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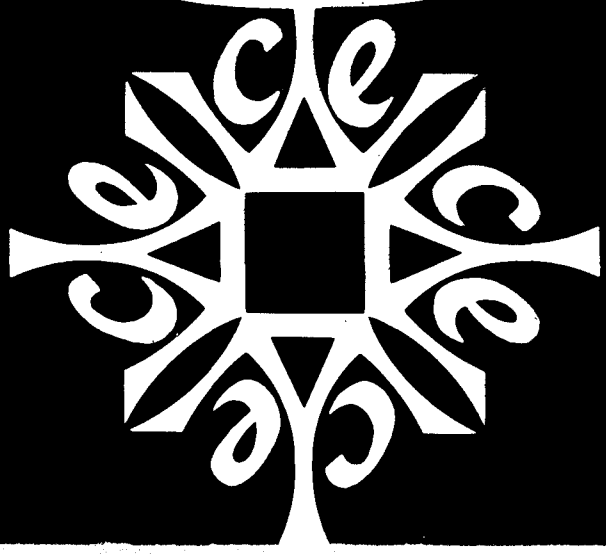
women on campus: 1970 a symposium



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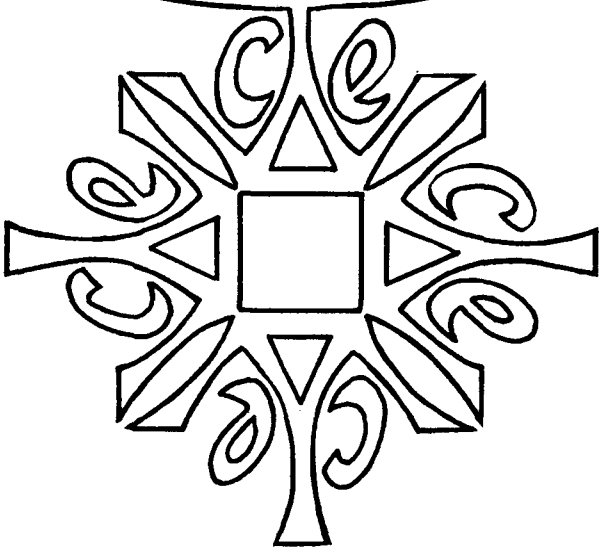
PROCEEDINGS OF THE SYMPOSIUM
OCTOBER 14, 1970

Louise G. Cain, Symposium Chairman

Morning Panel: Toward a New Psychology of Women
Noon Round Table: The Case of the Woman Graduate Student
Afternoon Discussion: The University and Women—What Directions?

The University of Michigan
Ann Arbor, Michigan



Foreword

1970 marked the 100th anniversary of the admission of women to The University of Michigan. It marked a new thrust in the movement toward women's rights. In the United States and abroad it may have marked an important turning-point in women's ways of thinking about themselves.

The specific goals of the Center for Continuing Education of Women since its founding have been to recognize and to remove barriers to achievement for women students, to encourage research on women and their problems, and to work toward a more rational planning of women's educational needs.

The 1970 Symposium was designed by the Center to focus on the academic woman: her activities, her achievements, her problems, her future at this University.

Psychological and Psychosomatic Responses to Oral Contraceptive Use

Judith M. Bardwick

When Joan Zweben and I began this study* there were few studies in the medical or the psychological literature about women's psychological responses to the oral contraceptives. But physicians had the impression that the easy acceptance or tolerance of the pill, or the marked rejection and physical discomfort experienced by some women, were due not solely to dosage levels, but also involved psychological dynamics. That was a logical hypothesis and we proceeded to explore this question using techniques that would measure the psychological variables that had been significant in previous studies of dysfunctions in the female reproductive system.

The three most important variables have been the following:

passivity, or the inability to express aggression directly,

dependence, or the need to perceive yourself as esteemed by others because that is your major source of self-esteem, and

denial, a primitive psychological defense in which reality is simply not perceived. The person who is very dependent upon others for feelings of self-esteem remains very vulnerable to rejection. The person who is unable to express hostility for fear of being rejected, is usually not as healthy psychologically as persons not significantly passive or dependent, and is likely to use the vulnerable defense of denial.

We were also interested in measuring levels of anxiety about sex, the psychological relationship to the body; feelings of trust or mistrust toward the sexual partner; goals, self-perceptions, what made the subjects happy, angry, or depressed; attitudes about contraception and the pills in particular, sexual responsiveness and sexual motives. In other words, we gathered all kinds of information which could conceivably have some relationship to the use or the rejection of this kind of contraceptives.

Because this was a predictive study, we saw each subject for about two hours before she began to use oral contraceptives. We administered the Franck Drawing Completion Test (a measure of unconscious body relationships), the Nichols Subtle Scale (a personality questionnaire that measures passivity), the Cornell Medical Index for Women (a detailed health questionnaire), and a standardized interview. Three months after the interview, after the subjects had three cycles on the pills, each one received a 4-card Thematic Apperception Test (measuring attitudes toward

heterosexual relationships, sex, passivity, dependence, and maternity), and a detailed questionnaire about her responses to the pill.

The 150 subjects were volunteers from Planned Parenthood in Ann Arbor, and University of Michigan students recruited through newspaper ads. An additional 100 subjects were later recruited through ads in order to extend the population of TAT responses. The majority were unmarried or recently engaged, usually students, and overwhelmingly white, middle class. Because there was no choice about pregnancy in their lives—they simply could not afford to become pregnant—our subjects were extremely motivated to use oral contraceptives successfully.

What we found in brief was that girls who were insecure in the heterosexual relationship, who were not sure they could trust their partners, who were anxious or ambivalent about sex or pregnancy or maternity, who felt compelled to participate sexually but who did not achieve orgasm, who were passive and could not express their resentments, and who used denial, were very likely to report that they experienced no symptom reactions to the oral contraceptives. They were likely to report that the pills were psychologically beneficial, sometimes that the pills were "magic" pills, doing such wonderful things as making your hair grow longer. Consciously, in the interview and on the follow-up, these subjects looked extraordinarily happy. The unconscious data revealed startling levels of psychopathology, heterosexual mistrust, anxiety, and guilt.

So these subjects then are characterized by an absolute denial of fear and anger, a denial of body processes, a stereotyped description of their partner, their goals, sexual motives and experiences, maternal desires—and so on. There is a quality of exaggerated goodness or a "Pollyanna" quality to the responses of these subjects. All women reported body changes as a result of the contraceptives. What distinguishes this group is their exaggerated interpretation of these changes as beneficent or, after they report the physical change, as functionally non-existent.

Women who were psychologically more normal showed a wider distribution of responses to the body changes and the responses were less extreme than those of the more vulnerable subjects. Less anxious subjects tended to note the body changes, tended to respond to them as symptoms, tended to regard them as normal, and tended to have psychologically mixed but not extreme responses to the changes. More normal subjects were able to describe their fears about the pill and sometimes their dislike of the pill and accompanying body changes. Normal subjects who were aware of their ambivalence toward premarital sex, who were not pathologically anxious, who accepted the menstrual cycle, and who experienced some sexual arousability, found that they could accept the body changes resulting from the pills. They accepted the body changes but did not regard them as magically beneficent.

Anxious, guilt-ridden, passive subjects who did not use denial found the

body changes frightening and regarded them as pathological symptoms. Women who were anxious about sex, who were passive, who basically resented taking the pill but who used denial were able to deny their fears and resentments and perceive the physical changes positively.

Thus, responses to the body changes induced by the pills seemed psychologically motivated. Certain physical changes are common and attributable to the endocrine changes induced by the pills. Psychological responses showed a rare range of variability and seemed psychodynamically motivated.

But while individual responses to the pill reflected individual motives, we found that in this population taking oral contraceptives is itself a critically important behavior.

While we set out to study psychosomatic responses, what we had really was a study of morals, ambivalence, anxiety, and motives. We all know that sexual mores have been evolving since the 1920's—but they have not changed.

We know that girls have always been traditionally motivated during adolescence by heterosexual goals. Unlike adolescent boys whose primary task is the evolution of a vocational identity, adolescent girls have always defined achievement as the establishment of a stable heterosexual relationship. As Douvan and Adelson found in their study of adolescents during the 1950's, criteria for self-esteem change for girls at adolescence. The pressure to attract boys becomes competitively more important and crucial to feelings of self-esteem. Academic achievement goals become less important, and affiliation needs generally become more important. Our data of the late '60's support the idea that, like morality, girls' criteria for self-esteem have not significantly changed. Since girls still achieve identity within the affiliative relationship and are anxious within the relationship, this era of uncertain morality has tended to increase their psychological vulnerability.

We asked girls why they had chosen the pill as a contraceptive. The most frequently cited reasons were its safety, convenience, low cost, and the fact that it seemed least mechanical. At another level, motives for using the pill revealed attitudes and anxieties about sex. The most common response and hope was that the pill would reduce anxieties about pregnancy and *that* decrease in anxiety would enable them to become sexually aroused. Disappointment in sex was often attributed to fear of pregnancy.

"The pill will reduce tension."

"The pill will make sex spontaneous."

"I find I don't resent taking the pill like I did having to use the diaphragm. I don't feel like I'm preparing for sex when I take the pill."

"The pill is dissociated from the sex act—it's more natural."

"I expect my sex life to be very happy."

"I expect the pill to make me able to reach orgasm."

"It's convenient and I suppose psychologically I don't think of it as 'birth control,' but merely a type of medication I take every day."

We asked if the subjects had any worries about using the pill. Some women denied any fears at all, and that seemed to express a determination to use the most certain form of contraception in spite of negative consequences widely cited in the media.

Responses of the subjects after using the pills tended to reveal great fears which had not been expressed in the initial interview but could now be discussed because the changes were not as bad as those they had imagined. Some subjects, however, indicated continuing fear, sometimes expressed through responses to body change.

"I refuse to be scared. I won't have to worry. It's too easy."

"I feel like a hard woman because taking the pill is an admission of what I'm doing."

"I detest these changes! Every time I have to swallow one of these pills, I dislike the relationship we have a little more."

"The pill makes you aware of your sexual actions at all times."

"Sometimes when I take the pill in the evening, I think I'm doing something against my body which isn't natural–like I would take away something of my femininity."

"Before I took the pills I was kind of scared that I couldn't have as much control over myself as before."

"I feel that to males the pill is kind of mystical because it prevents pregnancy."

"I don't expect that I'll become promiscuous. If anything happens I won't credit it to the pills."

"I dislike feeling that I cannot control my body but a pill can."

"Premarital sex I can justify, but you take the pill when you're alone, not romantic–whether you like him today or not."

"I don't have any strong feelings about the pill. I take it with my vitamin pills and feel the same way about it as I feel about them."

"I now think of the cycle as a function of the pill."

"I have the feeling that the menstrual cycle is now mechanical, something I *caused,* not a part of me."

"The pill is not a tangible contraceptive."

We asked each subject the following question: "If there were a pill for men like the pill for women, which partner would you prefer to be responsible for contraception?"

Responses to this question tended to indicate levels of trust or mistrust in the relationship. Responses also revealed a certain amount of resentment that the male can enjoy sex without much responsibility, and the idea that contraception is threatening to the male ego.

"I think I trust him better than I trust myself. Maybe me–because if anything happens, it happens to me."

"Me . . . I trust him . . . but I like to know that I take them every day."

"Me. Because the girl would take pregnancy more seriously than the boy."

"Before marriage, me–after, I don't know. In an affair like this it can break up, he could go, anytime."

"Women, because the man is more excited and he'd be less responsible."

"My boyfriend wants me to use the pill because he sees it as a commitment to the relationship."

"I think I'd still take me because women are more likely to take them. Men don't like to take aspirin."

"Men. Let him have the responsibility. The woman gets pregnant."

"Men should. It's bad enough that I feel funny taking all the responsibility and he's not doing anything. They should."

"Men. Women have enough problems. Women have to have kids, take care of them, stay home. Men want sex, women do it because they love him."

"Theoretically him–but pills don't bother me. Men would be better, more successful–women have to take them continuously. Hits the source with men."

"Him–because I'm more moral. It bothers me more than it would him. And it would give him more of a commitment than me."

"Women–because it's her baby and it would take away the masculinity of the boy."

"Women. It might diminish his enjoyment."

"I'm afraid, psychologically, that a man would feel impotent if he took a pill–and I don't care for myself."

"Me, since he's rather absent-minded. But perhaps both for double control."

"I prefer to think of it as a joint responsibility. I don't think it's fair for just one to be responsible."

We asked our subjects: "Why do you make love?" Their responses suggest that the pleasures of sex *qua* sex are rather rare in this population. Many answers were stereotyped responses, part of the cultural milieu, but not really true for the individual. For example, one of those responses was, "For the physical release," but those same subjects reported never experiencing orgasm, or reported experiencing something "pleasant,"–which is not an orgasm–or, "I don't know if I have an orgasm,"–which also means no orgasm. Perhaps the most frequent response was their perception of sex as an important technique for communicating love in a relationship which they hoped was mutual, or the observation that if they did not participate sexually he would leave the relationship. For most, physical sex is impor-

tant because the male makes it important; for these women, sex tended not to be important in its own right.

Sexual motives tended to reveal general heterosexual motives.

"Because it's a means of getting closer to him."

"I guess because I love him."

"With him it's a giving, sharing, relaxing experience. If I say that I don't feel like it, he'll just hold me instead. The ultimate in being together."

"I enjoy it to a certain extent. If I like the person, I have a desire to please; desire to please rather than be pleased."

"The emotional commitment resulted in my having an orgasm."

"I enjoy it and it makes the other person happy."

"Right now to please him."

"If I didn't love him, I wouldn't enjoy it."

"A very social thing to do—a way of reaching people."

"I don't know. I think it's really necessary as a symbol of the involvement."

"It's pleasurable I guess. It's expected."

"I enjoy it. I envy men their freedom and ability to see sex with nothing else attached."

"I don't mind not getting excited or reaching orgasm. It's nice when it happens, but sometimes it requires more work than it's worth."

"It seems natural and because at this point it would harm the relationship not to."

"Mostly to see my boyfriend's enjoyment."

"He demands it."

"Besides the fact that it's a natural thing to do and we enjoy each other's company, we want to feel united—and it's the first time I made a decision without someone helping me."

"I hate to deny my husband although he's very good."

Very few subjects reported reaching orgasm, and there was a kind of conscious disappointment, but it wasn't terribly important. What was most important was the feeling of closeness in the relationship which they insure by their sexual participation. But that is dangerous because when you are not certain of the mutuality of the commitment, when you participate in sex primarily in order to secure love, or because you are afraid of losing love, your psychological vulnerability overburdens the sex act.

Overwhelmingly, our subjects reported that they made love with one "special" boyfriend toward whom they felt deeply committed, or else had intercourse with their fiancé or husband. In spite of the absolute contraceptive effectiveness of the pill, we saw very, very few subjects who made love with more than one partner. While sex is thus conceived of within a relationship, the assumption of contraceptive responsibility is nonetheless threatening, because it means that the woman must acknowledge her

sexual decision and can no longer perceive sexual activity as the result of some temporary, guiltless passion. Taking the pill can arouse anxieties about morality, and this anxiety and guilt are strongly defended against. In spite of any "sexual revolution," sex remains emotionally threatening, because this population gets so little physical pleasure from coitus, and because they are afraid that they have degraded themselves and will be abandoned because they are immoral. These anxieties were clearest in the TAT themes.

The TAT stories were returned with the follow-up questionnaire, after each woman had been using the pills for three months. Unfortunately, we could not get TAT responses prior to pill use so these are not measures of change. These are themes of stories written by women, most of them unmarried, after pill use.

The most frequent themes were:

Repetitive themes of men walking out.

View of men as argumentative, even violent.

Fear of rejection by males; mistrust of males.

View of sex as illicit, and the need to expiate guilt.

View of the male as using the woman uncaringly, for his own pleasure.

Denial of hostility to men.

Fear of abandonment, of deception, of rejection.

Prostitution fantasy with much shame and guilt.

Shocked by the extremely high levels of anxiety, hostility, and what looked like general pathology centering on sexual themes in these protocols, we tested another 100 young women. Their responses were basically identical to the first 150 and reinforce the idea that sexual anxieties and ambivalence are generally characteristic of this population.

The last question which I will discuss here (although I have not exhausted the data) are the responses to the question: "What would make you happiest?" Traditionally, women have derived a feeling of worth within their heterosexual and maternal relationships. It was surprising to find that although most subjects were college students, very few responded in terms of some professional achievement.

"Doing things with someone who enjoys me as I do him."

"To always have my husband and child."

"A woman is successful when she's at peace with herself, which is when you give up your career. The greatest satisfaction is in being a good wife."

"Having a child."

"To be receptive and give to others."

"When you bring out the best in others."

"Contributing to a meaningful relationship."

"Coming to terms with myself."

"Total self-actualization. That means a guy, family, job, and especially inner attainment."

"A toss-up between having my first child and pleasing my husband—which is probably the same thing."

"Getting kids raised and seeing they're happy."

"Really help people. I have a passion for helping people."

The population whom we saw in this study are largely preoccupied with the achievement of significant heterosexual relationships and with an identity within that relationship. They participate in sex within the context of the relationship, although they are often aware that they are incurring guilt by doing so. On the other hand, the anxiety of being abandoned if they did not participate sexually is perhaps even greater. They are defining themselves within the traditional roles as helpmate, wife, and mother, with some self-aware need to understand themselves and to achieve some level of confidence.

Assuming the responsibility for contraception within the context of an uncertain sexual relationship served to increase powerful, negative emotions. Profound but unconscious levels of anxiety about sex were evident in the 250 subjects whom we saw. We suspect that these levels of anxiety are characteristic for this population and are not confined to those who might be considered neurotic. On a conscious level some subjects report fears that men would leave if they refused intercourse, but on an unconscious level prostitution anxieties and fears of abandonment were the consequences of having slept with him.

Without self-esteem and an independent identity, this is an unresolvable conflict. Women with high self-esteem are more likely to participate in sex as free agents, less vulnerable to feelings of being used, because they have not let themselves be used. But the women whom we saw were characteristically dependent upon others for acceptance, were fearful of rejection, defining themselves, esteeming themselves, in terms of others' responses—especially of the men in their lives.

Based upon the subjects we have seen in this college generation, conflict over the sexual use of the body has not diminished, in spite of safe contraception and an evolving sexual freedom in this culture. The origin of the conflict lies in the girl's ambivalence toward her reproductive system, her vulnerability in interpersonal relationships, her difficulty in experiencing sex as a physical rather than a psychological involvement, and the residues of an older morality which are still powerful and which have been internalized as a standard of behavior.

*The study was made in 1967-8.