The Quiet Murder

Richard F. Curran
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RICHARD F. CURRAN, M.D.

There is no cry of protest sent from the victim. It is done where no eye can witness. There is no grave with marker to identify or incriminate. This quiet murder is abortion. But it is not completely quiet. Someone bears a noise. I should like to discuss the someone and the noise.

The problem of abortion is of special concern to doctors. For, although the legal and moral arguments grow daily in complexity and volume, as physicians, we are still left to face, in our service to the patient, our own personal argument. As Catholic physicians, our medical convictions are shaped by our moral ones on this subject. We are, therefore, quite often reproached for a lack of objectivity on such a timely topic as abortion.

It is my hope in this article to present some considerations based on clinical experience. I believe these observations to be objective. No attempt will be made to enter the legal or moral arena. These are the thoughts of a Catholic who is a psychiatrist, not a "Catholic psychiatrist."

It is the workings of the human mind that we shall examine. It is the mind of one who is involved in a death. Such a mind is opened to mind that we shall examine. It is the mind of one who is involved in the interaction of the psyche and soma from the pregnant woman than from any other patient.

Let us return to the psychological problems. The normal instincts toward motherhood represent the positive wish to participate in the process of life and to offer oneself to this natural aim completely. Yet, as already noted, there may exist strong unconscious counter-wishes which spring less from the dread of biological demands than from deep seated attitudes toward impregnation and child-bearing. These attitudes are often the remnants of childhood wishes and fantasies. But, pregnancy is not a fantasy. It is a real event and demands a real and substantial strength of ego. Other- wise, neurotic and even psychotic mental defenses are employed. For some these attitudes represent the emergence of unresolved hostility and aggression toward figures in one's own life.

Some interesting research has been done concerning such attitudes. A group of investigators studied seventy-five women with histories of habitual abortion (more than three miscarriages). These women were found to have no related organic deficits such as hormonal imbalance or structural deformities. The results of the study indicated significant differences in the emotional makeup of this group and a control group of so-called normal women with several successful pregnancies. They found that the women of the group under study were usually more compliant and dependent, usually to a mother or mother figure. This compliance served to present a socially acceptable facade. Behind the facade was a goodly amount of hostility and resentment. The tensions and frustrations which resulted from their constant efforts to please would only periodically erupt. But for fear of losing whatever dependent gratification was available these emotions were usually stifled. It was felt that a psycho-physiologic explosive act was the result when these women were confronted with strong ambivalent feelings toward the pregnancy. The Rorschach responses were replete with ideas of competition, fighting and depreciation of human figures. There were an unusual number of responses concerned with weapons, fires, claws, blood, explosion, incomplete figures and violation of living tissue. The investigators concluded that there was certainly a significant relationship between the emotional structure of the studied group and their repeated unexplained miscarriages.

From this and similar studies one gains respect for the strange body compliance, as mental processes proceed to exert powerful directive forces. With this knowledge it becomes more understandable from whence the idea to abort emerges. The feelings behind a self-induced or assisted abortion are less mysterious. And one becomes more skeptical of the rationale for abortion. For behind every legitimate reason is the unreasonable potential for murder. For many the unconscious becomes conscious. The outer garment of logic, utility and practicability hides...
an ugly impulse. And no one is above such an impulse.

A chilling picture now comes to mind. It is a picture I have come to recognize when treating some patients with histories of abortion. The patient describes the predicament of an illegitimate or unwanted pregnancy, but with emphasis on the advice and help offered by the patient's mother. Usually there is undisguised bitterness as the patient details the coaxing, suggestion and direction given by her mother towards ending the existence of the unwanted child. The patient ultimately reveals a deep resentment of her mother. Usually there is an open and veiled reference to mother's destructive potential. These emerge partly from the need to shift blame and partly as an unwilling expression of their own deep disappointment in an idealized person. They are sad and hurt.

The potential for murder is universal as we have seen it develop at the unconscious level. And the onset of pregnancy presents the psyche of some women with a possible victim. The unique privilege of motherhood can create an immense burden to the disturbed or confused mind. Let us follow the thought to the deed.

Let us not limit our thoughts to the so-called illegal abortion. For we must keep in mind that whether the termination of pregnancy be at the hands of a surgical team with hospital approval or by self-administered tools and potions, or by clumsy, unsterile professional abortionists, the psychological burden of guilt rests with the woman. And it is no wonder that one hears of extreme fear, ambivalence and doubt as the hour approaches.

Eagerness to end the pregnancy is dampened by fears both realistic and unrealistic. Realistically things can and often do go wrong. The complications of hemorrhage, repair, mutilation and death give sufficient reason for apprehension and fear. The irrational fears usually spring from the growing doubts, guilt feelings and anticipation of punishment. Added to this is another fear, usually vague and transient, shared by most pregnant women, and even their husbands. It has to do with the strange feeling that one's life means to lose one. For some women this idea is so gripping that they await labor and delivery with absolute terror. This process of thinking is less strange if we try to appreciate the unique relationship of the prospective mother and fetus. There is a certain biological unity in the sense of a sharing of tissues, blood, nutrients and metabolites. There is a strong emotional bond which begins with the idea of pregnancy and develops according to the mother's self image and takes on shape and color according to the individual's identification with the fetus and to the resolution of her ambivalence about the pregnancy.

If there are those who fear sickness or death as a result of their decision to end a life within them, then there are others who seek such "punishment." For some women burdened by the emotional pressure of their conflict and overcome by the gravity of their decision proceed with an unnatural deliberation to seek out the most dangerous ways to abort. This presents us with the grisly drama of murder and suicide.

Once the deed is accomplished the mind is taxed anew. Ambivalence gave way to action. For some, there is nagging guilt of a misdeed that cannot be undone. Others become painfully aware of the fearful hostility in themselves; a hostility that can be acted upon. Still others experience a mounting hatred and distrust directed toward any and all who advised or assisted in the misdeed.

It is disheartening to consider the damage to the emotional make-up of a young girl, who has not attained a reasonable maturity of ego. The concept of self in terms of ideal values and images is dealt a mortal blow. The event is recalled again and again. Soon it becomes necessary to drown out the noise that is heard, as she is forced to review her act of murder. Powerful repressive forces stir as the ego tries to preserve a mental equilibrium. What cannot be pushed back into the vaults of the unconscious must be defended against. Thus, the emergence of neurotic or psychotic reaction patterns.

The milder reactions may take the form of conversion reactions, phobias or obsessive-compulsive mechanisms. These patterns are usually not brand new, but represent a re-emergence of old traits. Thus the compulsive type will often become more rigid in habits of cleanliness, punctuality or parsimony. Those women given to the expression of emotional conflict via the body language will develop psychophysiological disorders. The phobic disturbances are perhaps the easiest to understand when one grasps the symbolism behind the feared situation. I have treated patients with irrational fears of crowds, of solitude, of foods, bugs, knives. Others avoid visiting certain places or performing certain acts. Some will shun the doctor who performed the abortion and for those women who performed the act themselves one is likely to hear, for example, of the panic that descends when the central plumbing breaks down and the pathway to disposal of the "dead one" backs up.

A fear of instruments and weapons is not uncommon. If one remembers that a phobia represents a displaced fear against a forbidden impulse, this phenomenon makes more sense. Knives are scrupulously placed out of reach, not because of the searching hands of toddlers, but because of the doubtful control of the murderer.

Further pregnancies may be quite upsetting. The normal fears, doubts, and feelings of ambivalence become weighted with the memory of weakness and betrayal. The wish to retain and the wish to expel meet and wrestle anew. But now the contest seems less even, for the former contestant, "expulsion" has won the first fall.

The significance of other events may be overdetermined. Accidents, illnesses and reversals of one sort or another may be seen as punishment.

Then inescapably the menopausal
Regulation of Ovulation Time In Normal Women With Clomiphene Citrate and Perfecting the Practice of the Rhythm Method

J. G. Boutiell, M.D., N. Vons, M.D. and J. C. Ullery, M.D.

According to Marshall, the basic fundamentals of the rhythm method have been known to physicians for the past 35 years; however, this form of family planning has failed to obtain the confidence of a significant segment of the Catholic population. Even highly motivated and properly instructed patients frequently fail to accomplish their objective because of an unsuspected premature or late ovulation in an otherwise fairly predictable ovulatory pattern. These rhythm failures would imply that the responsible body processes which regulate the time of ovulation are not perfect and possess intrinsic peculiarities which prohibit repeated perfect timing of ovulation. Hypothalamic disturbance is but one example of how the pituitary-ovarian axis might disturb ovulation timing. During the past decade, many steroid compounds have been made available for use in the area of family planning and their efficacy has been virtually 100 per cent. Their mode of action is attributed to a three-fold mechanism, namely: (1) inhibition of ovulation, (2) production of a hostile cervical mucus, and (3) interfering with implantation of a fertilized egg by altering the endometrial environment. It is not within the scope of this presentation to discuss the morality of their use.

The purpose of this report is to discuss our experience with clomiphene citrate and its ability to regulate the time of ovulation. Clomiphene is a new orally administered non-steroid compound which is an analogue of the weak estrogen TACE. Clomiphene was made available in 1960 for infertile anovulatory patients. When administered to these patients, ovulation occurred and is characterized by all scientific criteria of ovulation, including pregnancy. In a summarized report by Johnson et al., it was noted that 1809 out of 2616 anovulatory patients ovulated following the administration of clomiphene citrate and approximately 40 per cent became pregnant during the first three clomiphene treated cycles. The mechanism of action of clomiphene is by the direct stimulation of the ovary or by the stimulation of the hypothalamic pituitary axis. In a careful review of the literature, there are no published reports concerning the use of clomiphene citrate in normal women for the regulation of ovulation time. The purpose of this study was to see if clomiphene citrate would regulate the time of ovulation and make the