOMEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and/or having babies</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>May be a life style</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Need for pregnancy</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>As support for self-esteem</td>
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<tr>
<td>Inadequate understanding of parenthood responsibilities and that contraception requires positive effort and alternate sources of gratification. Failure to distinguish between need for pregnancy and disinterest in (further) parenthood. Need to control spouse in either direction by imposing fertility or refusals.</td>
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<tr>
<td>Societal indifference and general view that more is better, or that non-creative sex is wrong. Grandparental pressure for pregnancy.</td>
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<td></td>
<td></td>
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<tr>
<td>MEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased libido</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resentment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Waste of self-substance</td>
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<td></td>
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<tr>
<td>Suspicions of infidelity</td>
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<td></td>
<td></td>
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<tr>
<td>Need to reaffirm manhood by evidence of fertility</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Same as for women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same as for women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARTNERSHIP</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expense or inconvenience of supply</td>
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<td></td>
<td></td>
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<tr>
<td>Decreased libido for both</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Conflicts about or disinclination in each other</td>
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<td></td>
<td></td>
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<tr>
<td>Need for doing what comes naturally</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Guilt about non-creative sexual activity</td>
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<tr>
<td>Inadequate communication between spouses, Discrepancy between partners concerning pregnancy or its prevention or conscious and unconscious levels—reaction to spouse's need or wish—pleasing him or her or putting something over him or her.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtle direction toward large families (parenthood rewards and tax allowances for children, etc.); religious influences. Pregnancy and children may be viewed as the only gratification in life. Decadent currents and non-awareness of the actual cost of proper enclosure of the young.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

method are similar. In one series reported, 70 per cent of women on placebo contraceptives developed "side effects." Other women feel guilty about "avoiding" motherhood by interfering with pregnancy, as though pregnancy and motherhood were an ever-recurring punishment or jeopardy they deserve. And those women who are best attuned to their biological womanliness may have the greatest difficulty of all.

Still other women feel that they are depriving their husband by taking away his sense of being fertile. Some husbands do feel deprived by their partner's sterile condition, and some feel that they are "wasting their semen," while at the same time they resent their lack of control over contraception. Others may object to infertility because they do not feel manly unless they can impregnate their partner. Extended family members also may put pressure on some couples to have a child.

Aside from feelings of guilt about interfering with pregnancy, some women truly enjoy life and feel whole only with something live inside them or with a young child to take care of. The Women's Liberation Movement probably would decry such an attitude as degrading a woman to the status of "birth machine," and these issues do touch upon the overall question of woman's roles in any society. But the phenomenon is well known to all workers in obstetrical or family planning clinics as the WEUP (Willful Exposure to Unwanted Pregnancy) syndrome. In any case, clear distinction must be made clinically between the motivation for pregnancy and that for parenthood, in both partners.

All these and other psychological and psychosocial consequences of interfering with fertility must be taken into consideration in any program with the objective of helping people achieve what they rationally plan. Intent aside, a close, intimate relationship between husband and wife, with open communication and cooperation for mutual sexual satisfaction, is essential to successful use of contraception. Sexual malfunction in either partner should be treated in order to keep the marital relationship healthy in the face of voluntary infertility.

Also needed are social contributions and changes that will insure significant limitation of family size. Here, as in medicine in general, implementation in the form of educational programs based on sound principles of emotional and social health is lagging behind the levels of knowledge and understanding already reached. Yet the underlying problems are complex and cannot be solved by the distribution of formal texts and educa-
Impediments to population stability

Hood for socioeconomic reasons, society must acknowledge the emotional problems involved and the validity of informed sexual activity with consent by the young, who may have no intent or ability to form permanent alliances, let alone accept the responsibility of family formation.

The states of adulthood and parenthood are taken to be synonymous, especially in the legal sphere. Becoming a mother at 17 or 18 carries the formal and informal implications of legal emancipation, although such premature pregnancy and parenthood may bespeak the young mother’s immaturity, as it stunts her emotional growth and her progress toward full maturity. Among the many class-bound disadvantages that limit real opportunities for the poor, for minorities, and for girls in general, premature pregnancy and parenthood, whether legal or not, rank high. Together they may constitute the greatest impediment to equal opportunity in life and to the attainment of mature adulthood.

Ambivalence—economic and ideological

Another element, operative especially in American society, that subtly promotes large families and an infinite increase in the population is our economic philosophy. Growth in numbers seems to us to be an essential ingredient to prosperity. Unfortunately, a society that wishes to stabilize its population must also come to grips with the need to stabilize living standards, at least in the material sense. The quality of life at the third level of creativity could be almost infinitely enhanced in a stable population.

But where lack of economic growth is proverbially equated with a declining standard of living, it is not enough to forswear limitless expansion. Society must modify the inequalities in the economic sphere because material disadvantages restrict educational opportunities. We now know that this provides additional stimulus for large families among that broad sector which may view pregnancy and children as the only gratifying life

tional materials through any or even all media. Ingrained sociocultural myths—especially those concerning the differences between the sexes, whether real or supposed—must be dealt with. Society has made allowance for the prolonged relative dependency and necessarily incomplete adulthood of men striving for professional status and a career, but has not made allowance for women with like goals and potentials that takes into account their temporary physical handicap during pregnancy. Once there are children, the woman is almost invariably expected to assume the major responsibilities for parenting, not only at first (when she is obviously the one who must do it), but throughout most of the family’s reproductive life.

Still operative although clearly weakening, is the taboo against sexual intercourse before marriage. To this day marriages are undertaken to legitimize sexual activity, if not a pregnancy. Yet such taboos cannot be reconciled with principles of good mental health for individuals, for marriages, or for families. Avoiding sexual intercourse before marriage may be ideal, but this society and other industrial societies must come to terms with the fact that the urge toward sexual activity is greatest during late adolescence and early adulthood. The age at which society is willing to grant adult status to the young may be delayed as much as a decade, depending on the educational goals and career expectations of the individual.

There is no evidence that sexual activity among the young as part of otherwise wholesome relationships is unhealthful in itself, although unprotected intercourse is socially undesirable and increases the risk of contracting and spreading venereal disease. In fact, so long as adequate contraception and effective venereal disease control were not possible, it may have been realistic to make sexual activity of the young difficult or well-nigh impossible. Of course this was done at the expense of burdening sexual behavior with conflict, guilt and at times severe overt punishment. In 1973 none of this is realistic social guidance. Because of the large-scale postponement of full adult-
experiences available to its members. From the mental health standpoint we are concerned with the impact of economic disadvantage on reproduction and with the evolutionary cycle of poverty begetting poverty for the next generation through early pregnancy and parenthood, marital or extramarital. Once started, a pattern of annual reproduction may set in, resulting in an overpopulated family which lacks many of the resources essential in modern society for proper parenting and development of the young. Yet we must realize that overreproduction among the poor is small compared to the overreproduction of the middle classes.

Whether they develop by design or by accident, overpopulated family units demonstrate the finiteness of family resources for educational and social development. The attitudes and policies of government reflect our society's low priority in providing needed services for these children, wanted or unwanted. Nevertheless it has been widely recognized that in general the children of the poverty sector are underprepared even for kindergarten, and assertions have been made by experts such as Anna Freud that enrichment programs must start in the first year of life. Despite this need almost no appropriate provisions in the form of day care centers have been organized in the United States. Even the few programs launched in the mid-sixties, primarily geared toward improved preparation for school, have been evaluated inadequately and starved financially. A great deal of undercare by communities and other governmental agencies is visible only in the number of abused and grossly neglected children who are found, and the number of inmates in mental hospitals and schools for the retarded.

If our national attitudes and policies, which are always interwoven with economic considerations, bespeak our lack of concern for children, our economic philosophy encourages child production. Our taxing authority makes allowances for large families without limit instead of taxing them more heavily because they consume a larger share of communal supports and resources.

The economic system of a population is a complex factor in the size of a population. It is possible to cite examples of contradictory correlations in almost all known groupings. Agricultural societies, for example, tend to favor many children per family as long as they are needed for labor, yet predominantly agricultural nations like Ireland or France have had stable populations, though not necessarily small families, over long periods of time. One dampening effect on family size in other times and countries has been the operation of inheritance laws and rules of primogeniture. Although children are an economic liability in modern industrial societies, urban and suburban families until recently have opted for more than three children, whereas the poor urban and rural families have desired fewer children. But because modern industrial economics favors ever-larger and more efficient production in hope of and indeed as part of a tremendous effort toward increasing consumption, this emphasis on production growth may have influenced human production.

The type of economic system seems to have less to do with reproductive attitudes and practices than does governmental policy, especially in authoritarian societies. Some nations have been effective in controlling their population, increasing reproduction or curbing it at different times. At present, China seems to do the latter. In general, Western governments seem to be more afraid of limiting industrial growth than of depleting resources. There are Western economists who view reproductive restraints as desirable for many reasons, especially for "other" parts of the world such as India, but there seems to be no clearly supportive mandate from the economic profession for population limitation as a necessity. Modern societies with economic systems as disparate as those of Sweden, Russia and Japan have low birthrates; but birthrates are high in South America and Egypt.
There is also a connection between the power concerns and the number of people in a nation or group. Nationalism, and racism as well, fosters these concerns. Currently some blacks view birth control as a genocidal tool directed against their race. While economic policy and philosophy often favor ever-increasing consumption if not consumers, higher material production and production efficiency do not necessarily require equivalent larger numbers of human processors. In fact, population increase widens rather than narrows the production-consumption gap by intensifying unemployment, which in turn diminishes consumption, creating further unemployment. From the mental health standpoint, such disfranchisement of large numbers of people from socially rewarding processes poses a distinct threat. Furthermore, neither the mental health professional, nor the student of the human condition can ignore such expert opinion about the finite character of world resources as expressed by the Club of Rome. Improvements in individual, family and communal mental health cannot be expected in the face of further population increases.

At least in the United States, society gives no evidence of being prepared to commit a larger share of its resources and its wealth to the care and education of the young. If this is true of a nation of over 200 million, there is no reason to assume that an improvement will occur when we shall be 300 or 400 million. Even a reduction in the disproportion between the dependent young and old on the one hand, and the productive adults on the other, cannot assure greater emphasis on nurturing and enculturating services for those who need them.

Our inadequate provisions for the dependent young and old sectors of society will be improved only if there is hope for improvement in the quality of life for all citizens. This hope seems to be justified only if we can achieve reproductive stability. Even granted the attainment of such stability we cannot predict but can only recommend that our society devote a greater share of its human and material resources to the proper development of the young and to an improvement in living conditions, health care included, for all. If population stability at an average of 2.1 children per family is not achieved, this society and others may experience at first hand behavioral and neurochemical disturbances comparable to those observed in crowded animal colonies, whether or not material resources and supplies keep pace with numbers. It must be appreciated that after a replacement-level birthrate has been attained, crowding will intensify for another generation because of the large proportion of women of child-bearing ages.

Our economic ideology influences reproduction in this country by encouraging a narrow attitude toward women, if not actual discrimination against them. During periods of economic stress, it is women (as well as the unskilled) who are the first to lose their jobs. During the great depression, for instance, it was considered almost unethical for both spouses to be gainfully employed on a full-time basis. This vague fear of nepotism is still of concern, if not spelled out as policy, in many institutions and enterprises. For the wives displaced by such pressures motherhood may prove the only rewarding alternative—not an ideal motivation for parenthood.

Furthermore, the differentials in pay scales for men and women, which customarily favor the men, have only recently come under attack and are being rectified only where the Federal Government exercises some leverage. Neither our economic system nor our service institutions have made appropriate allowances for the needs of women who may wish to and on the whole are expected to take time out from professional careers or employment during periods when their mothering functions are essential. For many complex reasons, some related to economic practices, democratic industrial nations have achieved the highest living standards during a period when they have forced most women into full-time mothering and housekeeping. This has diminished their opportunities for self-development in pursuing interests and careers that may best suit them, while housework and homemaking as occupations have been devalued.

With the high value placed on single-family dwellings it is
difficult to conduct a joint household in which a housekeeper or homemaker with her own children and possibly a husband lives as a family with another family for whom she works. Being a housewife and homemaker, whether for one’s own family or for an “adopted” family, can be a worthwhile and creative undertaking for many women, but it is not generally so viewed, nor is it suited to the talents of all women. And some women aspiring to be mothers might be better mothers were they not frustrated by the difficulties that beset their simultaneous pursuit of part-time careers outside the home.

Reproductive behavior is subject to many complex variables, and no one measure, no overall population policy as such, can be relied upon to insure attainment of a goal such as population stabilization. What can and must be done is to educate people about the issues attendant upon further wanton reproduction. Opportunity for informed decisions without coercion must be made available. The process of disseminating information that is involved here is not simple. Major governmental efforts are in order, if only as measures to improve individual and family health and mental health, and regardless of an official policy on population.

References


* Suitable for educational programs.
Services and education are two tasks operationally distinct and yet quite interwoven, since effective health care requires both instrumental and educational effort. It is health services rather than treatment services with which we are concerned here—preventive health services geared to the health and welfare of the individual, the family and the community. Fragmented clinical services are always a disservice for the patient at any time and under any circumstances. Discontinuous health care is equally incompatible with the continuing need of the individual for preventive health services including family planning. Only planned and properly spaced progeny commensurate with familial and social resources will prevent unwanted children. We are just beginning to provide comprehensive preventive health services to realize these aims through prepaid health organizations or government-supported neighborhood health centers. There remains the necessity that all physicians and all mental health professionals be alert to their patients' needs for the information, education and services they may lack in achieving a stable and enjoyable family life.

Education for family life is still deficient in spelling out the functions of the family, the roles and responsibilities of the parents, and the stages of the family life cycle (as discussed in Section 2). Many programs on family life and sex education for schools are available and in a few school systems some program is given in the school curriculum for every year. Unfortunately, however, education of a purely informational nature is ineffective. We must recognize that youngsters as well as older persons do only what comes naturally when they produce children. It should be obvious by now that the signal failure of family planning clinics and family life education makes improvement of our sex education programs imperative. These programs must provide opportunities for emotional growth in the educational process—for example, through the use of small-group seminars supervised by persons with practical experience in the developmental needs of the young.

**Reaching the target population**

We must find ways of insuring each couple, married or unmarried, couple-oriented attention and education on the issues of family formation and parenthood. In part this could be done in connection with marriage licensing, and through follow-up of newlyweds during their first year by a marriage or family counselor, much as we have rendered similar services in baby care through public health nursing. The time when each couple as a couple can be helped to decide what particular form of contraception suits them is at the time of their marriage or before. At this time they can be helped to guard against their more unconscious needs to reproduce which may lead them to forego the precautions they have consciously selected. A follow-up marital counseling service for all newlyweds would cost less than $100 million annually on a nationwide scale. (This would amount to two sessions with a counselor during the first year.) As the matter now stands, premarital medical attention in the form of blood tests and physical examinations places the burden of any preventive family advice on the medical profession.

When one considers that the law requires evidence of the applicant's ability to drive a car before issuing a driving license, it is not too far-fetched that it should require some evidence of family life education and competence for parenthood before issuing a marriage license. In the absence of some such legal
requirement, the moment of marriage may be late for appropriate guidance but it is better given then than not at all.

Family formation should be discussed with every newlywed couple by the physician whom they may consult premaritally, or he should arrange counseling services for them. The first pregnancy (as many as 4 out of 10 new brides may already be pregnant) often offers a further opportunity to acquaint or reacquaint the parents-to-be with the issues of family formation and family functions in the service of emotional growth during this period, as well as to provide proper prenatal and obstetrical care. It is also an opportune time to discuss and help the couple plan the number of children they want and how they want to space them should they desire more than one child. It may soon be possible to help couples realize their sex preference for a second child providing it is also possible to abort without legal encumbrance should the fetus be of the unwanted sex.

Section 4 mentions the many resistances to providing relevant education let alone the services. Expense is a major obstacle. Although the Federal Government lately has been more active than formerly in providing family planning services, at this moment abortion is not yet so supported as an appropriate adjucitive method despite judicial approval.

Obviously, the same services and educational opportunities should be provided alike for married couples and for unmarried parents or parents-to-be. Good day care centers for infants as well as for older children must be available locally if young parents are to pursue further education or gainful employment when they so desire.

The neighborhood health station
Educational services, as well as full prenatal and obstetrical services, are of critical importance in our inner cities and other poverty sectors because we know that women of low socioeconomic class suffer the highest incidences of stillbirth, prematurity and brain-damaged children. These problems are largely preventable given appropriate health care and adequate nutrition. The services must be available at neighborhood health stations locally based near those being served, not housed in distant medical centers. Furthermore, since family health care embraces all family members as individuals and in group, services must be open outside regular school and working hours.

Abortion consultation at the station. One of the major conditions for making possible humane reproduction by people who are informed, are prepared to become parents, and want planned children is the unhindered availability of abortion. Abortion services should not be integrated with obstetrical services such, but with the neighborhood health stations, which provide family-focused health care through teams of health professionals. Abortion should not be performed on demand, but the health care service should offer appropriate consultation to any woman who requests an abortion and also to her spouse, if any. Such consultation should lead to their adoption of contraception and family planning. Female personnel are preferred for these consultative services.

The ideal service arrangement can be envisioned as part of the neighborhood health station, which provides all the services for primary health care as well as offering family-focused medicine, including birth control and mental health services. The station should be staffed with health professionals who can provide all the necessary medical care for illnesses not requiring hospitalization, and in addition, preventive health services and health education.

Services of this kind should be made available to adolescents apart from their families if they so desire, but mindful that many such requests bespeak family conflict, which should eventually be resolved through counseling.

Health stations should be an integral part of a community service network, with connections to one or more hospitals or medical centers, schools and school health services, and to specialist services such as mental health centers, nursing homes,
rehabilitation centers and the like. This type of comprehensive health program is currently advocated, especially by the Federal Government, in the form of health maintenance organizations and neighborhood health centers. It is by no means a novel proposal. Similar services actually existed half a century ago in some of our larger cities but at that time were oriented primarily toward prenatal, baby and child care.

Currently few such centers are actually in operation and most of those that are find themselves understaffed for what they consider their primary and more traditional functions. Aside from deficient staffing related to low budgets, professionals in these centers confront two other problems being resolved with variable success: One is the problem of teamwork among professionals from various disciplines (physicians, nurses, educators) including the newer types of health workers; the other is the problem of community participation in the direction and governance of such centers. Some promising patterns of shared consumer and professional governance have been developed in the evolution of governing boards or councils for mental health centers serving specific catchment areas. There is educational pay-off from participating on such boards or councils, whose members also must concern themselves with the education and development of health personnel in their area.

Here the traditional role of the public health nurse and that of the community social worker already require of them the nuclear activities and skills needed to integrate all the services available at the center and at the homesite in providing family health care for an entire catchment area.

Contraceptive services

People throughout the world have practiced various forms of birth control. Through the ages methods have ranged from infanticide, especially of girls, to incomplete sexual acts and abstinence, with various forms of mechanical devices or post-coital applications in between. In a ninth century treatise, the Persian physician Al Razi listed 175 methods of birth control including abortion. Only in the last dozen years or so has scientific medicinal contraception in the form of the “pill” become generally available. Even though it has gained wide acceptance, especially among more educated groups, the pill remains less than satisfactory from the pharmacological and epidemiological standpoints. However, the development of coitus-independent contraceptives like the pill or the intrauterine devices has exposed certain deeply ingrained resistances and conflicts about “remote control” over fertility during any particular act of intercourse.

Health workers should be prepared to consult with individuals or couples in determining the method best suited to their needs. The staff must not only know the various methods in current use but must be aware of the psychological implications of each. No one method is as yet preferred over all others. The specifications for the ideal contraceptive are concerned with safety, effectiveness, economy, acceptability, and ease of use.

SAFETY

No actual or rumored hazard to health.
No impairment of fertility, preferably improving chances of pregnancy when desired.

EFFECTIVENESS

Less than one pregnancy per 100 woman-years of risk, given normal frequency of intercourse.
Effective period at least one month and preferably several years from a single application. (Many IUD designs fail here because of high expulsion and removal rates.) Period of effectiveness must be recognizable by a clear physiological or other sign of loss of protection.

ECONOMY

Very low cost in terms of both materials and labor (administering personnel).
Minimum requirement for highly trained medical or paramedical personnel to administer or explain to the user.
Easy and inexpensive distribution to both rural and urban dwellers.

**Conditions of use**
Easy to use in the absence of privacy, running water, or sanitary facilities.
Preferably not to be used at the time of intercourse.
To be used at an easily recognized and remembered time, preferably associated with menstrual period or specified days.
Implementation easily ascertainable at time of intercourse (e.g., by threads attached to IUD).

**Acceptability**
Minimum interference with normal sexual satisfaction.
Minimum violation of norms, taboos or beliefs.
No undesirable side effects (nausea, discomfort, bleeding, skin discoloration, etc).
Must be acceptable to both partners.

**Applicability**
Usable by women of all ages and parities, especially multiparas and younger women; or by men.

The two most efficient methods for women seeking temporary infertility are oral contraception and the intrauterine devices (IUDs). But the need for further research to discover the ideal contraceptive and the psychological aspects of voluntary infertility persists.

The steroidal hormone pills act through pituitary suppression of ovulation and changes in sex hormone balance. Effectiveness is about 99 per cent, but so far daily dosage is required. Side effects of concern are thromboembolic complications, and possible carcinogenesis. The latter risk is hypothetical to date, the former of questionable statistical significance. Under medical supervision the pill can be safely self-administered and physi-

icians can advise the user what side effects are indications for discontinuing this type of contraception in favor of another.

During the first few weeks, some side effects of oral contraceptives are unpleasant. For instance, breasts: discomfort, headaches and libido changes may be experienced, as well as depressive symptoms. Often these effects are in part psychological, especially when of prolonged duration, and this latter development should alert the doctor or nurse to the possibility of conflict about contraception.

**Table 3**

<table>
<thead>
<tr>
<th>Principle</th>
<th>Agent</th>
<th>Application</th>
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<tbody>
<tr>
<td>1. Inhibition of spermatogenesis</td>
<td>Anti-oestrogen</td>
<td>Experimental</td>
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<tr>
<td>2. Inhibition of sperm entry into vagina</td>
<td>Progestrone</td>
<td>Experimental</td>
</tr>
<tr>
<td>3. Blocking of sperm transport</td>
<td>Vasectomy</td>
<td>Outpatient or office procedure</td>
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<tr>
<td>4. Sperm destruction</td>
<td>Foreign body in vagina</td>
<td>Experimental</td>
</tr>
<tr>
<td>5. Blockage of sperm entry into cervix</td>
<td>Condom</td>
<td>Before or during intercourse</td>
</tr>
<tr>
<td>6. Antispermatidal action</td>
<td>Foam; jelly</td>
<td>Precupal</td>
</tr>
<tr>
<td>7. Inhibition of sperm motility by cervical mucus</td>
<td>Low-dose progestrone; prostaglandin</td>
<td>Daily pill</td>
</tr>
<tr>
<td>8. Blocking sperm entry to uterus</td>
<td>Diaphragm</td>
<td>Precupal</td>
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<tr>
<td>9. Ovulation inhibition</td>
<td>Progestrone; estrogen</td>
<td>Daily pill; progestrone by injection</td>
</tr>
<tr>
<td>10. Blocking ovum transport</td>
<td>Tubal ligation</td>
<td>Abdominal surgery or outpatient procedure</td>
</tr>
<tr>
<td>11. Increasing tubal motility</td>
<td>Estrogen; prostaglandin</td>
<td>Experimental</td>
</tr>
<tr>
<td>12. Inhibition of nidation</td>
<td>IUD [2]</td>
<td>Insertion by professional</td>
</tr>
<tr>
<td>13. Abortion</td>
<td>Progestrone</td>
<td>By abortion team</td>
</tr>
<tr>
<td>14. Decreased production of Müllerian tract</td>
<td>Saline injection, prostaglandin</td>
<td>See #9 above</td>
</tr>
<tr>
<td>15. Evacuation of uterus</td>
<td>Prostaglandin compound</td>
<td>Experimental</td>
</tr>
<tr>
<td>16. Rhythm method (&quot;natural&quot;)</td>
<td>Saline injection, prostaglandin</td>
<td>Experimental</td>
</tr>
<tr>
<td>17. Coitus interruptus</td>
<td>Abortion by suction</td>
<td>Outpatient until 12 weeks</td>
</tr>
<tr>
<td>18. Abstinence from intercourse</td>
<td>Avoiding coitus several days before and after ovulation</td>
<td>Daily temperature and checking of cycle</td>
</tr>
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</table>

Coitus by cohabitation
No genital sexuality
Estrogens can be given in larger doses the morning after intercourse. Although highly effective, estrogen produces many undesirable symptoms.6

The mode of action of the intrauterine devices is not definitely known. The plastic IUDs are designed in the form of a loop, coil, spring, shell, spiral, bow or ring. Side effects are dysmenorrhea and menorrhagia, which seem to increase in frequency with increasing size of the device. Expulsion may be related to an irritable uterus. Patients with one expulsion have a recurrence rate of 37 per cent. Endometritis may be induced by the IUD and can be treated with the device in place. Depending on the technique used, uterine perforation occurs in 1/1000 insertions. The risk of intestinal obstruction following perforation exists only in the case of the closed device.

Parents or nonparents who want permanent protection from conception can be sterilized after appropriate consultation and discussion. Surgical sterilization for both men and women seems to be gaining wider acceptance than formerly. In the United States men have been more reluctant than women to have themselves sterilized. The ratio is reputedly three women for every man. This situation seems to be changing as more men seek vasectomy. It is estimated that 8,000,000 men in the United States have undergone this minor surgical office procedure and that 1,000,000 of them sought the operation in 1972.7 Sperm preservation (through freezing) is also on the increase as a kind of insurance in the event the candidate should want another child after vasectomy.

Tubal ligation of women is a hospital procedure and its popularity therefore more accurately assessable although no statistics have been published. An outpatient procedure consisting of tubal cauterization through tiny openings in the abdominal wall is currently being tested.

Permanent infertility, whether voluntary or involuntary, carries the same potential for psychological and marital conflict as does temporary infertility. In one series of vasectomy follow-ups8 such disturbances ran as high as 30 per cent, although no statistically valid study of a representative cohort has so far been reported. Questionnaire surveys have indicated that 9 out of 10 sterilized men or women feel satisfied with their postoperative condition.8

Other methods of contraception will not be discussed further because we are concerned with the emotional complications involved in their use and with the potential psychosocial drawbacks of any particular method. Actually, emotional and motivational factors require exploration with each couple. The passive, compliant woman may prefer to have an IUD inserted, or might want her husband to assume contraceptive responsibility, while the woman desiring to be in control may be better off on oral contraception. Couples who have intercourse only rarely may find coitus-connected birth control most suitable. The IUD is cheap, and has the advantage of not requiring daily action. Whatever the method chosen, educational preparation for the responsibilities of parenthood and family limitation should be part of all contraceptive counseling. Yet the research for an ideal contraceptive obviously must continue.

Abortion services

Abortion is a widely practiced form of family limitation or avoidance of offspring. It is the most commonly employed type of birth control in some Eastern European countries and in Japan, as it may be in other countries where, because the practice is contrary to law, statistics are not available. In Hungary, two out of three pregnancies are aborted. In New York City the number of abortions currently equals the total of full-term deliveries. However, in New York City only about 60 per cent of recorded abortions are performed on city residents. Out-of wedlock births in the city declined 7.5 per cent for the first time in 1971.10

There is universal agreement that, quite apart from ethical, religious and sociocultural concerns, abortion is inferior, from
the medical standpoint, to pregnancy prevention as a mode of birth control. Nevertheless, so long as the practice of pregnancy prevention is not 100 per cent effective, abortion will remain and should be available as a second-line method of family planning, aside from its function for those women whose fetuses may have been damaged by exposure to certain infections or medications.

It is not necessary to consider abortion methods in detail. Suction and dilatation-curettage, combined or each alone, are the commonest techniques. They are quite safe if performed before the thirteenth week, in most cases requiring hospital care for only a few hours. Second-trimester pregnancies are more difficult to terminate, but can be terminated safely in conjunction with at least 24 hours of hospital care. Prostaglandins, currently under investigation, hold promise for simple nonsurgical abortion.11

Possible long-range adverse effects of abortion are not well known at this time except for those occurring after infectious complications. Immediate side effects of surgical abortion vary greatly in different series.12 During the first year in which abortion became readily available in New York City the complication rate was less than one per cent for all abortions and less than one-half of one per cent for those performed before the thirteenth week of pregnancy. There were 8 deaths in 168,000 legal abortions.13 This record points up the importance of early intervention. It follows that the medical decision-making process should be sufficiently expeditious as not to expose a woman to the higher risks of a second-trimester procedure.14

The traditional religious, cultural and legal interdictions against abortion, including the concept that the fetus is being murdered, often make it difficult and psychologically traumatic for women to seek and obtain abortion in many parts of the world. Yet major psychiatric complications due to abortion are virtually unknown. Despite this good record, until quite recently in most of the United States, 90 per cent or more of medically approved abortions were performed for "psychiatric indications" whenever formal medical certification of need was required by law. Usually the required indication of need consists of a predictive judgment by a psychiatric consultant that self-destructive behavior or a suicidal depression is likely to occur if the pregnancy is not aborted as requested.15 There is evidence, however, that from the mental health standpoint women who were refused abortions they requested fared less well than those who obtained an abortion, and that their offspring also suffered.16

Abortion should be performed by qualified professionals working as a team. It should not become a major activity for obstetricians or midwives, whose main motivation and interest are concerned with bringing forth life. In England, for instance, some centers accept the spirit of the 1967 abortion law and operate accordingly, but they find themselves doing abortions also for women from areas where implementation of the law is being resisted.17 An efficient abortion service responsive to need should operate on an outpatient basis to the extent possible, and should prevent any unnecessary delay without forgoing appropriate consultation and operative safeguards. The service could best function as an arm of the integrated neighborhood health service already discussed rather than in a traditional hospital department. Besides, every abortion presents a clear indication of need for contraceptive advice and consultation, and must be viewed as an opportunity for preventive education.

Historically, and clinically since the time of Hippocrates at least, induced abortion was correctly considered as endangering a woman's life, and in that sense also viewed as criminal. This consideration remained a realistic one until infection could be controlled or prevented, that is, until the mid-nineteenth century. Although many antiabortion laws were drafted before Lister's time, religious and social interdictions were not spelled out until the time of the edict of Papal Infallibility (Pius IX),
and some decades later in the United States with the advent of the Comstock era. Until this century, too, frequent pregnancy was desirable in the married state because of high infant mortality. Today neither danger of infection to pregnant mothers and young children nor sexual mores are what they were 75 to 150 years ago. It should be noted that regrets expressed about an operation such as abortion must not be misinterpreted as psychiatric sequelae.

It is clear that abortion, second choice though it may be, can be reduced as a major factor in family limitation only when pregnancy preventives are made universally and readily available to all couples intent on avoiding the birth of a child. This requires appropriate technical education and education that will overcome persisting psychological and emotional resistances to nonreproductive sexual union through clarification of conflicting attitudes toward sex, infertility, family formation and family size. This education must be addressed to both partners of the union.

**Supportive services**

The role of nurseries and day care centers in birth control attitudes has been discussed. These centers could well be tied in with health services but they must be readily accessible and primarily concerned with child care. Schools could be another appropriate location for a day care center, serving to introduce interested students to the care of young children. While a service of this kind can be staffed largely by volunteers or by parents spelling each other, it should always be directed by a qualified child care professional working full time. Otherwise the children might be better off at home, because it may safely be said that only a well-run agency can benefit children more than average home care. These centers should have ready access to developmental evaluations of the children they serve, over and above routine child health and development examinations. Both parents should be involved with the day care center serving them—in its establishment and in its operation.

Other community services with which the health center must have some collaborative relationship are adoption services, social welfare agencies, and legal consultation.

**Education**

So far in this country, we have failed to provide full family health care, beginning with humane reproduction, which is also a significant component of preventive psychiatry. We have failed, furthermore, from the mental health standpoint and from an ecological point of view to provide women in particular and parents in general opportunities that can help them to secure satisfactions other than those deriving from biological procreation. Men and women must learn that nonreproductive sexual activity is important and even primary to their welfare. Women motivated for humane reproduction must be helped to achieve gratification in work and opportunities other than or in addition to being wives and mothers. No doubt there are women who wish little for their lives other than those two roles, but they must be considered inadequate for most women. Half the adult life of a modern woman is not likely to be occupied with mothering unless it would be the mothering of children other than her own, and the single role of wife preempts the energy of but few women. Furthermore, women have the likelihood of spending the better part of a decade as widows at an age when they would be better off occupied in some productive fashion beyond caring solely for themselves.

Education for humane reproduction must incorporate much of the information presented in these pages. It should be aimed at families, that is to say, parents and children. Everyone must be taught the advantages of small families—from the standpoints of health and mental health, not to mention the quality of life. All must understand their family tasks as the functioning of a system, a system based today on psychosocial and economic interdependence with the larger community. The limitations of individual enterprise and resources, hence of familial independence, and the consequences of disregarding these con-
constraints on reproduction must be made clear to everyone through every means of communication utilizing the mass media as well as institutionalized educational systems.

Sex and parenthood education is needed from the earliest ages, throughout the period of formal schooling. These programs have experienced difficulties when proposed for inclusion in school curricula. Some vocal opponents insist that these courses interfere with parents' rights and prerogatives while others object to them as an unnecessary expense. It is, of course, true that more is learned from one's parents about how to be a parent than can ever be accomplished through formal teaching. Yet parents have been demonstrably deficient in preparing their children effectively for the sexual aspects of their lives, for the salient issues to be considered and coped with in marriage, and for determining knowledgeably the size of their future family, let alone providing them with the information needed to implement family planning.

The content of each school program must be appropriate to the age of the pupil and geared to his specific needs at that age. Young children can learn the facts of life; adolescents can learn about heterosexual relationships and how to practice humane reproduction. Only after such preparation can parenthood be discussed as a responsibility rather than a "right."

Nonreproductive creativity is easy for the child in latency. But it is not being cultivated sufficiently from then on, through school and community efforts for young and older adults in the form of avocational and adult education. Full maturation to a level of nonbiological generativity may be foreclosed by the adolescent's choice of the easier biological route to a legally sanctioned "maturity" through pregnancy. The more difficult-to-achieve maturity of nonreproductive creativity and compassion must be fostered by education.

The topics to be covered and some of the pedagogical modes for such a school program must be spelled out. Implementation of the program and concepts discussed in this book will depend

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<th>Topic</th>
<th>Content</th>
<th>Age</th>
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in large measure on public education. The full use of services will depend on acceptance and understanding of the program and on the ability of those executing it to dispel the emotionally laden socioeconomic resistances that still block widespread contraceptive practice.

The long-term view. Julian Huxley has pointed out that we are the only species conscious of its evolution.21 We are also
responsible for our evolution, inasmuch as we have succeeded in mastering some elements of it, specifically by postponing death. In 1970 in the United States, 1,797,000 more persons were born than died, with a birthrate of 18.2 per thousand. Obviously we are not increasing the death rate. Therefore population stabilization would entail a reduction in births to approximately one-half the rate of that for the last decade. We could approach this rate simply by preventing all unwanted births. How to remain a small family requires one activity only—appropriate child planning made possible through birth control. But this proposition implies that a couple is capable of and will be comfortable with nongenerative sexual activity, and will as well be motivated consciously and unconsciously to limit family size through contraception, abortion if necessary, or sterilization.

Although a national rate of 2.1 children per couple currently prevails, the causes of this decline from previously higher levels are unknown. It began in 1958, before wide usage of the pill. We therefore know that the reproductive rate could climb again as unpredictably and unexpectedly as it did in the forties and fifties.

Education about ecology is as essential as education about economy. We must spend a greater share of our wealth on human services including education if good health, a goal related to the quality of life, is to be realized. Malthus's specter of famine through overpopulation may not seem to be threatening the United States, or most Western nations, although our indifference is not justified on a worldwide basis even given equitable distribution of existing food supplies. However, the pollution of our country by people and their waste products is clearly an urgent concern of us all. Here again, we seem to be in the beginning stages of educating ourselves on the subject of pollution and it is especially promising that our young people are the ones who seem most seriously concerned.

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Goals of the comprehensive program

The goals of a nationally scaled comprehensive program for rational reproduction are fourfold. They are addressed to the individual and the family, and they must be sufficiently broad to apply to all groups, whatever their socioeconomic status. Simply stated, these goals are:

1. The family as a functional organism is viable today and has shown vitality over a long span of time through many vicissitudes, but community supports are essential to its full functioning (Sections 2 and 3).

2. Informed and rational parenthood is not only necessary to survival in this period of rapid technological development and overpopulation, but is essential to the humanizing processes that further the well-being of the individual, the community and the body politic (Sections 3 and 4).

3. Parental capabilities should be recognized, but they must also be supplemented to insure the health and development of every individual in the community, thereby reducing the incidence of genetic and environmental casualties.

4. Enhancing the quality of life requires population stabilization. This quality is contingent not only on calories and other material resources available to the individual, but also on the psychosocial resources of his family and of the larger community.

The educational programs required to meet these goals will be shaped by the development of appropriate information based upon simply stated basic principles. This book aims at providing some of this information to professionals for their development of a flexible variety of didactic and demonstration materials which would be readily adaptable for distribution through existing channels of communication:
1. Mass media
2. Formal education systems
3. Informal education systems
4. Collaborative information systems, especially health services

The educational content and pedagogic method would have to be designed especially for the group to be served, on the basis of certain considerations:

1. Age
2. Sex
3. Marital status
4. Socioeconomic status

Education of the educators is critical. Not all teachers or community workers are necessarily expert educators on sex and family life. They must be selected on the basis of their motivation and competence for this undertaking. They need special training in this area, and school systems must conduct special teacher workshops for those assigned to the tasks involved.

Certain developmental landmarks in family life present opportunities for educational input by means of these educational programs:

1. School entrance at whatever age
2. Point of choosing a vocation
3. Decision to marry
4. Decision for parenthood
5. Preparation for parenthood (prenatal period)
6. Postreproductive adult life

Medical doctors and all health professionals need special preparation in this field, because for the most part their own educational programs gave them little sex education. Medical schools are only beginning to schedule relevant courses and clinical exposure in their curricula.22 Clinical practice and training are usually focused on an individual (or an organ system), but in the matter of sex and family education doctors and nurses must learn to work with couples and groups.

A vast educational effort is needed to help all people accept the idea of a static population. This effort will involve the cooperation of all governments as well as of the health professions. The steady-state concept as applied to population still has to contend with important resistances deriving from our own profession and the medical establishment, from economic philosophy, from religious objections, and from a general indifference toward becoming the masters of our evolution. It is hoped that the considerations advanced here in behalf of individual and family welfare, community health and preventive psychiatry will aid in overcoming some long-standing impediments to responsible, humane parenthood based on informed consent and a stable population size.

Malthus' preoccupation with nutritional resources may appear one-sided, but he did recognize that reproductive behavior was amenable to "moral" influence. This was two hundred years ago. Seventy-five years ago we were warned by Sigmund Freud (see frontispiece).23 Today it is apparent that if we do not succeed through education and effective care systems to limit population growth, our governments, so long delinquent in providing leadership or resources in this field, well may dictate who can have babies and how many they may have.

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CONCLUSIONS AND RECOMMENDATIONS

As overpopulation has become an increasingly alarming concern for all peoples of the world, it has highlighted the need for control of human numbers. In a world where the number of children is fewer and each child is planned for and wanted, every child would then be entering a welcoming family willing to rear him to the best of its ability, and ideally entering a compassionate community concerned with the mental health and welfare of all its members.

The thesis that mental health and humane reproduction are significantly interrelated has been presented and documented to the extent possible in so brief a report. Certain related issues have been considered: the family as a functional, psychosocially essential system; the special stresses on family performance in modern society and the specific disadvantages for children of large families; the interdependence of the family and social systems; the pathogenicity of parental and social rejection of children; and some of the social and behavioral consequences of experimental overcrowding in a "healthful" environment.

The psychological and societal resistances to the proposition of humane reproduction have been discussed, with emphasis on the complexities of insuring responsible parenthood based on informed consent and planning by both partners. The motivation to match finite familial psychosocial and material resources with reproductive restraint depends on meaningful work and career opportunities for women, on appropriate community
resources such as child care centers, and on consonant societal attitudes and policies. Furthermore, contraceptive competence requires not only motivation of the partners but a capacity for nongenerative sexual intimacy and mutual satisfaction.

Services for planned and restrained reproduction should be offered by neighborhood health stations providing comprehensive medical and health care for family units. Abortion as a stopgap preventive must be readily and promptly available. Research for a reliable, nonhazardous contraceptive that will be simpler and cheaper than current methods and into all facets of sexual and reproductive behavior must continue.

Finally, education for humane parenthood must be based on full information geared to the age and life situations of the groups served. Health professionals and teachers must be educated to perform competently in this area. Humane reproduction would inevitably lead to population stabilization by reconciling biological drives with a compassionate and responsible psychosocial concern for the quality of all life.

FOR FURTHER READING

References suited for educational programs are marked with an asterisk (*).

   Ashley-Montagu: See Montagu.

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