IMAGINING A PSYCHOLOGY OF THE PILL:
WOMEN, EXPERTS AND CONTRACEPTION IN THE 1960s

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This dissertation explores the ways in which medical experts conceptualized the impact of the contraceptive pill on women’s psyches over the course of the 1960s. Analyzing journal articles, popular books, institutional archives, pill packages and advertisements, the project traces representations of women through psychiatry, pharmaceutical marketing, obstetrics/gynecology, and health feminism. In each of these settings, specialists invoked the language of the psychology and emotion in making claims about the Pill and its associated risks.

Psychoanalytic psychiatrists believed there would be a conflict between the foolproof certainty of the Pill and women’s ambivalent emotions about pregnancy, resulting in unprecedented emotional and social reactions. Marketers and those concerned with the emerging study of medication “compliance” promoted a vision of women as forgetful, immature, and in need of physician oversight. Pill packaging aimed to counteract women’s noncompliant behavior, while advertisements addressed physicians’ anxieties about patients’ unsupervised pill-taking. Obstetrician/gynecologists and other physicians worried over the moral impact of prescribing the Pill, and they considered how to manage doctor-patient relationships and medical education as they watched structures of authority shift. The women’s health movement saw the failures of medical paternalism and put forth a new conception of women’s psyches that called for women to control their own bodies, and critically analyze health information to guard against risk.

The Pill served as a canvas onto which debates over challenges to women’s nature were projected, and the political valences of the Pill shifted accordingly. As the Pill was normalized,
heightened concerns over women’s mental states and the moral and social responsibilities of pill producers and prescribers yielded to a broader and more encompassing pharmaceuticalization of modern life. The Pill became one of many pills being prescribed for daily use for a diversity of patients, and experts were no longer able to frame women’s interior lives and social roles so narrowly in relation to reproduction. As the terrain of pharmaceutical solutions and medical risks expanded, characterizations of particular types of patients extended far beyond any singular imagined psychology of women on the Pill.
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- INTRODUCTION -

WHY IMAGINE A PSYCHOLOGY OF THE PILL?

In the summer of 2008, I was sitting at a desk under a sign that read “Scholar’s Study-donated by Ortho Pharmaceutical Corporation,” beginning my dissertation research at the American College of Obstetrics and Gynecology (ACOG) in Washington, D.C. The scholar’s study was located in the office of the ACOG Resource Center and was filled with knowledgeable, charismatic women trained primarily as librarians. The phone kept ringing throughout the day and in addition to doctors, many of those calling the resource center were women seeking expert advice, assessing information and questioning whatever knowledge they could get their hands on. They seemed to have questions about all sorts of reproductive health issues, but especially preventive health and pregnancy. Though as a visiting history student, with my head buried in historical documents and my camera trained on what seemed like hundreds of packages of old birth control pills, I overheard requests for information on reproductive technologies like amniocentesis, confirming and planning pregnancies, and understanding Pap test results. The callers seemed relatively savvy consumers of medical information, and the staff were sensitive, respectful, and had a sense of humor that made the callers, and me as a visitor, at ease.

When one of the librarians asked what I was looking for, I explained my mission at the time, which was that I was interested in finding information about psychological conceptions of women in the 1960s, particularly in the context of the history of the contraceptive pill. The
librarian replied that I was welcome to look through whatever they had in their historical collection, but that I might not find much, since ACOG’s library contained only “clinical literature.” From the standpoint of 21st century obstetrics/gynecology, there is a distinction between what is considered clinical, medical literature and foggier, murkier category of “ideas about women” as people rather than bodies.

To those concerned with reproductive health and reproductive rights, much is at stake in being able to cordon off scientifically supported knowledge about healthcare from everything else.¹ Women’s reproduction has always been politicized, but in the polarized context of early 21st century reproductive politics, women, and especially those identifying as feminists or supporters of reproductive rights position themselves on the side of “medicine” and “sound science” that supports objective, “evidence-based practice” while politics, ideology, religion, and culturally-specific notions of women’s proper roles are suspect.² Reproductive health supporters rely upon a shifting and tentative trust that we can find enough common ground to empirically decide which birthing practices, cancer screenings, birth control methods, and abortion procedures optimize health. Such a belief in the clinical purity of medicine relies upon an understanding of its regulation and reform in the second part of the twentieth-century.³

¹ This standpoint is important because it is politically useful to be able to distinguish an objective realm of what is best for “women’s health” as separate and apart from ideologically-driven policies restricting and controlling reproduction and reproductive freedom.
² For example, on August 1, 2011, the advocacy group NARAL Pro-Choice America released a statement commending Health and Human Services Secretary Kathleen Sebelius for “accepting an expert panel’s recommendation that family planning be considered preventive health care.” The press release was entitled “Obama Administration Scores Victory for Sound Science and Women’s Access to Contraception.” http://www.prochoiceamerica.org/media/press-releases/2011/pr08012011_hhs-contraception.html (March 25, 2012). NARAL accuses the anti-choice movement of using misinformation to scare women and attacking “science-based research.” Similarly, Planned Parenthood’s press release of the same decision was praised as a decision “based on sound medicine” http://www.plannedparenthood.org/about-us/newsroom/press-releases/planned-parenthood-applauds-hhs-ensuring-access-affordable-birth-control-38582.htm (March 25, 2011). In this case, “science” and “medicine” were pitted against religious groups.
Particularly in the case of women’s health, this view regards the psychoanalytically inflected patriarchal attitudes prevalent in mid-twentieth-century medicine as a thing of the past.

Critics of contemporary biomedicine argue that the healthcare system does not take culture, context and the individuality of the patient into account. People are reduced to numbers, test results and data that allow doctors to more accurately assess their condition and provide an equitable and ethical level of care without prejudice or subjective influence. Though many believe we have gone too far in this direction and are pushing to bring a sense of humanity back into medicine, this dissertation illuminates some of the forces that supported this break towards depersonalizing the concept of the patient, and also questions how successfully contemporary biomedicine has been sanitized from what seem like antiquated preconceptions from its recent past. Theories and assumptions about women have always been inextricably tangled in clinical knowledge, and the history of this entanglement is central to understanding the Pill.

This dissertation is a study of shifts concerning the meanings of mind and body in women’s reproductive healthcare. Though the contraceptive pill is now understood as a commonplace product with well-understood modes of action on the body, this was not the case in 1960. The Pill’s effects on the body and mind, and on women’s conceptions of themselves and their relationships to others was uncertain, and experts of all kinds seized upon the opportunity to speculate about what the Pill could bring, for better or for worse. The perceived meanings of the Pill called into question the complicated relationships between women and men, doctors and patients, and the roles of pharmaceuticals, hormones, and the psyche in shaping

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5 Finding hidden values in supposedly value-neutral science and medicine is a long-standing tradition in feminist science studies. For example, see Donna Jeanne Haraway, *Simians, Cyborgs, and Women: The Reinvention of Nature* (Free Association Books, 1991).
bodily experience and medical belief. Psychological ideas about women’s reproduction, or lack thereof, shaped the history of the Pill, as the ability, or even the possibility, of pregnancy was fundamental to women’s social and cultural roles as well as to their senses of self.6

I became interested in exploring how medical experts viewed women’s psyches while flipping through 1960s issues of the gynecology journal *Fertility and Sterility*. Looking for an article on the side effects of birth control pills, amid the ads for antibiotics, anti-fungal preparations and birth control pills, I was bombarded by advertisements for “minor” tranquilizers and other psychotropic drugs. In a sea of black and white text punctuated by grainy diagrams, these vivid, provocative advertisements were the only images in color, and they commanded visual attention. I knew that these drugs were extremely popular and profitable beginning in the 1950s and 1960s, but I did not fully understand why they would be so heavily advertised in a gynecology journal.7 Postpartum depression and discomforts related to menopause and aging were represented as the types of women’s complaints that might be improved by a Valium prescription. In the *Journal of the American Medical Association*, the same prescriptions were advertised as drugs for men, but the complaints necessitating their prescription were completely different. Gastrointestinal complaints and high blood pressure resulting from the stresses of work were predominant complaints afflicting men in crisp business suits.

These cultural artifacts intrigued me and led me on a journey towards trying to understand how these images of women and men as patients made sense to doctors at the time. I was not drawn to the difficult task of trying to understand patients’ experiences per se, but to

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representations, and more specifically the concept of patient representations as the production of experts’ beliefs and imaginations. Reflecting upon the level of mediation implicit in most medical sources, historian of medicine Harry Marks wrote, “I have yet to encounter a source that would tell me much about patients, other than as researchers imagined them.” Though historians of medicine have done important work uncovering the patient experience, I have taken the question of how researchers and other experts “imagined” their patients not just as an incidental finding, but as the subject of my own inquiry.

I locate and trace these ideas about women through four settings: psychiatry, pharmaceutical marketing, obstetrics/gynecology, and health feminism. While these four ways of viewing the Pill developed concurrently, each set of historical actors framed their new forms of knowledge in relation to change, and the risks associated with change. Psychiatrists aimed to understand the Pill because they believed the prospect of women reliably controlling the ability to get pregnant would cause unprecedented emotional and social reactions. Marketers and those concerned with the emerging study of medication “compliance” believed that women might not take the Pill as prescribed, and that physicians might have reservations about patients managing their own medication regimens. Obstetrician/gynecologists worried about overpopulation, the sexual revolution, changing doctor-patient relationships, and the need to produce new physicians able to persuasively address the social responsibilities of their profession. Women’s health movement activists, rather than responding to change, sought to create it by critically analyzing knowledge about the Pill, and creating new models for analyzing and dealing with health risks based on women’s experience. In each of these four arenas, women challenged medical authority and claimed responsibility for managing the risks associated with the Pill.

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A Context of Ambivalence and Risk

The history of the Pill mirrors Ulrich Beck’s description of a transition between a modern, industrial society concerned with the distribution of “goods,” to a reflexive “risk society” most concerned with the distribution of “bads.” In Beck’s model, scientific and industrial developments result in sets of risks, the individualization of social agents, especially women, and the “demonopolization of scientific knowledge claims.” Risks defined evaluations of the Pill throughout the 1960s, and women increasingly took on responsibility for managing these risks. The women’s health movement’s critique of the Pill demonstrates the components of the “risk society” that Beck outlines in his model, arguing that “the more successfully the sciences have operated in this century, that much faster and more thoroughly have their original validity claims been relativized.” In addition to challenging the scientific monopoly on truth about the body, it demanded that women live with and manage the risks of the Pill themselves, rather than count on experts to make the right decisions. In addition to Beck’s “risk society,” the history of the Pill is also intertwined with several other theorizations of the development of contemporary biomedicine.

The history of the Pill throughout the 1960s followed the lines of “mutation” that Nikolas Rose uses to characterize the changing meanings of “life itself” in 21st century biopolitics. Rose finds an increasing emphasis on individual responsibility, and this is particularly evident in the field of health, where patients are urged to become “active and responsible consumers of

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10 Ibid., 156.
11 Ibid., 163.
medical services and products,” managing their own affairs. Rose argues that contemporary biotechnologies, including pharmaceuticals, allow individuals to experience themselves in new ways. Though experts concerned with the psychology of the Pill in the 1960s used different language, it was the possibility of patients’ self-transformation that raised concern. Indeed, the Pill elicited many of the shifts that Rose sees as indicative of contemporary biopolitics including “novel forms of authority and expertise,” and fields of knowledge weighted with ethical and political meanings.

It is no surprise that multiple sets of meanings surround pharmaceuticals. Different types of experts and patients see the Pill from unique vantage points, and individuals can regard drugs with ambivalence, experiencing their multiple meanings simultaneously. Emily Martin’s ethnographic work on psychotropic drugs in the contemporary US reveals that Americans view pharmaceuticals both positively and negatively yet, despite this ambivalence, ingest them in massive quantities. Martin explains that the dangerous parts of the American pharmakon are displaced by social processes and hidden from direct view. From looking at sales figures, it would be easy to draw the conclusion that Americans take on new forms of self-management using mind-enhancing and mind-altering drugs unreservedly. However, Martin’s ethnography reveals that this is not the case, and people have complex and conflicted relationships with the drugs that they take.

I argue that the same is true of the contraceptive pill in the 1960s. Despite the common assumption that the Pill was greeted enthusiastically and without reservation among those who

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13 Ibid., 4.
14 Ibid.
15 Emily Martin, “The Pharmaceutical Person,” *BioSocieties* 1, no. 03 (2006): 274. The Greek word pharmakon is used to illustrate that pharmaceutical remedies can also be interpreted as poison.
16 Martin uses the ancient Greek word ‘Pharmakon,’ which meant both remedy and poison. Much of the danger of the pharmaceutical industry is displaced through the process of exporting clinical trials. See Adriana Petryna, *Life Exposed: Biological Citizens After Chernobyl* (Princeton University Press, 2002).
took it, varying levels of ambivalence were present, though often displaced, unrecognized or hidden. This project traces Americans’ ambivalence with the pharmakon further back historically, and explores how doctors and patients managed their ambivalence about drugs before there was a unified system for measuring, codifying and displacing side effects. Ambivalence and risk are closely linked. As Robert Nye has observed, “our postindustrial ‘risk’ society presents us with a rage of dangers between which we must, but yet cannot choose, inducing a persistent condition of personal ambivalence that has become the psychological trope of our times.”\(^{17}\) This project analyzes the contraceptive pill as a marker of this new era and explores how doctors and patients managed the risks and uncertainties surrounding the Pill.

There is little historical work on the psychological space opened up by the Pill. In the psychoanalytic ethos of the 1960s, reproduction was fundamental to women’s lives. The importance of motherhood in the psychology of women had already been firmly established in the 1940s by Helen Deutsch, an internationally renowned expert on female psychology and follower of Freud.\(^{18}\) Deutsch regarded maternity and childbirth as biological imperatives, and the psychological foundations of femininity.\(^{19}\) Later, Therese Benedek’s work in the 1950s represented a methodological reorientation in the psychology of women away from the primacy of anatomy, as indicated by Freud, and towards physiology.\(^{20}\) Benedek understood the menstrual


\(^{19}\) Buhle, \textit{Feminism and Its Discontents: a Century of Struggle with Psychoanalysis}, 198.

\(^{20}\) Ibid., 200.
cycle and particularly the pattern of hormonal fluctuation as playing a central part in women’s emotional life.\(^\text{21}\)

As understandings of women’s psychology privileged anatomical, biological, physiological, and hormonal explanations over the course of the 20\(^{th}\) century, reproductive processes remained central. The Pill had the potential to alter aspects of all of these frameworks, and its implications were significant to a wide range of health professionals. Grete Bibring’s psychoanalytic work on the psychology of pregnancy explained the implications of cultural change on women’s psychological adaptation, as well as implications for how to treat pregnancy in obstetrics/gynecology. Bibring found that pregnancy was usually a maturational and gratifying experience for women, though on occasion it would reinforce existing neurosis.\(^\text{22}\)

Writing in the 1970s, Bibring believed that since the late 1950s and early 1960s, there had been “a major shift in the self-image of many women and in the cultural changes toward freedom of choice for them with regard to pregnancy and childbearing.”\(^\text{23}\) Still, she was certain that the main issues had not changed. Despite the fact that contemporary young people had “progressed to a more independent, dispassionate perspective” and had carefully developed ideas about parenthood and sexual relations, they privately complained about a range of symptoms ultimately stemming from “persistent unconscious anxieties and guilt” about their sexual experiences.\(^\text{24}\) Thus, she concluded “cultural changes, which on the surface appear to come


\[^{22}\text{Bibring and Valenstein, “The Psychological Aspects of Pregnancy,” 369.}\]

\[^{23}\text{Ibid.}\]

\[^{24}\text{Ibid., 369–70.}\]
about quickly, may take generations to affect the biopsychological substratum, if they do so at all."25

What, then, were the implications of the Pill on the psychology of women? The Pill was an exemplar of women’s new position regarding freedom over pregnancy and childbearing, and it opened up the whole of women’s psychology to pharmaceutical tinkering. Furthermore, it was unknown if adjustment to cultural changes could be accomplished in the course of generations, or if it was even possible at all. The unknown impact of the Pill on the psyche dominated the concerns of psychiatrists in the first part of the 1960s, and over time these initial anxieties developed into a number of specialized issues. Psychological experts identified outright fear of pregnancy, as well subconscious, conflicted emotions about pregnancy as deep motivators for women’s and sometimes men’s thoughts and behaviors. Forgetting and memory became central as an emerging science of compliance considered whether women would be able to reliably take their pills at home, and notions about what would be appealing to doctors and patients were reflected in the marketing and packaging of various pill regimens. In light of the sexual revolution, many were concerned with the nature of sexual impulses and their control. Perceptions of social change led to the psychological study of the doctor-patient relationship as well as the place of sexuality in the medical school curriculum. Women’s liberation activists also considered the impact of the Pill on women’s roles and relationships. In sum, the Pill served as a canvas onto which debates over challenges to women’s nature were projected, and the political valences of the Pill shifted accordingly.

The historical actors appearing in this narrative are not just psychologists and psychiatrists, but a range of experts who mobilized claims about the psyche to theorize the

25 Ibid., 370.
impact of the Pill. Gynecologists, social workers, family life and sex education specialists, social workers, marketers, pharmaceutical executives, biologists, sociologists, demographers, activists, and population control experts all appear. These specialists invoked the language of the psyche and emotion in making claims about the Pill in order to achieve a broader impact on public life over the course of the 1960s. Ellen Herman described the widening scope of psychology in society as a “romance” that enabled psychological experts to carve out a “progressively larger sphere of social influence” during this time period.\footnote{Ellen Herman, \textit{The Romance of American Psychology: Political Culture in the Age of Experts} (University of California Press, 1996), 2.} In Herman’s description of a “wide-ranging campaign to infuse society with psychological enlightenment,” she covers most of the social sciences, as well as work carried out by interdisciplinary teams.\footnote{Ibid.} I take an approach similar to Herman’s in conceptualizing the broad scope of psychological expertise. Thus, identifying a psychology of the Pill contributes to the larger project of understanding how psychological insights were effectively exported throughout a range of settings.

**Pill Historiography**

This account begins in 1960 after the Pill first went on the market for use as a contraceptive. In the history of medicine, the 1960s are not known so much for any single “magic bullet” advance like the germ theory, antibiotics, anesthesia or surgical technique, but for changes in power dynamics and interpersonal relationships. The women’s health movement and consumer rights movements, new rules concerning drug regulation that empowered the FDA, informed consent and human subjects regulation shifted power relations and perceptions of
While most histories of the Pill have concentrated on its pharmaceutical development, including the phases of research, approval and clinical trials, I am shifting the focus to how perceptions of the Pill changed after it became available. This provides a clear opportunity to chart the Pill, from its first iteration as twenty identical white tablets in a brown bottle in 1960, to the elaborate and complex variety of forms, colors, packages and regimens that came soon after. Much of what characterized of the early era of the Pill had changed by the time this dissertation ends in the early 1970’s; the Pill had become more commonplace, and reproductive healthcare and abortion laws had changed. Concerns about overpopulation fueled several volumes on psychology and population, which represented the height of this field as a subject of research, though it would soon fall out of favor but not disappear entirely. Psychological perspectives on contraceptive use appeared as late as the 1980s, and “ambivalence” about pregnancy was later reconfigured as an explanation for intermittent contraceptive and condom use by innovative, feminist public health researchers. Concerns over the Pill’s safety shifted to the dangers of concurrent cigarette smoking and use in women

29 There is a connection between abortion politics and the research on emotional effects of the Pill. Both types of research theorize emotional problems that arise in women when supposedly natural processes of childbearing are medically interrupted. For example, Rosalind P. Petchesky, Abortion and Woman’s Choice: The State, Sexuality, and Reproductive Freedom (Northeastern University Press, 1990); Leslie J. Reagan, When Abortion Was a Crime: Women, Medicine, and Law in the United States, 1867-1973 (University of California Press, 1998); Rickie Solinger, Wake up Little Susie (New York: Routledge, 2000).
over the age of 35. In addition to Roe v. Wade, 1973 also marked the transition between the pills of the 1960s, which frequently contained 50 micrograms of estrogen, and the emergence of the 35 microgram pills that were used in the 1970’s, 1980’s, and later.

The Pill has been credited as being the first prescription drug given to healthy patients without the intention of curing or preventing a disease, the first drug to have its own “compliance dispenser” to help with its dosing regimen, and one of the first drugs to include a patient safety information insert. The pill came out of developments in reproductive endocrinology, a marginalized discipline, and was surrounded by controversy from the very start. A number of themes characterize the history of the Pill: the opposition of the Catholic Church and related concerns about morality, the relationship between the Pill and the sexual revolution, debates over the Pill’s safety and role in reforming drug labeling and sparking feminist protest.

Elizabeth Watkins’ book, *On The Pill: a social history of oral contraceptives, 1950-1970* is a foundational history that analyzes the social forces at play that encouraged the development, acceptance and controversy surrounding the Pill. The major contributions of this book are chapters focusing on the debates surrounding the Pill’s safety, culminating in the 1970 Senate hearings, discussions of informed consent, and the patient safety information insert. Lara Marks, Base

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a British historian of medicine, has contextualized the Pill in a wider, global context in *Sexual Chemistry*. Marks compared the use of the Pill in the U.S. and Great Britain, and also wrote extensively about the pill trials and health risks of thrombosis and cancer. The strengths of *Sexual Chemistry* are its international perspective and especially the careful and detailed treatment of the early scientific development of the Pill.

Andrea Tone’s book *Devices and Desires: a history of contraceptives in America*, is also broad in scope; it covers all forms of contraception from over the twentieth-century and brings a business history perspective to the topic. Tone’s chapter on the Pill drew my attention to the “problem of patient compliance,” the prevalence of anti-anxiety drugs, and men’s psychological reactions to the Pill. Tone aims to understand the everyday practices surrounding Pill usage, and thus looks beyond the most popular public controversies and scientific development stories that generally characterize the history of the Pill.

The strength of the existing literature is that it tells a comprehensive and detailed story of how the Pill was developed and adopted. The post-1960 historiography is focused on the major moral and safety controversies that arose, with less emphasis on the subtleties of how these controversies shaped the conventions surrounding Pill use. For example, the literature has made it clear that the Pill changed the relationships between doctors and patients and was part of a larger movement towards medicalizing birth control and reproduction. However, the details of these changes are unclear and often left unchallenged as uncontroversial rules of medical necessity. The fact that doctors told women to return for refills every six months or year, for

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example, or to take a certain number of pills in a row each cycle, were not arbitrary choices but concrete decisions at a time when the conventions of women’s reproductive healthcare were in rapid transition.

Analyzing the psychiatry and gynecology research on patients’ emotional reactions to contraception illuminates how patients mattered to the development of oral contraceptives, and more directly, how experts conceptualized and described the users of these drugs. Ideas about contraceptive users were inscribed into the packaging, regimens, and marketing of the Pill. Pharmaceutical packaging is an understudied but fascinating area and the birth control pill is an exemplary case with which to explore this issue because of its compliance packaging, patient safety information inserts, and especially because of the many different regimens and variations that went on the market. As with any exceptionally profitable pharmaceutical product with a broad market, the makers of each brand went to great lengths to stand out in the minds of critical doctors and consumers.

The popularity of the Pill meant that healthy women were suddenly much more likely to be subject to cancer screenings and inquiries into their sexual health. These norms of surveillance became cemented in conjunction with the norms of writing prescriptions. The field of obstetrics/gynecology, and to a lesser extent family practice and marriage counseling, seized upon popular interest in the pill as ways to carve out professional territory and expand the scope and importance of their fields. The women’s health movement brought attention to the gendered power inequalities in American medicine and the lack of informed consent surrounding the pill, which meant that most women in the 1960s took the pill without adequately understanding the

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risk of deadly physical side effects, such as blood clots and strokes.\textsuperscript{38} This project analyzes the feminist response in the context of a new psychology of women that at times drew from and reacted against the past.

**Psychotropic Historiographies**

My study builds on an already-strong scholarship addressing the gender dynamics of diagnosis and psychotropic drugs as they related to representations of patients in the 1960s and 1970’s. The advent of modern clinical pharmacology and dramatic changes in drug regulation also occurred during the 1950’s and 1960s. In particular, anti-anxiety medications became the best selling drugs in pharmaceutical history, and the majority of the patients taking these in the 1960s were women. Because cold war political culture was intimately tied up with concerns about creating and maintaining the ideal, healthy American family, historians such as Elaine Tyler May have shown how the culture of experts diffused into the domestic sphere. This meant that consumer choices, gender relationships, and the pills that kept families physically and psychologically healthy were deeply charged. Historians have relied heavily on concepts of medicalization, consumerism, the role of experts, and “cold war culture” in order to make sense of pharmaceuticals. The concept of expert knowledge, and challenges to it, play an important role in the historiography of medicine and gender in the 1960s.\textsuperscript{39}

Jonathan Metzl has explained how anti-anxiety drugs were not just prescribed to treat serious mental illnesses, but were seen as prescriptions for “the pressures of motherhood, single-

\textsuperscript{38} Barbara Seaman, *The Doctors’ Case Against the Pill* (New York: P. H. Wyden, 1969). This is a formative text as the women’s health movement related to birth control pills. Some of the controversy over side-effects died down as the extremely high doses of estrogen in the early pills were progressively lowered to more tolerable levels.

hood, and other historically specific forms of essentialized womanhood. The culture of consumption, paired with the often restrictive roles of housewives, helped to cement the popularly imagined link between white, middle-class women and psychotropic drugs. These anti-anxiety drugs were framed not just as important for keeping women happily in the domestic sphere, but as important to the functioning of a successful household with a breadwinner husband and well-adjusted children.

Metzl shows how psychoanalytic ideas about gender did not fall by the wayside as psychiatry transitioned to a field driven by neurotransmitters and their regulation by pharmaceuticals. In fact, Metzl argues, gender norms were actually reinforced, as they became instantiated in the new paradigm of biological psychiatry. Metzl’s argument has not been extended to non-psychiatric fields of medicine, yet the same Freudian logic can be traced in the history of the Pill; the supposedly sanitized, biologically-based answer to contraception. The gender ideology so evident in the historical study of Valium can also be located in non-psychotropic medicines and treatments as well. Since healthy women were more likely to see a gynecologist or general practitioner than a psychiatrist, especially if they were having children or regularly taking prescription oral contraceptives that needed refilling over the course of years, these doctors, and not psychiatrists, ushered in the first wave of psychopharmacology. This study suggests that gynecologists, in particular, may have been even more important in the processes of pharmaceuticalization than historians have previously recognized.

40 Metzl, Prozac on the Couch, 71.
41 An example of this type of work is Carolyn Herbst Lewis’ work on the premarital pelvic exam. Lewis illustrates the role physicians played in linking marital stability with community security. Rather than leave the job of a wife’s initiation into healthy heterosexuality to a bumbling bridegroom, gynecologists worked to help make sure brides would make a smooth adjustment. Carolyn Herbst. Lewis, “Waking Sleeping Beauty: The Premarital Pelvic Exam and Heterosexuality During the Cold War,” Journal of Women’s History 17, no. 4 (2005): 86–110.
42 Andrea Tone found that minor tranquilizers were most likely prescribed by generalist physicians in the 1950’s. By 1960, only a small minority of those providing tranquilizers were psychiatrists. Andrea Tone, The Age of Anxiety: A History of America’s Turbulent Affair with Tranquilizers (Basic Books, 2008), 90–91.
Scholars have also argued for why pharmaceutical marketing mattered in the postwar era in a way that is utterly unfamiliar to those of us who have grown accustomed to the recent history of direct to consumer advertising.\footnote{Martin, “The Pharmaceutical Person.”} Historians Jeremy Greene and Scott Podolsky have written about pharmaceutical marketers as respected physician educators and valued partners in keeping up to date with the latest knowledge.\footnote{Jeremy A Greene and Scott H Podolsky, “Keeping Modern in Medicine: Pharmaceutical Promotion and Physician Education in Postwar America,” Bulletin of the History of Medicine 83, no. 2 (2009): 331–377; Jeremy A. Greene, “Attention to ‘Details’: Etiquette and the Pharmaceutical Salesman in Postwar American,” Social Studies of Science 34, no. 2 (April 1, 2004): 271–292; Jeremy A. Greene, Prescribing by Numbers: Drugs and the Definition of Disease (The Johns Hopkins University Press, 2008).} Relying on interviews with employees in pharmaceutical marketing and sales, Emily Martin has shown how pharmaceutical advertisers played a substantial role in educating doctors about depression in the 1950s and 1960s, and how these employees make sense of their own work.\footnote{Emily Martin, “Pharmaceutical Virtue,” Culture, Medicine and Psychiatry 30 (July 12, 2006): 157–174.} In order to educate physicians, pharmaceutical companies collaborated with psychiatrists, such as Frank Ayd, to develop lists of “target symptoms” of particular conditions. Detailmen taught these symptoms to doctors, who then repeated them back when asked how to recognize a diagnostic category, all too clearly illustrating the workings of Ian Hacking’s concept of “looping effects of human kinds.”\footnote{Ian Hacking, “The Looping Effects of Human Kinds,” in Causal Cognition: A Multidisciplinary Approach, ed. Dan Sperber, David Premack, and Ann James Premack (Oxford University Press, USA, 1996), 351–383. Detailmen were the marketing representatives who informed doctors about pharmaceuticals.} In the case of the contraceptive pill, many patients were able to recognize the “symptom” of wanting to prevent pregnancy and present themselves as ready patients, while others had to be screened, encouraged, or even coerced into taking the Pill.

Though “detailing” the Pill to physicians was unique in that pharmaceutical companies and salespeople needed to broach the subject delicately so as not to offend certain doctors,
pharmaceuticals played an important role in the “expanding postwar consumer culture.”47 While the antibiotics of the 1940s were known as the first modern pharmaceutical “magic bullets,” the pharmaceutical breakthroughs of the 1950’s and 1960s were associated not only with curing acute diseases, but with modifying everyday mental states and preventing chronic conditions such as high blood pressure.48 This was also part of a broader transition from health interventions focusing on discrete disease entities that could be prevented with a single vaccine or cured by a single round of treatment to a model of diagnosing and treating chronic diseases and conditions that rendered people patients for much of their lives.

David Herzberg notes a shift in which not only medications and their markets grew, but consumer culture refigured the medical system so that doctors and patients became consumers. Herzberg writes, “Like suburban houses, new cars, and washing machines, medicine became part of a new consumerist ‘American dream’ that reconfigured conceptions of what a good middle-class life—what happiness itself—ought to be like.”49 The Pill was consistent with the transformations that Herzberg and other historians of pharmaceuticals the postwar era describe. Reliable family planning that allowed for children to be timed and spaced cohered with visions of an idealized, happy family. Beyond this, the Pill implied a certain lifestyle. It not only connoted freer sexual relations, but it was a way of experiencing and mediating bodily experience. Like Valium, which could be used to mediate nervous tension and anxiety, the Pill regulated the menstrual cycle, alleviated cramps and pimples, and allowed a woman to control

47 David L Herzberg, Happy Pills in America: From Miltown to Prozac (Baltimore: Johns Hopkins University Press, 2009), p.4 on the "detailing" of physicians, [Interview with Percy Skuy, founder of the world’s largest collection of contraceptive devices and retired pharmaceutical executive, personal communication, 6/10/09.]
48 Greene, Prescribing by Numbers: Drugs and the Definition of Disease.
49 Herzberg, Happy Pills in America, 4. Also see Lizabeth Cohen, A Consumers’ Republic: The Politics of Mass Consumption in Postwar America (Vintage, 2003); May, Homeward Bound.
aspects of her bodily experience. From timing when to schedule a period to deciding when to get pregnant, the Pill offered a technological means of achieving one type of bodily control. These interventions offered possibilities for managing and optimizing the possibilities of the human body. The Pill, as a technology, embodied what Nikolas Rose terms “disputed visions of what, in individual and or collective human life, may indeed be an optimal state.”

Focusing on the contraceptive pill, my study does not replicate this work, but was greatly influenced by the way that historians of medicine have considered the overlapping metaphors found in medical advertisements and other representations as they figured into medical profession and practice. What if the same types of analysis that historians of medicine have brought to Valium were applied to a supposedly non-psychotropic drug? Though advertisements are only a very small part of this study, their colorful, provocative presence cued me in to the question of how patients were imagined, pictured, idealized, and symbolized by all sorts of producers of medical knowledge.

Outline of the Project

This dissertation is about the operation of different types of expertise, and each of the remaining chapters is structured around a particular type of expert knowledge; psychiatry, pharmaceutical packaging and marketing, obstetrics/gynecology, and health feminism. Throughout the 1960s, these experts all struggled to define and maintain authority in relation to

50 In the 1960s, the Pill was promoted for what might be considered cosmetic purposes including the promises of clearer skin and larger breasts. See Robert Kistner, The Pill: Facts and Fallacies About Today’s Oral Contraceptives (Delacorte, 1969). The Pill promoted the “popular vision of bodily modernity” that Laura Freidenfelds would call the “modern period.” See Lara Freidenfelds, The Modern Period: Menstruation in Twentieth-Century America, 1st ed. (The Johns Hopkins University Press, 2009).

51 Rose, The Politics of Life Itself, 6. The emergence of the Pill to some extent fits all of the “mutations” that Rose develops to characterize 21st century biopolitics (molecularization, optimization, subjectification, somatic expertise, economies of vitality).
the Pill as the cultural and medical landscape shifted.

Chapter 1 takes the theme of uncertainty and ambivalence as an entry point, looking at psychiatrists’ concerns with emotional reactions to the Pill. Some believed that there was a physiological basis for patients’ reactions to the Pill, while others argued that most side effects were essentially subjective or psychological responses. In practice, there was no clear way to distinguish between the two, as hormones, synthetic or natural, were believed to affect both the mind and body. Pharmaceutical companies, family planning agencies, and private physicians struggled with questions over how to manage patients’ complaints of various unexpected side effects and reactions. In many cases, psychiatrists and gynecologists collaborated in order to try to untangle the impacts of the Pill on women’s psyches, feminine identities, and the interpersonal dynamics of men and women’s sex roles in marriage. Though clear answers never emerged, the research functioned to produce a body of contested knowledge about the psychological impact of the Pill that reflected conflicted and shifting views about the meanings of controlling reproduction.

Chapter 2 explores the emerging concept of the contraceptive pill as a daily regimen that was integrated into women’s lives with the help of pill dispensers, packages and patient instruction manuals. These materials provide a rich source of information about the way in which taking a pill every day became normalized, and how patients and medical experts oversaw and managed this shift. The information and advertisements directed towards physicians painted images of anxious and ambivalent women who were apt to forget to take the Pill and were generally in need of supervision. Representations of women’s pill-taking, exemplified by the “compliance package” invented for the Pill, reflected notions of deep-seated ambivalence evident in the psychiatry research featured in Chapter 1. Thus, popular perceptions of women’s psyches
were reflected in the way the Pill was packaged and marketed to physicians.\textsuperscript{52}

Chapter 3 explores the Pill in relation to the social changes that came to be associated with it; namely the moral consequences of the sexual revolution and concerns about excessive population growth. However abstract and divorced from the contexts in which the Pill was most often prescribed, conceptions of these broad-based social problems provided a forum for obstetrician/gynecologists to articulate concerns over the “social responsibility” of their profession. While the Pill had the potential to curb unwanted births and population growth, it was also perceived as fueling immoral sexual behavior. But regardless of personal views, physicians recognized the Pill as an effective strategy for bringing women into their offices during a time when their professional authority seemed threatened. Not only were doctor-patient relationships and the conventions that shaped these interactions in flux, but so too were the relationships between physicians, medical students and nurses. Physicians recognized an imperative to train the next generation of medical students to manage the challenges associated with shifting structures of authority in the context of the sexual revolution.

Chapter 4 considers the reconfiguration of expert knowledge promoted by the women’s health movement. At the end of the 1960s and into the 1970s, women challenged, appropriated, and redefined the stakes of expertise surrounding the Pill. Safety concerns catalyzed national attention, Senate hearings and regulatory reform. The initial refusal to consult women as patients or as experts in these proceedings became a subject of debate and protest. At the same time, other women’s health activists focused their attention on what the Pill meant for their lives and interpersonal relationships, and in the process developed new understandings of women’s minds.

and psyches. Other feminists believed that the Pill was obscuring attention from issues of greater importance, or being promoted due to racist and imperialist motives. Controversy over the Pill did not unite women, but revealed fault lines and conflicted relationships. Still, by the early 1970s, the Pill no longer seemed quite as remarkable as it had in 1960. Access was more freely available and the decision to take the Pill, or not to take it, became accepted as a routine part of women’s healthcare.

Taken together, each of these chapters provides a glimpse into how a different type of expert imagination shaped the history of the contraceptive pill and the history of women’s health more broadly. The overall arc of this project traces the Pill from its inchoate beginnings on the market and in the clinic, to its place as a lightning rod at the center of debate, to its relative ubiquity. Though not all women embraced the Pill, its impact on women’s healthcare was unavoidable. The existence of the Pill framed discussions of control over reproduction, menstruation, medical care and access to drugs. Expert understandings of women minds, as well as their bodies, have shaped and continue to shape understandings of what is natural, and what is possible.
In 1962, the Pill was quickly on its way to becoming the leading method of birth control chosen by American women. Though there were only about a million women using oral contraceptives in 1962, the numbers quickly increased.¹ By 1965, about a third of all married women had tried the Pill, and married women counted it as the most frequently used method of birth control.² While there were still doubts about the long-term safety risks of the Pill, and it was only initially FDA approved for continuous use for 2 years at a time, ongoing research signaled a positive future. There was general agreement that a woman was essentially 100% protected from ovulation, and therefore pregnancy, if she took an Enovid tablet containing 9.85 mg of norethynodel, a progestogen, and 0.15 mg of mestranol, an estrogen, each day for 20 days in a row each menstrual cycle. G.D. Searle, the manufacturer of Enovid, the first oral contraceptive, was conducting studies to keep track of adverse events, and several pharmaceutical companies were poised to release competing products with much lower levels of

² Elizabeth Siegel Watkins, *On the Pill: A Social History of Oral Contraceptives, 1950-1970* (The Johns Hopkins University Press, 2001), 61. This is based on data from the 1965 National Fertility Study. Parts of this chapter were presented as: “Psychiatry, Gynecology, and the Effort to Understand Emotional Reactions to Oral Contraception.” American Association for the History of Medicine, Case Western Reserve University, Cleveland, OH, April 2009.
hormones in the near future. Detailed medical information was not easily available to patients, and physicians were in charge of collecting information, controlling access, and managing risks.

Researchers generally agreed that the physiology of the Pill, though still under continuous study, was understood on its most basic level. The successes of the “golden age” of steroidal chemistry revealed the basic structures of estrogen and progesterone, how to synthesize them, and how they influenced reproduction. With the long developmental phase of the Pill completed, including years of experiments on rats, rabbits, and women in Massachusetts and Puerto Rico, it seemed that the basic workings of the Pill had been resolved. With these successes, and the immediate realization that the Pill was one of the most socially, morally, and politically charged developments of the time, researchers came to address a broad range of issues raised by the Pill. With the perception that the more concrete and technical problems of the physiology of the Pill were solved, researchers were able to consider some of the less obvious, psychological factors that influenced its use. Beyond the basic issue of the safety of the Pill, a variety of more subtle doubts about the psychological meaning and experience of contraception began to emerge. While the available research techniques were well suited to study physiology and to record serious physical side effects, there was not an established language for exploring some of the more complex and amorphous doubts that emerged in the early years of the Pill. Psychiatry was the medical discipline that seemed best suited to theorize these issues, but other medical specialties and social science disciplines contributed as well.

Since many of the concerns that surfaced as a result of the Pill seemed completely unprecedented, each individual healthcare provider, whether a psychiatrist, an obstetrician/gynecologist, a psychologist or a social worker, struggled to approach the issues that

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arose. In an attempt to summarize these reactions, the authors of an article based on a survey of physicians and their attitudes toward family planning concluded that physicians harbored a “persistent ambivalence.”⁴ Since procreation was such a meaningful part of life, “any attempt at a ‘rational solution’ of the population explosion by means of contraception meets with objections which stem from the depths of a person’s aesthetic, ethical, and religious feelings.”⁵

Struggling with these issues, a variety of researchers explored the question of the psychology of the Pill in the 1960s. Psychiatrists and gynecologists tried to understand the psychological impact of oral contraception on their patients, while others tried to understand how matters of the psyche influenced research findings and physician attitudes. Though it may have seemed to researchers at the time that the physiological issues surrounding the Pill were better understood than the psychological ones, the two research programs were carried out simultaneously. There was even a potential for disagreement between the two modes of thought. One the one hand, some physicians argued that there was a physiological basis for reactions to the Pill, while on the other hand, some argued that these reactions were essentially emotional responses. Not only did these contrasting views represent different causal models, but they also had different practical meanings and uses. With little uniting the researchers on the psychology of the Pill, their research questions and methodologies spanned the disciplines and were quite elastic and variable. Still, the Pill posed a variety of new problems in the minds of physicians, and psychological explanations were persuasive and useful in helping them make sense of the Pill in a number of contexts.

⁵ Ibid.
First, the Pill was unique in that it was a prescription drug that did not cure a specific disease and it was to be taken by healthy patients over a relatively extended period of time. This meant that patient acceptance and side effects were a particularly pressing issue. G.D. Searle, the manufacturer of Enovid, supported many of the published studies on the emotional effects of the Pill. Searle was based in Skokie, Illinois, and despite some initial hesitancy and reservation, Enovid turned out to be enormously profitable. The company’s sales increased from $37 million in 1960 to $89 million in 1965, with profits of $24 million in 1964 alone. Thus, Searle had a great interest in supporting any research that might help illuminate some of the practical issues surrounding patient acceptance of the Pill and the finer points of side effects. While side effects from pharmaceuticals were nothing new, the Pill seemed to have a variable and endless list of side effects whose causes were unknown. Many of the side effects were so vague and common, in fact, that researchers postulated that the causes of these side effects were probably psychological rather than physiological. The issue of whether the side effects were physiological or psychological was quite important. If reactions to the Pill were based on physiological responses, then the problem was based in the formulation of the Pill, and it was essentially the manufacturer’s responsibility to develop a new and improved formulation. If, however, the problem was in the patient, or in the patient’s mind, then the side effects were beyond the scope of what could be controlled by changing the components of the drug. An entirely different set of responses, aiming to address attitudes and perceptions of the drug, would be in order.

Searle was also deeply concerned with the most serious and noticeable side effects, such as blood clots, as these could quickly lead to hospitalizations, deaths from heart attacks and stokes, and the attendant lawsuits. Historians, too, have focused their energy on uncovering the

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histories of these serious safety issues because the response to these issues would help to radically change the entire regulatory climate surrounding drug approval and the information available to patients.7 However, the more minor and subjective side effects were a serious concern for pharmaceutical manufacturers, doctors, and patients because they were far more commonly experienced, and patient acceptability determined how widely a drug would be sold. The purpose of the research on the minor side effects was not to write off women’s complaints as simply imagined, but to seriously understand the mechanisms that led to these complaints and potentially learn how to fix them. The research exploring the everyday experiences of side effects also provides additional insight into the processes of negotiation that resulted in the development of a major blockbuster drug.

A second practical issue that helped promote this research was the acute need to understand the frequency of side effects and adverse events for the sake of drug regulation. Since the hormones in Enovid influenced so many of the body’s systems, the side effects were incredible in their diversity and adverse events were hard to isolate. Ideas about patient psychology played a role in complicating the process of collecting these data, and these complications continued to intensify over time.

The Planned Parenthood Federation of America prescribed the Pill to thousands of women across the country and conducted the arduous task of trying to record the actual incidence of adverse events. The headquarters in New York did this by painstakingly tallying reports from telegrams they received from Planned Parenthood affiliated clinics.8 The large amount of information gleaned from these reports was useful to Searle, since Searle was trying to

8 Planned Parenthood Federation of America Records, Series II, Box 68, Sophia Smith Collection, Smith College, Northampton, Mass.
gain approval for the long-term use of Enovid. Searle developed a close relationship with Mary Steichen Calderone, the Medical Director of Planned Parenthood, and Alan Guttmacher, the President, and together, they endeavored to produce evidence that would prove that women using Enovid for longer than 2 years did not have an increased incidence of adverse events. Thus, Searle relied on the large number of patients being served through Planned Parenthood in order to use these women’s records as a data set. In exchange, Planned Parenthood received a discount on Enovid, but they also faced the difficult task of figuring out how to collect accurate information without overtly misleading their patients. Planned Parenthood was concerned about acting within the ethical standards in place at the time, but this was complicated because these standards were changing rapidly over the course of the study. Furthermore, telling patients that they were taking Enovid on an experimental basis or asking them too many questions might introduce fears into their minds and invalidate the findings. Thus, the seemingly objective task of recording the incidence of side effects became a complex test case on the psychological impact of the Pill.

Finally, fears of overpopulation in the US and around the world contributed to a sense of urgency surrounding issues of family planning. Since contraception seemed to be an emotionally charged issue, it made sense that psychological experts would be called upon to weigh in on the problem of family planning. Those interested in promoting family planning in the 1960s faced many frustrations and obstacles including widespread fear and skepticism as a result of the long history of eugenics and forced or coercive sterilization promoted by U.S. government programs. Thus, in addition to the belief that family planning was important, there was hope that a new, technologically advanced, effective and reversible method would prove to be more satisfactory to patients. The question of what would be acceptable to patients was a complex one, and “the
psychology of birth planning” eventually emerged as a means to understand why the Pill did not work as well as family planners had hoped. For a variety of reasons, the Pill did not quite turn out to be a panacea to the world’s problems in the spirit of the “magic bullets” that characterized popular understandings of progress in postwar medicine. Instead, physicians and patients alike expressed a vast array of concerns and uncertainties about the very concept of a contraceptive pill, and these concerns became the subject of research in and of themselves.

Psychiatrists such as Ruth W. Lidz at Yale conducted small and often informal research projects using their own patients’ reactions as data. Sometimes psychiatrists collaborated with obstetrician/gynecologists in an attempt to parse out bewildering patient reactions. While research psychologists and other academic researchers contributed to these projects, practicing physicians drove the majority of the early studies. This situation reflects the fact that the problems at hand emerged from issues arising in general practice. The researchers concerned with the psychological impact of the Pill were not necessarily most interested in research for the sake of increasing understanding, but were primarily concerned with problems they noticed in their practice. In addition, Searle funded many of the early studies, and this funding was provided to physicians, perhaps with the expectation that they would publish in medical journals read by others who could prescribe the drug. Researchers who received funds from Searle indicated the support in their published articles. Other pharmaceutical companies, too, had similar concerns as Searle, but there is not the same clear evidence that they financially supported research in the same manner.

**Context surrounding Enovid**

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One of the very first works to carve out a psychology of family planning was Lee Rainwater’s *And the Poor Get Children* (1960), a sociological and psychological study of sex, contraception and family planning in the working class. Rainwater’s study was conducted with the support and encouragement of the Planned Parenthood Federation of America, and the initial stage of the project was conducted with many interviewers and research assistants. The study was informed by Kinsey’s work on human sexuality, but it aimed to get beyond Kinsey’s method of “outlet counting” in order to understand the importance of sexuality in relation to contraceptive behavior and attitudes.  

Rainwater’s methodology relied on the extensive use of material paraphrased from interviews with study participants, and through these, Rainwater painted a picture of the relationships and interactions that comprised working-class life. The study participants came from a range of ethnic and religious backgrounds and were either urban residents of Chicago or rural migrants to Cincinnati. After a comprehensive discussion of social class and patterns, assumptions and orientations in family planning, Rainwater eventually came to classify the personality characteristics of women that made them either effective or ineffective contraception users.

Most of the women who were effective contraceptive users strove toward “mutuality” in their sexual relationships with their husbands, which meant that they recognized intercourse as a duty and understood its importance in making their husbands happy and their relationships solid. These women also tended to enjoy intercourse to some extent themselves, and had less conflict over using contraception. For this reason, the effective contraceptive users were particularly quick to accept the “feminine appliance” methods such as the diaphragm. The ineffective

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women, on the other hand, rejected their husbands and their feminine sexual identities and roles in marriage. Such women found intercourse repugnant and tried to avoid it as much as possible. These women also tried to avoid contraceptives, especially the diaphragm, because it required handling the genitals, and it also had unappealing “medical” connotations.”

Rainwater found a class differential between the effective and ineffective contraceptive users, with lower-lower class women more likely to fall into the rejecting, ineffective category than upper-lower class women. Thus, women at the bottom of the class hierarchy were plagued with greater numbers of unwanted pregnancies, and Rainwater cited the saying “the rich get richer and the poor get children.”

When speculating about whether or not poor women would be good candidates for an oral contraceptive, Rainwater was not optimistic. The lower class found it “difficult to plan consistently or to follow routines that do not seem ‘natural.’” Therefore, it seemed unlikely that these women would have the motivation to follow through with a strict pill-taking regimen. Moreover, participants in the study reported that they believed that a pill that would prevent contraception would be too potent, and it aroused “anxieties about being desexed, sterilized, poisoned, or damaged in some other way.” Thus, Rainwater warned that in order for oral contraceptives to be effective, family planners would need to provide a great deal of counseling and encouragement.

The idea that the Pill was difficult to take and required high motivation and intelligence emerged from the first large-scale human trials of Enovid in the 1950s, and has been a consistent concern for Planned Parenthood ever since. In fact, part of the reason why the first large-scale trials...

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12 Rainwater, *And the Poor Get Children: Sex, Contraception, and Family Planning in the Working Class*, 158.
14 Ibid., 166.
15 Ibid., 165.
trials were conducted in Puerto Rico was to see if the Pill was effective in a setting with high illiteracy and poverty. Puerto Rico also seemed like a convenient testing ground because there was an established network of birth control clinics, a history of population control and sterilization programs with U.S. involvement, and many poor patients interested in birth control. However, it is important to note that the initial need to conduct the trials outside of the continental United States was due to the fact that the Comstock laws were still in effect in many states including Massachusetts, where Gregory Pincus and John Rock were organizing the trials from the Worcester Foundation for Experimental Biology. The Comstock law in Massachusetts meant that it was illegal to provide contraceptives or to conduct contraceptive research. In the early phases of research, Rock was able to avoid this problem because he ran an infertility clinic and had been legitimately been using the compound that would become Enovid to treat infertility. Rock understood that Enovid prevented women from ovulating, and he thought that women might be more likely to become pregnant after a short course of progesterone.

In fact, when the FDA first approved Enovid, in 1957, it was indicated not for contraception but for short-term use for the treatment of menstrual and gynecological disorders such as endometriosis, infertility and miscarriage. Enovid carried a warning to doctors that the drug would prevent ovulation, and as women found out about this by word of mouth between 1957 and 1959, a suspiciously large number of patients came forth complaining of conditions that could be treated with Enovid. Though Enovid was only advertised in medical journals and not directly to patients, by the end of 1959, 500,000 Americans were taking Enovid. When

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17 Oudshoorn, Beyond the Natural Body: An Archaeology of Sex Hormones, 133. Direct to consumer advertising was not allowed at all before the 1980s, and uncommon until the FDA significantly relaxed regulations in 1997.
Enovid was approved for use as a contraceptive in 1960, it was only recommended that patients use it continuously for 2 years at a time. At this point, prescribing a drug to a healthy patient was a novelty, and the large-scale use of prescriptions for long-term, chronic conditions was also a new trend that was just taking off. In 1958, Merck released the drug Diuril for treating chronic hypertension, and this marked a new era in terms of preventative medicine with patients taking pills everyday not due to symptoms but due to “risk factors.” Therefore, when Enovid was approved, there was essentially no precedent for a prescription drug to be taken indefinitely by a healthy patient. The two-year time limitation was highly unusual as well, but it conveniently meant that the question of long-term safety could be postponed until more data were available.

Planned Parenthood and the “25 Month Club”

In October, 1962, Harriet Pilpel, legal counsel for the Planned Parenthood Federation of America, met with William Goodrich, the general counsel of the Food and Drug Administration, in Washington, DC. The purpose of the meeting was for the two lawyers to discuss the two-year limitation on the use of Enovid. Enovid had been approved for use as a contraceptive just over two years ago, and some of the first patients were coming up on their two-year anniversary on the drug.

All of the parties involved understood that doctors regularly prescribed drugs in ways that did not exactly fit the uses for which they were approved, and Enovid was certainly no exception. William Goodrich was aware that some patients would take Enovid for more than two years, and conceded to Harriet Pilpel “individual Doctors were free to act as they thought best

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18 Greene, *Prescribing by Numbers: Drugs and the Definition of Disease.*
regardless of the two-year limitation.”\textsuperscript{19} However, the issue at stake was that “if an individual
doctor did so proceed and ‘anything went wrong’ whether it be an attack of thrombosis or
anything else” then the doctor would “have very little chance in a malpractice action and might
even be prosecuted.”\textsuperscript{20} After Harriet Pilpel delivered this information to Dr. Alan Guttmacher,
President, and Dr. Mary S. Calderone, Medical Director of Planned Parenthood, they began to
devise a plan that would allow their patients to continue taking Enovid without risking a
lawsuit.\textsuperscript{21}

Several weeks later, Dr. Guttmacher and Dr. Christopher Tietze met with FDA
Commissioner Larrick to discuss these plans. Commissioner Larrick was enthusiastic about
Guttmacher’s proposition of “making our Planned Parenthood Enovid patients experimental
material for the accumulation of observations on long term use.”\textsuperscript{22} Guttmacher was also anxious
to initiate the program and worked with G.D. Searle to establish a protocol for supplying and
prescribing the Enovid for those in the study. Of course, since Enovid was not yet approved for
continuous use, Guttmacher assured the FDA that the patients “would be told that they were
taking part in an experiment and that they must agree before continuation on such terms.”\textsuperscript{23}

As Medical Director, Mary Calderone was charged with explaining the new Enovid
protocol in a letter she addressed to all Planned Parenthood affiliated clinics. Since the patients
continuing to take Enovid were technically in a study, they were subject to extra examinations
and more stringent surveillance. Calderone explained to her Affiliates that “the forms and
requirements sent to you have been agreed upon with the Food and Drug Administration, so no

\textsuperscript{19} Harriet Pilpel to Alan Guttmacher and Mary Calderone, October 5, 1962, Planned Parenthood Federation of
America Records Series II (PPFA II), Classified Files, Box 68, Sophia Smith Collection, Smith College,

\textsuperscript{20} Harriet Pilpel to Alan Guttmacher and Mary Calderone, October 5, 1962, PPFA II, Box 68, SSC.

\textsuperscript{21} Ibid.

\textsuperscript{22} Alan Guttmacher to Dr. Heino Trees, New Drug Division, FDA, November 12, 1962, PPFA II, Box 68, SSC.

\textsuperscript{23} Ibid.
modifications of the procedures will be possible. We realize that the extra examinations, etc. will add to the burden in centers and we regret the necessity for them, but Affiliates will surely realize that in the end such a study will be in the best interests of PPFA and its Affiliates.²⁴

Beyond the additional paperwork and examinations that increased the workload of the busy clinics, some Affiliates questioned whether they should bother telling the patients that they were taking part in a study at all. In 1962, just prior to the passage of the Kefauver-Harris drug amendments, physicians were under no obligation to tell their patients about the experimental nature of any drug they were given.²⁵ Disclosing this information was not standard practice, and doctors vigorously defended the status quo. Some were concerned, for example, that if they were forced to disclose the experimental nature of a given treatment, then they would have no choice but to tell a patient if he had a life-threatening condition.²⁶ In the early 1960s, physicians were not obligated to share detailed information with patients, and it was common practice to give a patient a prescription without even explaining what the drug was called or the reason it was prescribed. Pharmacists dispensed prescriptions, but were not supposed to provide the patient any information about the nature of the drug or the condition it was meant to treat.²⁷ With this kind of authoritative secrecy surrounding prescription drugs commonplace, it seemed fully within the realm of the physician’s judgment to withhold information about whether or not a drug was experimental.

Senator Estes Kefauver, however, was determined to expand the regulatory powers of the Food and Drug Administration so that new drugs would be tested for efficacy, and not just

²⁴ Mary S. Calderone to all affiliates, January 15, 1963, PPFAII, Box 68, SSC.
²⁵ Tobbell, Pills, Power, and Policy.
²⁶ Rothman, Strangers at the Bedside, 65
²⁷ Controversy arose over this issue and the conventions changed over the course of the 1960s. In the 1950’s, for example, physicians could prescribe Meprotabs if they did not want the patient to know they were taking Miltown, a psychotropic drug. Herzberg, Happy Pills in America, 46.
safety, as was required since 1938.\textsuperscript{28} The issue of whether patients should be told about the experimental nature of drugs was also central in the hearings Kefauver convened because news of the thalidomide tragedy in Europe was just becoming publicized. Thalidomide was prescribed to pregnant women as a treatment for morning sickness, but it quickly became apparent that it caused unusual and distinctive birth defects consisting of warped or missing limbs. Though thalidomide was never approved for use in the United States, senators at the hearings were shocked to learn that American women had taken thalidomide without their consent or knowledge.\textsuperscript{29} These women had taken the drug as part of a trial where the experimental nature of the drug was not disclosed. In the end, even though the 1962 amendments did not provide nearly as much regulation and protection as some senators had hoped for, the new regulations meant that physicians conducting research, including those at Planned Parenthood, were faced with new challenges and decisions in terms of how they would share information with their patients.\textsuperscript{30}

When Planned Parenthood Affiliates asked Calderone what to do about the new regulations, she struggled to balance the new rules with the research protocols. Calderone was careful to explain the new regulation that patients be informed, but she was reluctant to come up with any means of enforcement or standardization. Thus, Calderone told her Affiliates that “the new drug regulations state that it is advisable to tell patients who are taking part in a study, except if this would adversely affect the study or the physician-patient relationship.”\textsuperscript{31} The last point about whether or not telling patients would adversely affect the study was critical in that it

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\textsuperscript{28} Rothman, Strangers at the Bedside, 64. \\
\textsuperscript{30} Herzberg, \textit{Happy Pills in America}, p.27. \\
\textsuperscript{31} Mary S. Calderone to all affiliates, January 15, 1963, PPFAII, Box 68, SSC.
\end{flushright}
left this matter up to the Medical Advisory Committees of the Affiliates to make their own decisions.  

Guttmacher and Calderone also had to begin planning how they would instruct their Affiliates to respond to their patients’ queries, so they drafted a letter to address the Affiliates’ concerns about telling their patients of the “study nature” of the Enovid program. Guttmacher and Calderone went through several drafts of this letter and sought advice from Harriet Pilpel regarding the language of the letter. The issue of how patients would react to hearing that they were in a study was one of the central points, and the language surrounding this was negotiated and revised. The first draft of the letter stated that “although we agree that in most instances the patient should be informed, there will undoubtedly be exceptions, as for instance the woman who might tend to react neurotically, thus possibly distorting the results of the study.” The final version of the letter was more clear in acknowledging that “we feel very definitely that in almost all instances the patient should be informed” even though telling “the woman who is highly neurotic...would distort the effects of the study.” The letter was remarkable to the extent that it spelled out the fear that neurotic patients would throw off the data collection effort.

Guttmacher and Calderone also framed the issue in such a way that Affiliates could broach the issue with their patients as innocuously as possible. The letter suggested that clinicians approach the issue by simply “saying to the patient, ‘You have reached the two-year anniversary of the birth control pill. How do you like it?’” Assuming that the patient was satisfied, then the clinician could explain that the “government is interested in having us follow patients who are going to use the drug for more than two years, largely because there has been no

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32 Mary S. Calderone to all affiliates, January 15, 1963, PPFAII, Box 68, SSC.
33 Draft of letter to chairman of affiliates re: two-year plus Enovid study, PPFA II, Box 68, SSC.
34 Ibid
accumulation of such observations in this country since the drug is relatively new.”\textsuperscript{36} The patients were reassured, however, that even though “Uncle Sam” wanted to keep track of them, patients in Puerto Rico have been carefully followed for over seven years and “everything has gone exactly as it did in the first two years of their using the drug.”\textsuperscript{37} For this reason, Guttmacher and Calderone believed that the patient would not notice a difference based on how long they had been taking the drug, and their tone indicated to the Affiliates that this was the attitude they should project toward their patients.

As of April 1965, G.D. Searle was providing Enovid tablets without charge to Planned Parenthood so they could dispense the tablets at reduced or no cost for patients in the study.\textsuperscript{38} Since Searle wanted to track this portion of the Enovid supply that they were providing for free, Gordon W. Perkins and Frederick S. Jaffe of Searle issued patient identification cards and an information booklet in attempt to keep track of “drop-outs.” By 1965, Ortho, Parke-Davis, Mead Johnson and other competitors had new and different formulations of oral contraceptives on the market, so there was also concern about patients switching between brands and formulations.\textsuperscript{39} Planned Parenthood and Searle also started calling the study the “25 Month Club,” though Dr. T.G. Hiebert, the Director of the Division of Medical Intelligence at Searle, initially indicated that he thought Planned Parenthood should come up with “a more descriptive, if not sophisticated” title for the study.\textsuperscript{40} By providing patients with a lower cost product specially packaged “For 25 Month Club Members” only, Planned Parenthood and Searle took advantage

\textsuperscript{36} Ibid \\
\textsuperscript{37} Ibid \\
\textsuperscript{38} To all affiliates, medical directors, executive directors and presidents, From Gordon W Perkins, Frederick S Jaffe, March 5, 1965, PPFA II, Box 68, SSC. \\
\textsuperscript{40} Letter from TG Hiebert, Director, Division of Medical Intelligence, G.D. Searle to Alan Guttmacher, January 7, 1965, PPFA II, Box 68, SSC.
of the allure associated with membership in an exclusive club. In fact, when Planned Parenthood eventually sent a letter uniformly explaining the study to patients, the news was framed in the form of a flattering “Congratulatory Letter.”

Congratulation on your membership in the “25-Month Cub”. You are one of a select group of over ten thousand women who have joined this program which is sponsored by Planned Parenthood. The scientific results of the program will contribute to increased progress and understanding in this important area. As a responsible parent, you have decided that your children will be planned so that they may be brought up in a climate of love, mutual respect and consideration. As with most thoughtful parents, you plan to give affectionate instruction and guidance to your children with the hope that they may be brought to a well-balanced maturity and eventually to a meaningful life of their own.

The letter was clearly designed to make women feel positive about their membership in the select group. In addition to pointing out that the women were contributing to the important project of scientific progress and understanding, the letter also provided commentary on a framework of values that the women were assumed to have adopted. The use of the Pill was not a reflection of these women’s desires to postpone childbearing or even have fewer children, but rather an indication that they were thoughtful, responsible parents. Far from being a tool for emancipation and greater opportunities for women, choosing the Pill was conflated with holding certain values about instructing and guiding children toward meaningful lives. Thus, Planned Parenthood aimed to flatter the participants, but also chose to present the project as ultimately centered around positive benefits for the family. This approach seems designed to counter any opposition to Planned Parenthood’s mission by explaining that family planning was a morally sound choice. Drawing on the concept of planned children growing up in ideal circumstances of

41 Revised “25-Month Club” Congratulatory Letter, May 14, 1965, PPFA II, Box 68, SSC.
42 Ibid
love and mutual respect also reassured the growing number of Americans deeply concerned about poverty and population growth in the 1960s.

In the end, no amount of flattery or positive patient relations could rescue the project from discontinuation by Searle. By August 1966, 30% of the patients had disappeared and there appeared to be “no hope of tracking them down.” Searle was also dissatisfied with the quality of the information gleaned from the 38 clinics in the study. The major concern with the data was that the “trivial side effects seem to increase in frequency as a woman remains on the pill.” This was exactly the finding that the study was designed to disprove, and Guttmacher and Calderone clearly indicated this hypothesis to the Affiliates when they explained the project in the outset.

Despite the project’s failings, Dr. Hiebert, Director of the Division of Medical Intelligence at Searle, proceeded to extract what he could from the data. Hiebert did not start with the assumption that the increase in trivial side effects was due to the action of Enovid. Rather, Hiebert worked with a computer in an “attempt to analyze this situation with the idea that this effect which is so different from that obtained in other studies, might be the result of the influence of frequent interviewing.” With the data obtained from the study, there was no means of separating out which of the reported side effects were the results of frequent interviewing, and which were caused by the long-term use of Enovid. Moreover, Hiebert did not even indicate a mechanism by which the interviewing caused the reporting of side effects, though he was likely referring to the idea that patients would start to notice symptoms more if they were repeatedly asked about them and thus started to pay closer attention.

43 Meeting with representatives of the Searle Company, August 1, 1966, PPFA II, Box 68, SSC.
44 Meeting with representatives of the Searle Company, August 1, 1966, PPFA II, Box 68, SSC.
45 Meeting with representatives of the Searle Company, August 1, 1966, PPFA II, Box 68, SSC.
The lack of decisiveness about which side effects were legitimately caused by Enovid and which were not was evident in the report that emerged from the study. The researchers’ frustration with their inability to understand the causes of the side effects was also apparent. The information from the “25 Month Club” Study was condensed into a “Status report on long term Enovid users” in 1966. Despite more ambitious intentions, the final report used data from only 915 patients. Nelly Oudshoorn has made the important observation that starting from the first trials of the Pill in Puerto Rico, researchers counted the number of treated menstrual cycles rather than years that an individual patient was treated. Therefore, “representing woman as menstrual cycles resulted in a major increase of scale” and the numbers of treated cycles appeared much larger and more impressive than the numbers of patients.46

The status report was immediately clear in stating some of the more disappointing limitations of the study. For starters, there seemed to be inexplicably large disparities in findings from relatively similar locations. For example, two locations in Puerto Rico, Rio Piedras and Humacao, situated forty miles apart, had yielded very different findings. This was suspicious, and led the author to conclude that the findings reflected more of the “individual preferences and prejudices of the examining physicians” than actual differences in findings.47 Two of the findings that Searle met with the greatest skepticism were the results on weight gain and hirsutism, or excess body hair. These were both examples of the “trivial” side effects that were proving to be so persistent and difficult to measure. The section of the report that analyzed physical examination data struggled with the issue of how to reconcile expectations about side effects with actual findings. The section on weight gain stated, “There has long been an implication that the exogenous female hormones cause significant weight gain” even though it

46 Oudshoorn, *Beyond the Natural Body: An Archaeology of Sex Hormones*, 132.
47 Status report on long term Enovid users, PPFA II, Box 68, SSC.
was not known if this was a persistent or a transitory problem. To make matters worse, “there has been no clearcut indication as to whether this is entirely physiological or psychological, or a combination of both.” With no clear data on this issue, some physicians speculated that when women became less worried about pregnancy they were more carefree and likely to overeat. While some physicians blamed estrogen for causing water retention and bloating, another physician wrote, since “there are no calories in these tablets,” the cause of weight gain must either be “greater caloric intake or a lower expenditure of energy.”

In the case of hirsutism, the possibility that the side effect was due to the pharmacological action of Enovid was almost entirely discounted from the outset. The report read, “hirsutism has been a very questionable complaint as regard to Enovid since the progestin in Enovid is not androgenic in its pharmacological action. The incidence of the finding of hirsutism among these Enovid users must be interpreted in the light of no prior information as to the presence of hirsutism and no general definition for this condition among the observers.” The difficulties faced by Planned Parenthood and Searle over the course of the “25 Month Club” study reinforced the concept that oral contraceptive side effects were difficult to measure, and that the role of patient psychology was probably significant. While the status report on long-term Enovid users did not provide much conclusive or persuasive data, by the time the report was completed, enough data from various sources had accumulated and the two-year limitation had been lifted. At least a quarter of married couples using contraception had chosen the Pill by this point, and it would have been difficult to limit access to such a large and critical mass of people.

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48 Ibid p.9
50 Status report on long term Enovid users, PPFA II, Box 68, SSC.
Published Research on Searle’s Enovid, 1962-1966

In addition to its collaboration with Planned Parenthood, Searle also provided some level of support to psychiatrists and other types of physicians at research universities and in private practice. Even though physicians generally considered the Pill to be an unprecedented type of birth control that posed completely different psychological challenges due to its mechanism of action and perfect effectiveness, there were some precedents for understanding the psychology of contraception.

One discipline that contributed to this area was the field of psychosomatic medicine. Psychosomatic medicine became popular in the late 1940s and used psychoanalytic theory to explain the causes of physical symptoms such as asthma and ulcers. In the postwar era, an Americanized version of psychoanalysis that emphasized scientific virtues and the ability to successfully cure patients was a dominant force in psychiatry and taught at virtually every medical school.\textsuperscript{51} 1945-1965 was also the “golden age” of the popularization of psychoanalysis, and the concept of psychosomatic medicine traveled across domains particularly effectively.\textsuperscript{52} By the 1950s, entire textbooks of psychosomatic medicine could explain the psychological origins of almost any type of disease, and the concept that “emotions can make you sick” was common in popular women’s magazines.\textsuperscript{53} Since psychoanalysis was geared toward addressing issues of sexuality and sexual adjustment, psychosomatic gynecology was a relatively large subfield. Psychosomatic gynecology described the psychological basis of gynecologic and obstetric

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\item\textsuperscript{51} Nathan G. Hale, \textit{The Rise and Crisis of Psychoanalysis in America: Freud and the Americans, 1917-1985} (Oxford University Press, USA, 1995).
\item\textsuperscript{52} Ibid., 282.
\end{itemize}
problems such as menstrual disorders, morning sickness, and infertility, and it also described the pitfalls of common methods of birth control.

Kroger and Freed’s 1962 textbook *Psychosomatic Gynecology* explained many of the complications that they observed with the use of different types of birth control. Even though condoms and the diaphragm were the most common forms of birth control before the Pill, and they were generally considered safe, Kroger and Freed cited cases of patients who developed frigidity associated with these methods. Even coitus interruptus, considered one of the most natural forms of birth control, was the “worst possible method” because it resulted in anxiety reactions and severe frustration.\(^5^4\) Patients with “strong religious scruples” and guilt faced additional problems.\(^5^5\) Kroger and Freed reported that the statistical incidence of family planning “accidents” among these patients was high when compared with the general population.\(^5^6\) Based on these experiences, the context of psychosomatic gynecology helped explain why some physicians were prepared to expect that the Pill would pose psychological problems. In addition to this, psychosomatic gynecology also provided a precedent for psychiatrists and gynecologists to work and think together about the issues facing their patients.

One such collaboration was that of a gynecologist named William E. Crisp and a psychiatrist named John R. Zell. In September 1962, at the District VIII Meeting of The American College of Obstetricians and Gynecologists, Zell and Crisp presented a paper on the psychiatric evaluation of the use of oral contraceptives. The study was based on the two doctors’ observations of their own patients in Phoenix, Arizona, and they would later publish their findings in the journal *Obstetrics and Gynecology* in 1964. Zell and Crisp explained that their

\(^{54}\) ibid., p.276  
\(^{55}\) ibid., p.278  
\(^{56}\) ibid., p.278
study began with a series of psychiatric-gynecologic consultations in 1959. The authors began
their project together as a result of “growing concern over the psychic side effects of vasectomy
in the male, and of surgical contraceptive procedures in the female.”57 In light of the psychic
side effects Zell and Crisp observed in their patients after elective sterilization, the goal of their
investigation was to explore whether there were fewer psychiatric complications in the use of
oral contraceptives. Of the 250 patients observed in the study, all were observed for 1-3 years
and 31 received psychotherapy for 1-3 years. The identities of the patients were not disclosed in
the article, but the patients were possibly middle-class since they attended a private practice, and
probably did not know they were part of a study. The authors noted that they chose to study
Enovid because it produced fewer undesirable side effects. However, during most of the period
that Zell and Crisp observed, Enovid was the only option available on the market.

The most common side effect that the patients reported was a reduction in the amount of
menstrual flow, and 5% reported, “a cycle characterized by nonappearance of the menstrual
flow- the so-called ‘silent’ menstruation or ‘skipped period.’”58 While this was a common side
effect of Enovid, it had both gynecologic and psychologic consequences, in addition to
challenging the concept of what menstruation signified among users of Enovid. The experience
of a skipped period “sometimes precipitated an emotional crisis and doubt as to the efficacy of
the medication.”59 However, since users of Enovid did not ovulate or naturally menstruate, an
absent period came to signify not pregnancy, but a side effect of effective contraception. Thus,
absent menstruation was a side effect of Enovid working correctly, and it was also the most

58 Ibid., 657. While some physicians recognized that the skipped periods were not technically menstruation but
“withdrawal bleeding,” most preferred the terminology of menstruation because it promoted the concept that Pill use
could be part of a natural cycle.
59 Ibid., 658.
blatant sign to users of contraceptive failure. To make matters even worse, Zell and Crisp noted that the side effects of Enovid also included some other telltale signs of pregnancy including “breast engorgement and a sensation of bloating, accompanied by weight gain.” These symptoms “extended to include all symptoms of early pregnancy which varied from an exceedingly mild degree to rather severe psychic effects.” Since early pregnancy tests were just being developed at NIH and they were not very sensitive, accurate or widely accessible, patients had little choice but to keep taking their pills and trust their doctors.

In addition to reporting side effects that patients experienced after taking Enovid, Zell and Crisp also commented on patients’ concerns about using Enovid before they began the drug. Zell recovered this material by interviewing his patients who were in psychotherapy prior to beginning the contraceptive program. The first general class of fears Zell and Crisp identified concerned the possible carcinogenicity and masculinizing effects of Enovid. Patients also reported general fears about ingesting “oral medication which was perceived as a foreign substance.” The authors did not comment on the legitimacy of these fears, but wrote, “It usually became obvious which of the patients’ fears were realistically based and could be handled by reassurance, and which represented phobias or deep-seated conflicts.” In light of the controversy surrounding the Pill, and the lack of definitive data on long-term side effects, the authors were remarkably definitive about what fears were realistic and which were not. Rachel Carson’s influential *Silent Spring* had just been published and Carson presented a rationale explaining how elevated levels of estrogens were linked to cancer. The core of her argument,

60 Ibid.
61 Ibid.
64 Ibid.
though, was not about birth control pills but the role of pesticides in damaging the liver and thus reducing its ability to eliminate excess estrogen from both endogenous and exogenous sources.  

The second category of fears identified by Zell and Crisp were concerns related to the control of sexual impulses and changes in sexual impulses in general. While some women had fears that they might become frigid if they were no longer ovulating, others had fears based around the concept that they “would become sexually aggressive if they were no longer dominated by fear of pregnancy.” One patient under intensive observation discontinued Enovid because of a concern that she would exhibit uncontrollable sexual behavior if she no longer had to fear pregnancy. This analysis highlights the recurrent theme that fear of pregnancy played a significant role in women’s lives, and that no longer having this fear would be a radical and unknown change.

A third class of fears concerned the Pill’s oral route of administration. Since all forms of contraception in use at the time with the exception of the Pill involved some connection to the genital organs or to the sex act, the oral route of administration apparently made it difficult for some women to accept that the pills would work. For others, “the use of the oral route cloaked the medication with an almost magical aura” and an “almost too-ready acceptance of its efficacy.” Zell and Crisp wrote that one of the most significant aspects of oral contraception was the “separation of the decision concerning contraception and the sexual act itself; that is, the taking of the pill in the morning or at dinner time separated sharply the act of contraception from the act of sexual relationships.”


67 Ibid.

68 Ibid., 659.
with guilt and other negative emotions. Women who “had an adequate sexual adjustment prior to the use of Enovid….expressed pleasure at the lack of mechanical interference with their sexual relationship.”\(^{69}\) In contrast to diaphragms, condoms and other forms of contraception, the Pill seemed to be a different sort of solution to the problem of contraception in that it was not mechanical, but chemical, and reported to be 100% effective. To Zell and Crisp, this separation tended to increase the conscious control patients had over their fertility, and as a result, “women who were previously unable to recognize their conflicts over this subject began to produce a rather large quantity of material” on this topic through dreams about pregnancy.\(^{70}\)

In contrast to the woman who feared losing control if she no longer had to fear pregnancy and the social commentators who lamented the promiscuity and amoral behavior that the Pill would enable, Zell and Crisp reported that the Pill had the opposite effect. Zell and Crisp cited the case of a patient who had been “afflicted with a compulsive promiscuity” and found that “the drug played an important role in allowing her to develop a greater respect for herself” and begin more meaning relationships with men for the first time in her life.\(^{71}\) Enovid also provided a highly satisfactory solution in cases where men with marginal psychiatric adjustment requested vasectomy. Since Zell and Crisp believed that in such men “vasectomies often precipitate clinical illness requiring psychiatric care,” the use of oral contraceptives by the wives of these men would provide a solution to the problem of contraception without the psychiatric risks of vasectomy.\(^{72}\)

\(^{69}\) Ibid. 
\(^{70}\) Ibid. 
\(^{71}\) Ibid. 
\(^{72}\) Ibid.
Oral contraceptives were also helpful for women facing the predicaments that occurred when “their own feelings and the realistic demands of our culture conflict.” Zell and Crisp provided the following example:

Blanche was the mother of 4 school-age children of whom the oldest was starting college. Although she had everything necessary to make her a happy and successful woman, she was gradually becoming aware of a growing sense of boredom and inadequacy….She felt that had she finished college she could have found an interesting job….Between economic uncertainty and her own uncertainty as to what she really wished to do, she found herself with many mixed feelings concerning her role as a woman and her sexual relationship with her husband. Old resentment about being female, which she had experienced while growing up, seemed to come to light again. Psychotherapy helped her recognize her true feelings and problems. In this setting, she was able to utilize fully the benefits of an oral contraceptive; it gave her the increased security that she could consciously determine her further reproduction with a high degree of certainty and also allowed her a greater freedom of relationship, both socially and with her husband, because she no longer needed to be on guard as she had been in the past.

Here, the oral contraceptive was described as a tool to help reinforce normative gender roles and support women through the cultural and psychological conflicts they faced. The oral contraceptive was not promoted as a tool of social change or empowerment, but merely as a useful bit of intervention to help hold the family intact and prevent it from breaking apart as a result of disaffected wives and mothers. Zell and Crisp provided a compelling scenario in which oral contraception could be framed as a tool to help strengthen the loosening ties that challenged the cohesiveness of the American family. With Betty Friedan’s *Feminine Mystique* published just a year earlier, a certain narrative form was coalescing around the expression of women’s dissatisfactions with their lives, and this was also reflected in the way Zell and Crisp recounted their patients’ narratives. To Zell and Crisp, the goal of the Pill was certainly not a radical

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73 Ibid., 660.
74 Ibid.
feminist revolution, but perhaps the Pill could help women better adjust to the demands physiology and culture had placed upon them in the tradition of Friedan’s liberal feminism.

Similarly, the Pill acted as a mechanism by which the perceived contradictions women faced in their roles as wives and mothers could be eased. To illustrate this situation, Zell and Crisp described the case of Mary, a 23-year old mother of two who came to the office looking worn out. Mary was facing difficulty sexually responding to her husband after the births of her children. Zell learned through therapy that Mary was having trouble because “her concept of a good mother was that of someone who did not partake in sexuality.” However, in the course of therapy she came to see that the two roles were not incompatible and she decided to try oral contraceptives. Once Mary took Enovid she was able to relax and she no longer had to “constantly keep in mind the need to be careful.” Thus, Enovid helped this young mother prone to fits of crying and bad temper become a well-adjusted wife and mother. Through freedom from her fear of pregnancy, she was able to be both sexual and nurturing. Though the roles of mother and sexual partner might not seem to be necessarily contradictory, this was an important issue since one of the most frequent concerns cited by men was that their wives avoided or refused intercourse.

Though Zell and Crisp were generally positive in their assessment of the Pill, they concluded their article with a discussion of an area of unresolved concern. By taking hormone pills, women were substituting their natural estrogen-progesterone cycle with an exogenous hormone-influenced cycle, but the influence of sex hormones on the psyche was still being debated. If hormones themselves exerted a force on the psyche, then using exogenous hormones

77 Ibid.
would cause not just incidental side effects, but the drug itself would be responsible for altering the individual taking it. If the very hormones themselves were the causes of emotional changes, then this would not be a side effect, but an action that was inherent in the drug, and could not be fixed. Zell and Crisp’s concern about hormones and the psyche stemmed from a psychosomatic study from 1952 in which Therese Benedek, a psychoanalyst, suggested that each phase of the female reproductive cycle contained certain characteristics. The progesterone phase, for example, was characterized by “passive receptivity on the part of the woman, as well as an emphasis in her unconscious thinking on the question of motherliness.” 78 Meanwhile, the estrogenic phase corresponded “to an emotional condition characterized by active heterosexual libido” and these hormonal variations corresponded to emotional cycles. 79 With these natural phases replaced by a uniform dose of estrogen and progesterone each day, it was not known if some of the essential psychological characteristics of womanhood would be altered. Thus, not only were further studies of the influence of oral contraception on emotional response needed, but Zell and Crisp sought an answer to the question of whether oral contraceptives exerted the same effect on the emotions as naturally occurring progesterone. 80

Ira Glick, from the Department of Research at Hillside Hospital in Glen Oaks, NY, summarized some of the literature on mood and behavioral changes associated with exogenous hormones in an article supported by a grant from Searle. Glick presented a review of this literature at the Symposium “Recent Advances in Psychiatry” sponsored by the Department of Psychiatry, New York Medical College. 81 The early portion of the literature that Glick cited was

78 Ibid., 661.
not based on studies of contraceptives per se, but of studies using estrogenic and progestational compounds as therapeutic agents. Estrogens had been used to treat several cases of post-partum psychosis in the 1940s and 1950s, and a number of researchers used Enovid to see if it would help psychiatric patients in the 1960s. Despite his efforts culling data, Glick concluded only that it was clear there was no consensus about the effects of contraceptive agents including Enovid on mood and behavior. What was important, though, was that there was some possibility that hormones had an impact on psychological functioning. These findings might have been useful if Searle sought to use Enovid to treat psychiatric conditions, but the findings did nothing to answer the standing question about what caused the minor oral contraceptive side effects.

Dr. Cornelis Bakker, a psychiatrist at the University of Washington School of Medicine, and his collaborator, a social worker named Cameron R. Dightman, provided yet another perspective on the issue of psychological factors in fertility control. Bakker and Dightman were able to situate their psychological work on contraception as the logical successor to the large body of literature on the physiological factors in oral contraception. While physiological factors were “most obviously relevant and could be studied rigorously with available techniques,” Bakker and Dightman saw psychological research as the next step. Once scientists were able to solve “the more basic and concrete problems,” they moved on to investigate a variety of less obvious psychological factors, which had come into view and gained importance.82 In 1964, Bakker and Dightman believed that the study of fertility control had reached a new level.

Some factors, previously not unnoticed but of less vital importance, have become of great significance now that the technical side of fertility control has come closer to being mastered. If basic research has provided man with adequate means for the accomplishment of family planning and if it promises even better controls in the future, then the success of the actual application of these controls depends entirely on the intra- and interpersonal factors that are relevant to the

82 Bakker and Dightman, “Psychological Factors in Fertility Control,” 559.
problem. Therefore, while the study of the basic physiology of sterility and fertility continues to move forward, it is necessary that the sociological and psychological factors involved be subjected to systematic study.83

Bakker and Dightman made it clear in their methodology that the subjects under study were not just women taking Enovid, but their husbands as well. In fact, they were more concerned with the relationship between the psychological characteristics of husband and wife than on either husband or wife alone. Bakker and Dightman studied 72 women taking Enovid and their husbands recruited from the University of Washington Hospital’s obstetrics and gynecology clinic in Seattle. The only personal and demographic details provided about the couples were that they were primarily lower-middle and upper-lower class, and consciously highly motivated to control their family size. Almost all of the additional information recorded about the couples came from three psychological instruments: the Minnesota Multiphasic Personality Inventory (MMPI), the Edwards Personal Preference Schedule (EPPS), and the 16 Personality Factor Questionnaire (16PF). These tests required a significant commitment, and couples had a fairly long-term involvement with the study. Follow-up interviews were scheduled every 3 months for 2 years. Bakker and Dightman used the material from these interviews to rate the women on “(1) the occurrence of pill forgetting and (2) presence and type of major somatic complaints.”84

Bakker and Dightman’s analysis of the personality characteristics of the women with regards to pill forgetting and somatic complaints seemed to conform to their expectations. “Women with a considerable degree of immaturity, who avoid taking responsibilities, and who tend to be impulsive and inclined toward action rather than contemplation in the solving of

83 Ibid.
84 Ibid., 561.
conflicts are more likely to forget pills than the more mature ones."\textsuperscript{85} Meanwhile, women who complained of side effects such as breakthrough bleeding, nausea, headaches, cramps, and fluid retention were not significantly different from those who did not. What mattered was how the woman’s personality characteristics correlated with her husband’s personality.

The women who complained of side effects were found to have personality characteristics that closely matched their husbands’. This was particularly true with regard to the tendency to report somatic complaints. Bakker and Dightman emphasized that this did not mean that complaining women were more likely to score high on the personality scale measuring tendency to report somatic complaints, but rather that women who scored similarly to their husbands in this regard were more likely to report side effects from Enovid. This finding was noteworthy because it suggested a huge influence on the part of the husband. A woman might score very low on the personality scale measuring the tendency to report somatic complaints, but if her husband also scored very low on this measure, then she was more likely to report side effects from Enovid. Thus, the tendency to report somatic complaints from Enovid was completely independent of a woman’s own tendency in this regard, and entirely a matter of her similarity to her husband. Bakker and Dightman did not offer any explanation for this surprising finding, but it seemed to support the assertion that many oral contraceptive side effects were psychological in nature, and potentially based around women’s unconscious conflicts with their own sexualities and husbands.

The question of whether or not certain personality types were more likely to complain of side effects or respond to placebos was not a new one in the field of clinical pharmacology. The influential physician and founder of the field of clinical pharmacology, Louis Lasagna, had

researched the concept that certain personality types were more suggestible than others in 1954.\textsuperscript{86} Lasagna found that some hospital patients suffering from pain after surgery experienced a degree of relief when they were administered injections of saline solution. These patients were called “placebo responders” and Lasagna tested the personality characteristics of these patients to see how they differed from those who did not respond to the placebo injection. The personality findings were not robust enough to be considered definitive, but it was a landmark study that attracted attention and offered compelling evidence that physicians needed to re-think the factors that resulted in therapeutic efficacy. Thus, even though Bakker and Dightman failed to find definitive evidence that patient personality correlated with suggestibility, there was a strong precedent for this type of logic. Other researchers studied the influence of intelligence on the tendency to respond to placebos and to notice side effects. An Australian study published the findings that among women taking the Pill, the subjective symptoms of feeling “a little lethargic” and “not completely well” were “much more common symptoms amongst intelligent women than among those of lesser degrees of intelligence.”\textsuperscript{87}

Bakker and Dightman’s “pill complainers” were not necessarily more intelligent, but they tended to be similar to their husbands. Quite the opposite was true for the “pill forgetters,” another group Bakker and Dightman identified. The pill-forgetting group of women had opposite personality characteristics from their husbands. These differences were particularly pronounced with regard to the couples’ “orientation in sexual matters, their dependency needs, their level of self confidence, [and] their temperament” as measured by the personality scales.\textsuperscript{88} Echoing previous findings, the women in the pill-forgetter group were not only likely to forget to


\textsuperscript{87} Shearman, “The Mechanism of Action of Oral Contraceptives and Their Side Effects in Clinical Practice.”

\textsuperscript{88} Bakker and Dightman, “Psychological Factors in Fertility Control,” 562.
take their pills, but they were also the “least likely to be successful with mechanical
contraceptives” due to their lack of responsibility, impulse control, and ability to plan their lives
with a long-range perspective.\textsuperscript{89} For those women who need to prevent pregnancy to protect
their health or sanity, Bakker and Dightman did not consider oral contraceptives a safe option.
Instead, sterilization “surgery remains the treatment of choice.”\textsuperscript{90}

While Bakker and Dightman were lacking an explanation as to why pill-complainers had
similar personality characteristics to their husbands, they were able to speculate as to why the
pill-forgetters scored opposite their husbands on most personality characteristics (with the
exception of the tendency to be domineering and exhibitionistic). Because the pill-forgetting
wife differed from her husband with regard to “sexual adjustment and the woman’s tendency to
act out her hostile impulses,” these characteristics frequently led to pill forgetting. In this sense,
pill forgetting served “the function of an immature, revengeful act against the husband,” and the
possible resulting pregnancy an act of revenge.\textsuperscript{91} To make matters worse, husbands and wives
who both had a tendency to be domineering and exhibitionistic faced an even greater risk of pill
forgetting. Because these personality factors were so important, Bakker and Dightman
concluded that it was important for a doctor to know his patients in order to help them achieve
successful outcomes in family planning, even if a referral for family counseling was the most
practical step. If a physician was facing some ambivalence himself or problems with his
patients, perhaps reading an article like Bakker and Dightman’s would provide some insight and
encouragement.

\textsuperscript{89} Ibid.
\textsuperscript{90} Ibid.
\textsuperscript{91} Ibid., 566.
“What the Pill does to Husbands”

The studies by Zell and Crisp and Bakker and Dightman presented a scenario in which the relationship between husband and wife was critically important to the successful use of the Pill, but the real subject of research was the wife and her reactions. The impact of the Pill on the husband was not considered at great length. There were, however, several researchers who focused on the psychological impact that the Pill had on men. Researchers who focused on men were generally less sanguine about the impact of the Pill on marriage, and this shows the versatile uses of the research findings. Dr. Robert Kistner, a prominent and respected Harvard gynecologist, wrote both medical textbooks and popular advice books on the Pill. He used material excerpted from his book *The Pill* to produce a *Ladies’ Home Journal* article entitled “What the pill does to husbands.” Kistner explored a series of cases in which wives took the Pill and became more interested in sex because of their confidence that they would not become pregnant. Kistner described the Pill as a liberatory force for women, and this had potentially problematic consequences for some marriages. When wives suddenly lost their fear of intercourse, some of them became demanding and aggressive towards their husbands. In addition to this, Kistner explained, the complex games surrounding courtship were confused when there was a change in the wife’s libido. In some cases, husbands became disturbed when their wives stopped refusing intercourse.

Kistner did not think that the Pill typically brought new troubles into a marriage, but it had the effect of bringing latent problems in the relationship to the forefront. Kistner sympathized with the American husband, and cited research showing that tension, stress and

fatigue lowered a man’s sperm count. Financial worries and nervous anticipation surrounding board meetings meant that an average husband came home “mentally and physically spent- in no mood to satisfy his newly libidinous, pill-taking wife.”

Or perhaps, as Kistner wrote, “the effects of nudity everywhere, bare legs, bare bosoms, and free love superimposed on a ‘temporarily sterile’ but overly aggressive wife” rendered the husband docile.

The images that Kistner evoked were reminiscent of the psychological concept of momism, which arose in the 1940s and 1950s. Psychiatrists such as Dr. Edward Strecker at the University of Pennsylvania believed that aggressive wives and overprotective mothers prevented men from attaining psychological maturity, and that this contributed to a broader crisis in masculine identity.

Consistent with this theme, Kistner found that the Pill disturbed power relations in marriage. Kistner described a wife who threatened to throw her birth control pills away if her husband bought a new sports car. The threat of the wife throwing out her pills, quitting her job and getting pregnant was enough of a threat for him to keep his old car. In this sense, the Pill had the potential to give women so much power that it effectively removed “the biological basis of the double standard.”

Wives could use the Pill as a threat to not have children and retain their independence, or they could stop taking their pills, have more children, and effectively cancel out their husband’s earning power. Despite these dire scenarios, Kistner was by all means an advocate of the Pill since he believed that it caused no problems in most cases. The style of the piece suggests that Kistner was perhaps intentionally trying to titillate his female readers.

94 Ibid.
95 Ibid.
The concept that the pills might change the “biological basis of the double standard” was also supported by a 1964 article published by Dr. Monte Jay Meldman, a psychiatrist at The Forest Hospital in Des Plaines, Illinois. Meldman’s article, published in the journal *Psychosomatics*, described the case of a man who developed “neurotic” symptoms including “dizziness” and impotence the day after his wife began taking birth control pills. Another husband developed “an extensive delusional system concerning his wife’s supposed infidelity.” In this case, the husband developed his symptoms after his wife began taking the pills, and Meldman suggested that once the husband realized that his wife was free to have sex without the fear of pregnancy, there was no way to ensure her fidelity. Not only did the Pill free women from the greater consequences of pregnancy, but also this new freedom meant that men brought new insecurities associated with the use of oral contraceptives to the psychiatrist’s office. In an additional twist of gender norms, Meldman described the disturbing symptoms of this new form of “sexual inadequacy” in terms of the classically feminine symptoms of lightheadedness and dizziness. The psychiatric and gynecologic research on pill acceptance further reinforced the idea that men, and specifically husbands, were potentially important factors in whether or not the Pill was adopted successfully. The findings were also remarkably variable and could be used to reach starkly different conclusions, each serving the desired audience as needed.

Family dramas related to the Pill were not limited to husbands and wives. In the minds of some parents and psychologists, mothers assisting daughters in getting the Pill was a complicated matter. “I faced a major crisis this week,” a woman referred to as “Mrs. E” wrote in her description to Vogue magazine of what happened when her daughter asked for help obtaining

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birth control pills. The mother knew that her daughter would “not abstain much longer,” and she wanted her to be “safe,” but at the same time she could not bring herself to cooperate. As a result, the mother consulted a psychologist, who helped her realize that she sympathized with her daughter, but did not want “sympathy to mean complicity.”

The psychologist’s response, which was paraphrased as advice for the reader, explained that the very request for help indicated “a lack of readiness for adulthood: She wants the gratifications of an adult with the responsibilities of a child.” Not only did this psychologist discourage a teenager from seeking contraceptive advice from a parent, but the psychologist explained that that the struggle to obtain contraceptives was an important part of growing up. A parent who gave her teenager contraceptives would “deny them a vital experience: the inner struggle without which there is no inner development.” Psychiatrist Harold Lief believed that a mother bringing a daughter in for pills could even ruin the girl’s view of sex if she developed such a fear of getting pregnant “that all of sex becomes ugly and nasty.”

Similarly, Graham B. Blaine, chief of psychiatry at Harvard University Health Services considered a mother slipping a diaphragm to a daughter a mark of over permissiveness. The outlooks promoted by these experts exemplified many common attitudes about young people accessing the Pill. Parents, doctors, and psychologists did not doubt that young people had a need for contraception, but they were conflicted over whether they should actually assist young people. Accessing the Pill was meant to be a struggle, and obtaining it provided proof of a certain degree of maturity and foresight. Functioning as

100 “Parents Talk About Sex” excerpt from an article in Vogue, October 15, 1969, p. 158, found in Louis Lasagna Archive, Box 4.7, University of Rochester.
101 Ibid.
102 Ibid.
103 Ibid.
gatekeepers, physicians maintained responsibility for controlling access to the Pill and its attendant risks.

**Ruth Lidz’s Research at Yale-New Haven Hospital**

As the research about emotional reactions to oral contraception developed throughout the 1960s and into the early 1970s, it became more geared towards making practical recommendations for physicians to utilize. Dr. Ruth Lidz conducted research on patient acceptance of oral contraceptives with the practical concerns of family planners very much in mind. Lidz mobilized the concept that oral contraceptives were virtually 100% effective as a way to frame her research. If the oral contraceptive compounds were essentially foolproof in their operation at the physiological level, then any failures were the result of the psychology of the user. Thus, the psyche could be used as a means to explain inconsistencies in drug effectiveness. Lidz presented this concept to the ob-gyn residents at Grand Rounds at Yale-New Haven Hospital with the captivating introduction, “You may wonder, what I as a psychiatrist hang out at the family planning clinic for.” Lidz was a clinical professor of psychiatry at Yale and wrote about the emotional and psychiatric issues she saw surfacing in patients after they visited the Yale-New Haven Hospital family planning clinic in the late 1960s. Lidz explained to the residents that her interest in contraception first arose when she noticed a “contradiction between enthusiastic reports of nearly perfect control of conception with hormones and IUDs and the high rejection rate by clientele in birth control clinics.”

The intrauterine device (IUD) was a polyethylene plastic or stainless steel device taking the shape of a spiral, loop, or bow that was placed in the uterus by a physician. The IUD was

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106 Personality and Emotional factors in the success of contraception, talk for Grand Rounds in OBGYN, New Haven, (n.d), Theodore and Ruth Lidz Papers (MS 895), Folder 29, Manuscripts and Archives, Yale University.  
first available in the United States in 1960, but family planning advocates were initially cautious about promoting it because there was relatively little research and no consensus on how it worked. In the late 1960s, both the Pill and IUD were considered new methods worthy of study. While the Pill was considered “our best current method,” the IUD was the least understood, and more frequently used in other countries.  

Lidz interviewed her patients before they started using either the pill or an IUD, and then six weeks to two months later, and for up to two years if the patients were experiencing difficulties. One of the advantages of doing a comparative study of women using both IUDs and birth control pills was that Lidz was able to observe similarities between the psychological side effects experienced by women in both groups. Because the women experienced similar reactions regardless of whether they used the Pill or the IUD, Lidz was able to confirm findings that the reactions were purely psychological and not the physiological result of hormonal manipulation.  

Lidz found that the women in the study were pleased to speak with her openly about their experiences, and because they were generally “simple rather than highly educated women…they expressed themselves freely, and did not tend to intellectualize.” Although the women came from a variety of ethnic backgrounds including African-American, Puerto Rican, Italian, Polish and Irish, Lidz found that the women were uniformly traditional in their views that they were to gain their sense of value and worth from their status as wives and mothers. The desire to excel in this role paired with financial constraints that necessitated limiting family size meant that these women faced guilt and conflict over using contraception. Unable to cope with

108 Leslie Aldridge Westoff, From Now to Zero; Fertility, Contraception and Abortion in America (Boston: Little, Brown, 1968), 52.
the conflict, it seemed only natural to Lidz that these women would react with a host of reasons to avoid using contraceptives reliably.

To Lidz, profound emotional reactions to birth control were not a shock, because interrupting fertility touched upon “mental complexes which are intensely affectively charged”.\textsuperscript{111} In this sense, using effective contraception was not simply preventing or postponing pregnancy, but entering a definitive state of infertility, in which the conflicted “unconscious and irrational components” of one’s attitudes towards procreation inevitably surfaced.\textsuperscript{112} The emotional conflicts brought upon by the effective control of fertility were not just a continuation of the same contraceptive troubles Americans had been dealing with for years, such as the inconvenience of the condom or the difficulty of the rhythm method. According to Lidz, the Pill and the IUD represented a radical break in the history of controlling fertility because the psychological experience of using a virtually foolproof method was historically unprecedented. A woman could no longer rely on her “ambivalence” each month to cushion the disappointment of discovering an unintended pregnancy, or to shield her from the disappointment of not discovering a desired pregnancy.\textsuperscript{113} Throughout Lidz’s work, women faced a tension between subconscious guilt and frustration about not being pregnant, despite a conscious desire to avoid pregnancy. Thus, when women were able to replace the “ambivalence” of using relatively ineffective birth control methods, which they often used irregularly, with relatively effective ones, emotional difficulties arose.


\textsuperscript{112} Ibid.

\textsuperscript{113} Lidz may have adopted this meaning of ambivalence from J. C Flugel, \textit{Men and Their Motives; Psycho-Analytical Studies} (New York, N.Y: International Universities Press, Inc, 1947). See Emily Martin, \textit{The Woman in the Body: A Cultural Analysis of Reproduction} (Boston: Beacon Press, 1987) for an analysis of how menstruation has been modeled as failed pregnancy.
In addition to oral contraceptives, IUDs warranted a relatively large amount of attention from psychiatrists because some women had an inability to tolerate them. Lidz believed that a woman who was controlling and needed to be in charge of all aspects of her body would reject an IUD because it was placed in her uterus by a physician, and it thus “forced her into passive acceptance.”\textsuperscript{114} Lidz was fond of citing a certain patient who was unable to cope with the conflict between her desire for fertility and her refusal to have children. Through a prolonged period of inconsistently using birth control, the patient became pregnant three times and had a series of illegal abortions. Finally, her physician inserted an IUD, but the patient became incensed and pulled it out herself, despite pain and bleeding.\textsuperscript{115} Lidz attributed this woman’s self-destructive behavior to her anxiety at being put in a passive position by a physician controlling her fertility. In order to find a way of dealing with this difficult situation, Lidz sought to devise a psychological test in which to “measure a woman’s capacity for passive, trusting acceptance as opposed to her need to exercise control over herself and her fear of passivity.”\textsuperscript{116} Thus, Lidz believed that the problems of IUD and Pill rejection could be managed through greater control and understanding of the psyche.

Other aspects of the psyche surfaced in how patients reacted to side effects such as bloating and weight gain. Even though Lidz believed bloating was purely a physiological reaction, the ways in which women responded to this side effect was strongly influenced by their gender identity. Lidz described the case of a young, slim, businesswoman who was physically active and enjoyed wearing fitted suits. This woman was “much upset” when she found herself

\textsuperscript{114} Personality and Emotional Factors in the Success of Contraception talk at Grand Rounds in OBGYN, (n.d.), Theodore and Ruth Lidz Papers, Yale University.

\textsuperscript{115} Woman: Fertility and Self-Realization, Theodore and Ruth Lidz Papers, Yale University.

\textsuperscript{116} Tourkow, Lidz, and Marder, “Psychiatric Considerations in Fertility Inhibition,” 625.
feeling bloated. On the other hand, “a young girl, who had considered herself ‘poorly developed,’ enjoyed the growth of her breasts.” Meanwhile, another woman loved the Pill because she enjoyed feeling “fat, lazy and sexy.” Lidz’s observations corroborated previous findings that found women’s reactions to the Pill were related to their acceptance of femininity. In general, physical complaints appeared to be more frequent in less feminine women.

Similarly, Lidz observed a number of cases in which the Pill caused disturbances for husbands because it challenged aspects of their masculine identity. Lidz wrote that many men saw their ability to impregnate their wives as a measure of their own potency, and they expressed dissatisfaction when they did not make their wives pregnant. Lidz quoted one husband as having said “You get kind of resentful when you keep feeding a dime in a machine and nothing comes out.” Lidz wrote of other men who were upset by “wasting semen” and threatened their wives by implying they would pick up another woman who was not “‘a dud.’” One resentful husband even threatened to flush his wife’s pills down the toilet. Lidz’ observations indicated that there was a general sense that the Pill mattered to many aspects of marriage, family and identity. Following Mary Calderone, who devoted a portion of her book Release from Sexual Tension to attitudes towards contraception, Lidz developed a diagram in order to explain how a husband and wife’s attitudes towards infertility and parenthood mutually influenced one another.

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118 Lidz untitled paper, (n.d.), Theodore and Ruth Lidz Papers, Folder 17, Yale University.
120 Lidz untitled paper, (n.d.), Theodore and Ruth Lidz Papers, Folder 17, p.10, Yale University.
121 Ibid.
122 Ibid.
More than any other researcher, Lidz was able to articulate the issues at stake in her research. From reassessing the oral contraceptive failure rate to deciding which patients and couples would be good candidates for which contraceptive, Lidz had a clear sense of how psychological factors explained the problems of contraception. Furthermore, Lidz made a clear case for psychological issues standing in the way of the Pill’s perfect effectiveness rate, and therefore, for psychiatry’s place in family planning.

**Conclusion**

At the end of the decade, Edward Pohlman’s *Psychology of Birth Planning* provided a literature review of where the field had progressed during the 1960s. Like Rainwater’s study, Planned Parenthood also supported Pohlman’s study, and Alan Guttmacher praised Pohlman’s work for filling a void in the area. While there had been much work on contraceptive attitudes and practices, there was still “precious little on the psychic processes which father attitudes and
Pohlman’s work was impressive in scope, but still reflected frustration about the state of the field. In his introduction, Pohlman wrote that many of the studies he cited were thoughtful discussions, but they did not report any systematic, original research. “Many of these authors wrote their articles about ‘The psychology of birth control’ (or ‘contraception’ or ‘family planning’) with little demonstrated awareness that anyone else had ever written on the topic.”

Thus, the research never coalesced into a well-developed field that established methodological conventions or consensus around key theories. Instead, the psychology of birth control was haphazard and dispersed, propelled by the practical problems of medical practice, put to use in different settings at different times, and more or less a reflection of physicians’ and patients’ changing attitudes and beliefs. One of the few ideas that most physicians agreed upon was that birth control was one of the most affectively charged and key defining issues of the changing times.

The very concept of studying the effects of synthetic hormones and a new form of highly effective birth control, however, did open up some new paradigms. The Pill, with its supposed 100% efficacy rate among those who took it correctly, also helped initiate new ways of assessing side effects and health risks. While the physician Edris Rice-Wray, involved with the first large-scale trials, initially thought that Enovid had too many side effects to be generally accepted, she and other physicians were quickly proven wrong. 126 As amorphous as the side effects were, the efficacy of the Pill changed the calculation of what exactly the risks and side effects were to be measured against. On the one hand, physicians such as Lasagna argued that oral contraceptives carried a very small but real risk of serious or fatal side effects. Meanwhile, the existing

125 Ibid., 5.
methods of barrier contraception were understood to be entirely safe with no dangerous side effects whatsoever. When completely safe methods of contraception were already available, to suggest that a patient switch to a method associated with both serious and minor health risks seemed unsound. Lasagna caused a hubbub by famously telling a group of Maryland pharmacists his opinion of the Pill: “I personally would not give them to my wife.”

However, rather than measuring the side effects and risks of oral contraceptives against existing methods of contraception, an entirely different framework for measuring risk was emerging and becoming the dominant trope. Physicians started to compare the risks of oral contraception to the risks of death from pregnancy, and later, abortion too. The possibility of perfect conception control afforded by oral contraception helped to facilitate this revolution. Even if diaphragm use was free from side effects, it did have a decent chance of failing every now and then, and pregnancy did occasionally result in serious consequences and death.

While this framework initially emerged from physicians concerned with public health on the scale of populations, rather than those advising individual patients, the risk of death from pregnancy became a unit for measuring the risk of using contraceptives. Dr. Anna Southam, Associate Professor of Obstetrics and Gynecology at the College of Physicians and Surgeons at Columbia, estimated that in 1963 “well over a million women in the world are taking these compounds. If all these women were to become pregnant it would result in 260 deaths in a US white population, 1000 deaths in a US nonwhite population and 7000 deaths if one were considering an Indian population taking these compounds.” Therefore, oral contraception was sound public health policy, and the side effects and risks of oral contraception could be measured on the same scale as the risks of the natural event of pregnancy. The side effects of the Pill

127 Thomas Fenton “Birth control pill questioned: Experts see possible link to fatal strokes” The Baltimore Sun, March 5, 1965, in Louis Lasagna archive, University of Rochester, Box 3.4, Jan.-Mar 1965.
started to sound a lot more tolerable once it became routine to compare them to the risks of death from pregnancy.

In addition to this, studying hormones as exogenous agents also had implications for understanding the action of endogenous hormones, making them seem more mechanistic and, as an extension, malleable. For example, it became possible to refer to the physical experiences of non-pharmacologically mediated menstruation as symptoms or even “side effects.”128 No longer simply an unavoidable part of life for most women, menstruation was conceivably optional and the result of biological processes that could be controlled. Sex hormones were not just simply a component of the body, but they could exert an effect upon the body as either an internal or an external force. By studying regular physical experiences as caused by hormones, they became understood as not just simply normal or natural but potentially foreign.129 If hormones could be easily mediated and molded, then certainly they could be optimized and customized for the individual. This possibility opened up enormous opportunity for constructing new and different hormonal formulations and combinations, and their associated representations and experiences. As the market for the Pill grew, companies scrambled to produce unique formulations, regimens, and brands that would represent their Pill as natural, or even better than natural. If research on the Pill meant that menstruation could have “side effects” and pregnancy had risks, it also helped to promote a subtle revolution in the evaluation of these experiences.

128 Glick, “Mood and Behavioral Changes Associated with the Use of the Oral Contraceptive Agents,” 370.
129 Ibid.
Psychiatrists were hardly alone in assessing the impact of the Pill. Though psychiatrists were instrumental in addressing uncertainties so as to ultimately make the Pill more acceptable, they focused on subconscious psychological processes that were difficult to access and largely beyond the scope of intervention. Women’s psychology might not have seemed amenable to quick alteration, but aspects of the Pill itself could be easily adjusted, and marketers focused their attention on the optimal means of promoting and packaging the Pill. Since taking the Pill entailed remembering to do something almost every single day, the very act of taking the Pill became a subject of interest, research and innovation. The Pill has long been considered unique in that it was intended to be taken by healthy women, not under the direct supervision of a physician, and for extended periods of time.¹ Thus, women and physicians were quite concerned with several main questions about the Pill: whether it was safe, what its side effects were, and what impact it would have on sexual behavior and society at large. The Pill challenged people to

¹ Marks, Sexual Chemistry: A History Of The Contraceptive Pill, 90. Parts of this chapter were presented as: “Please do not try to make your own rules”: Contraceptive Pill Compliance Dispensers and the Domestication of Everyday Pill-Taking.” American Association for the History of Medicine, Mayo Clinic, Rochester, MN, April 2010, and Gendered Drug Standards: From Historical and Socio-Anthropological Perspectives, University of Granada, Spain, November 2011. Parts of the chapter are expected to appear as: "Managing medication and producing patients: imagining women’s use of contraceptive pill compliance dispensers in 1960s America" in Gendered Drugs and Medicines: Historical and socio-cultural perspectives, Edited by Teresa Ortiz Gómez and María Jesús Santesmases, Ashgate Press.
consider how much risk was acceptable for a drug that was not meant to cure anything, but to prevent pregnancy. Historians, too, have been drawn to these same weighty issues.

This broader prospect of treating the healthy with pharmaceuticals has drawn focus away from the more prosaic issue of how experts managed the transformation of healthy women into patients with an every day pill-taking “habit.”  This issue is particularly easy to overlook since prescriptions for chronic conditions, such as hypertension, were just coming onto the market in the 1950s and 1960s, and the pace of the “pharmaceuticalization of modern America” has only accelerated since. The concept of taking a medication every day has only become more and more common, and therefore harder to see as something that was new and unusual. Physicians and those who designed packaging and advertisements for the Pill had an interest in making the Pill seem like a normal, and even a natural, part of life. Patient instruction manuals, Pill packages, popular books, and Pill advertising from the 1960s indicated that the “how to” details of taking the Pill were seen as quite important. Physicians, in particular, understood their patients’ adherence to treatment protocols as indicative of the reach of their authority.

The Pill is a special case with which to study the adoption of a medication regimen. The Pill was not always taken every single day, and each brand was defined by a specific regimen, which was individually and actively constructed. Pharmaceutical manufacturers and marketers used specific pill regimens and dispensers to define each brand of pill, and these attributes became each pill’s defining characteristics. In 1963, an engineer named David Wagner patented a special dispenser called a “DialPak” in order to help patients make sure that they adhered to

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their pill regimen. The iconic, round Dialpak dispenser was considered to be the first “compliance package” intended to help patients remember to take a medication correctly.4

Historians have assumed that the popularity of the compliance package was due to the fact that women had trouble remembering to take the Pill.5 While forgetting the Pill was certainly a problem, this simple explanation does not fully explain the scope, scale and complexity of contradictory material concerning remembering to take the Pill. This chapter argues that the rhetoric surrounding compliance to the Pill regimen served greater functions. First, materials produced by pharmaceutical manufacturers and physicians served to make pill-taking seem like a normal and natural domestic occurrence in a time when the everyday taking of prescription medications was a novelty. Thus, pill-taking instructions and popular books focused on integrating the Pill into familiar, domestic routines, while playing on anxieties about the Pill’s effectiveness. Second, Pill advertisements aimed at physicians stoked concerns about patient compliance and served to buttress physicians’ sense of authority and control as patients learned to manage medication more autonomously.6 Taken as a whole, these materials reflected and reinforced prevailing psychological and psychoanalytic conceptions of women as ambivalent and immature with regards to sex and pregnancy.

This Pill, as a technology of “liberation,” came packaged in a technology of compliance, and required women to be motivated managers of their adherence to the new regime. In exchange for a greater sense of freedom from unwanted pregnancy, women became more deeply

4 Gossel, Patricia Peck, “Packaging the Pill.”
5 Ibid.
6 Writing about the intentions of pharmaceutical companies and pharmaceutical advertisers is notoriously difficult. The archives of pharmaceutical companies are generally closed, and lost in corporate mergers. I unsuccessfully attempted to contact the major companies who manufactured the Pill in the 1960s: Syntex, Eli Lilly, Parke-Davis, Searle (now Pfizer), Ortho, Upjohn (now Pfizer), Wyeth. I was only able to speak with one corporate archivist at Pfizer, who assured me that she had no information. Archivists and historians of pharmacy generally accept this as a limitation (Discussion at the Modern Medicines conference at American Institute of the History of Pharmacy, October 2008).
embedded in a growing system of medical surveillance and supervision, as their experiences of the menstrual cycle were translated into the pill cycle. Women were active participants in this process, counting days, turning dials and managing their pills and periods with dispensers and calendars.

**The Pill Trials**

Concern about women forgetting to take contraceptive pills did not originate in the 1960s research on contraceptive pill acceptance, but emerged in the very early contraceptive pill trials in the 1950s. In her groundbreaking analysis of the trials, historian Lara Marks has persuasively argued that, “the notion that women could be reduced to their reproductive physiology was the very foundation on which the early trials of the pill were built.”

The compounds in the contraceptive pill were isolated after years of experimentation on rabbits and rats in a laboratory; not on women. Therefore, when physician John Rock and biologist Gregory Pincus were ready to start testing the compounds on women, they faced a challenge. Rock and Pincus wondered how they would recruit women who were willing and able to adhere to their difficult, invasive and time-consuming study protocols. Katharine McCormick, the primary financier of the early pill research and trials, was puzzled as well. Marks argued that the early pill trials were based on a conception of women as perfectly compliant experimental subjects. The subjects of research in the trials were not so much women, but hormonal “cycles” to be managed and controlled. The difference between laboratory rabbits and women became quickly apparent,

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8 McCormick wrote to birth control supporter Margaret Sanger, in a quote exemplifying Marks’ argument, that the real problem was how to get a “‘cage’ of ovulating females to experiment with.” McCormick to Sanger, May 31, 1955, Margaret Sanger Papers, Sophia Smith Collection, Smith College, cited in Ibid.
however, and the researchers had to navigate the complexities of human behavior, knowing that perfect control over their subjects was an experimental fantasy.

John Rock and Gregory Pincus became intrigued with one another’s work after a chance meeting at a conference in 1952. 9 Rock was working on finding ways to better identify the time of ovulation to improve the rhythm method and to treat infertility, and meanwhile Pincus was conducting contraceptive research on rats and rabbits. Rock administered large, daily doses of estrogen and progesterone to his infertility patients for months without a break, and these women experienced symptoms commonly associated with pregnancy such as nausea, tender breasts and the absence of menstruation. When these women stopped taking the estrogen, they were disappointed to find that they were not pregnant, although a number of women did become pregnant after their estrogen-induced pseudo-pregnancies, in a phenomenon dubbed the “Rock rebound.” Pincus suggested to Rock that he should try administering the hormones for only 21 days of the menstrual cycle to encourage some menstrual bleeding and prevent the patients from believing that they were already pregnant. Limiting hormones to 21 days each menstrual cycle was a practice that was used for the treatment for menstrual abnormalities in the 1940s. Ironically, the 21-day cycle that came to characterize contraceptive Pill use originated in the experiences of women who were seeking to become pregnant.

The women who took part in the initial biological and laboratory tests were recruited due to their close proximity to the hospital and they included Rock’s infertility patients at the Free Hospital for Women in Boston and patients with schizophrenia confined to the Worcester State Hospital. 10 Using psychiatric patients meant that the researchers could study the effects of

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9 Marsh and Ronner, The Fertility Doctor.
10 Marks, “‘A “Cage” of Ovulating Females’: The History of the Early Oral Contraceptive Pill Clinical Trials, 1950–59,” 227. Leah Aronowsky recently found evidence that Rock also hoped to test the Pill as a hormone
progesterone on mental illness, and they even tested the compound on men since progesterone was thought to possibly have sedating qualities. While the patients at the Worcester State Hospital made excellent subjects, Rock’s infertility patients were also a clear choice for the trial. Rock’s infertility patients had shown a high level of motivation and willingness to undergo invasive and onerous procedures with the hopes of getting pregnant. Though Rock’s infertile patients were desperate to conceive, Rock questioned whether fertile women would undergo so much trouble just to become sterile. Small numbers of nurses and medical students also participated, and were considered ideal subjects due to their ability to carefully follow the complicated study routine. The study protocols demanded a high degree of cooperation and active participation as the women were subject to detailed and repetitive tests including biopsies, and keeping track of their own vaginal smears, urine collection, and the taking of as many as six or eight pills per day. The investigators understood that what they were asking was difficult, and that a woman needed to be exceptionally devoted, intelligent and persistent in order to complete the trial. The success of Rock’s work depended on the dedication of Miriam Menkin, an expert in reproductive physiology who supervised clinical trials, interviewed patients, and carried out lab work.

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12 Ibid., 232.
Once the trials moved to the next stage, the large-scale “field” trials, women at sites in Puerto Rico, Haiti, and a number of cities and rural areas in the mainland US participated.\textsuperscript{15} Extending the small studies was a challenge because there were a limited number of sites with the appropriate personnel and equipment necessary to conduct proper laboratory tests. Puerto Rico was selected based on the reliable personnel at the School of Medicine at the University of Puerto Rico, the need to circumvent anti-birth control laws in Massachusetts, and the large number of women already receiving birth control at local clinics.\textsuperscript{16} Dr. Edris Rice-Wray, a faculty member at the Puerto Rico Medical School and medical director of the Puerto Rican Family Planning Association, ran the first large-scale trial.\textsuperscript{17} Rice-Wray had American training, impressive data collection skills, and the connections necessary to run the study.\textsuperscript{18} Celso Ramon Garcia, a Spanish American gynecologist working at the Puerto Rican School of Medicine, devised protocols and procedures for examining women in the trials. The study’s funding came primarily from Katharine Dexter McCormick, an MIT graduate trained in biology who had been consulting Margaret Sanger about how best to invest her inherited fortune in contraceptive research. McCormick and Sanger believed that a pill, rather than a mechanical device, was the solution to population growth, and McCormick relocated from California to Boston in order to oversee Pincus’ experimental work.\textsuperscript{19}

\textsuperscript{17} Marks, \textit{Sexual Chemistry: A History Of The Contraceptive Pill}, 101.
\textsuperscript{18} Ibid.
\textsuperscript{19} Ibid.
In the process of moving from Boston to Puerto Rico, the researchers went from a series of small-scale investigations in tightly controlled settings to a large-scale project with volunteers from a wide range of backgrounds. Many of the women in the “field” trials were living in poverty and in rural areas with transportation problems. Though the large-scale trials did not demand the same degree of repetitive testing, there was also far less supervision than in the laboratory trials. The women were visited once monthly by a social worker sent to provide a supply of pills, but communication was not always regular. Protocols were loose, and many women were lost to follow-up and transportation difficulties. Thus, the researchers’ suspicions were verified when they found that not all of the women took the pill correctly in the “field.” Though women complained of side effects, Pinus discounted them as merely psychological, believing that Puerto Ricans were more suggestible than mainland Americans.20

In Haiti, as many as 20 percent of the women in the trial were reported to have forgotten to take the Pills sometimes and many found the instructions difficult to follow.21 Supplying women with a calendar was not found to improve adherence, as many women were illiterate or innumerate. In Puerto Rico, some women were reluctant to follow the instructions to take a five day break between each month’s supply of pill for fear that any lapse would result in an immediate pregnancy.22 Though adherence was spotty, the trials were considered a success. If impoverished women were able to successfully take the Pill, Rock reasoned, then they could successfully be used anywhere.23 That the study was seen as a success even though so many women reportedly forgot to take the Pill seems like an obvious contradiction. But because the

22 Ibid., 236.
Pill still prevented pregnancies despite less than perfect adherence, it was easy to frame the Pill as more reliable than the women taking it.

Though participating in the trials was quite a different experience from taking the Pill after it was FDA approved, some important precedents about what was required to successfully use the Pill had been set. First, the sense of difficulty in finding patients who would take a pill every day in a regular manner was engrained in the minds of the researchers. Women were far less reliable than lab animals, and women who were not confined or obligated to visit a hospital frequently seemed completely unreliable. Second, there was the perception that only meticulous, intelligent women would be able to follow a prescribed regimen. Class, education and motivation also played a role in determining whether physicians would consider women good candidates for taking the Pill.

While the first small-scale trials were based on a conception as woman as little more than their reproductive physiology, this model was quickly challenged. Rock and the other physicians in his team had to adjust protocols in order to respond to the needs of women. By the time the Pill was passed the trials, the women users were conceptualized as very particular kinds of subjects. Not only were there problems with side effects and women taking the Pill incorrectly, but being accustomed to working with infertile women desperate to become pregnant, researchers debated exactly how much women would be willing to put up with merely for contraception.

Research about whether or not women took the Pill as directed was contradictory, and studies did not corroborate one another or point to any clear conclusions. On top of this, concerns about “ambivalence” and “pill forgetting” conducted by psychoanalytic psychiatrists
and psychosomatic gynecologists added a new level of complexity to the problem. Beyond merely an issue of being unreliable, illiterate, uneducated or simply disorganized, forgetting to take the Pill was diagnosed as a potential sign of subconscious interpersonal conflict. Forgetting to take the Pill could be interpreted as a means of revenge against one’s husband or a way of managing guilt surrounding the decision to not become pregnant. The experiencing or reporting of side effects were similarly seen as potentially psychosomatic and indicative of larger conflicts about a woman’s femininity and family role. According to psychoanalytic researchers, “forgetting” the pill was just one of many possible side effects that plagued women who were conflicted over their freedom from the “biological basis of the double standard.” Though psychoanalytic factors were usually not the only issues that physicians considered, the psychoanalytic logic surrounding the Pill was a pervasive undercurrent, making women’s behaviors and reactions always seem suspect. These questions were never resolved through clinical trials, but instead they continued for many years under the rubric of research on contraceptive pill “acceptance.” The concept of “acceptance” encompassed both physical side effects and reasons for discontinuation with subjective psychological experiences and behaviors. Pill acceptance was a compelling subject of research in the field of population control, but it was also a subject of research for physicians concerned with their educated, white, middle-class patients, who made up the largest demographic group of pill-users in the 1960s.

26 Westoff, From Now to Zero; Fertility, Contraception and Abortion in America; Pohlman, The Psychology of Birth Planning.
A group of respected physicians at the University of Pennsylvania conducted one of the most comprehensive studies of the reasons that women stopped taking the pill. Among the factors that influenced “patient acceptance of oral contraception,” forgetting to take the Pill barely made an impact. Among private patients, only one out of 40 Enovid “dropouts” attributed their decision to discontinue oral contraceptives to the subjective feeling of “Tired of taking pill.” In comparison, three women discontinued Enovid due to weight gain and two due to headache. Meanwhile, among American Indian patients, only one patient out of an initial 459 who started Enovid discontinued due to “Inability to remember to take pills.” About a quarter of the American Indian women, however, were lost to follow-up. Among the private patients, 40% complained of breakthrough bleeding and another 30% complained of nausea. In sum, the problem of forgetting to take the Pill was far less prevalent than a host of more commonly experienced side effects and problems. Still, marketers and researchers were preoccupied with their imaginations of women’s inability to take the Pill as directed.

Adoption of the Pill

For the majority of American women on the Pill and the social scientists eagerly studying them, what stood out were not the problems surrounding the Pill, but the incredible success and speed by which the Pill was adopted in the mid-1960s. The problem of forgetting the Pill did not stand out quite as much as the observation that the Pill was being incorporated into everyday life at a rapid clip.

One example of this rapid incorporation came from analysis of the 1965 National Fertility Study. Based on a sample of 5,600 married women, the study was considered the most

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comprehensive and authoritative study of reproductive and contraceptive habits ever completed in the United States.⁹

Findings from the study were published in a number of different journals and books for both scholarly and general audiences. One such book, *From Now to Zero*, was a sociological analysis of the 1965 findings intended for a general reading public.⁹ The book was co-written by Leslie Aldrige Westoff and her husband Charles F. Westoff, one of the Fertility Study’s principal investigators. The “zero” in *From Now to Zero* referred to the path to achieving zero population growth, which many mainstream sociologists and demographers considered a noble and necessary goal. Appropriately, *From Now to Zero* placed a large emphasis on the Pill and its important and growing role in American life.

The book’s chapter on the Pill began with a graph showing the accelerating rate at which married women had begun using oral contraceptives. Though the Pill was relatively unknown and just newly available in 1960, by 1965, one in every six women of childbearing age was taking it, including over 40 percent of women under the age of 30.¹⁰ Not only were the numbers of women who adapted to the new routine of taking the Pill impressive, but the speed at which the Pill became integrated into women’s everyday lives commanded attention too. Noting that the Pill had only further increased in popularity since the completion of the fertility study, the Westoffs remarked, “By now probably some eight to nine million women swallow one every morning with their orange juice and black coffee. If they remember to take it, memory being the one prerequisite of this method, this thin white tablet to keep them safe from unwanted pregnancies.”³¹ The authors effectively crossed between the statistical scale of “eight to nine

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²⁸ Westoff, *From Now to Zero: Fertility, Contraception and Abortion in America*, xxi. The 1965 National Fertility Study was funded by the National Institute of Child Health and Human Development and the Office of Population Research at Princeton University.
²⁹ Ibid., xix.
³⁰ Ibid., 87.
³¹ Ibid., 89.
million women” to the individual woman by placing the Pill into the domestic scene of a particular woman’s breakfast of orange juice and black coffee. In this personalized and domesticated setting, the subjective matter of individual memory entered into the global equation of unwanted pregnancy and population growth. On both the local and the global scales, the ritual of taking the Pill was a new and noteworthy event.

Women interviewed in the fertility study were quick to note that the Pill allowed them to avoid the pitfalls and drawbacks of earlier contraceptive devices. The Pill was remarkable in that it did not “interfere with the sex act” by some messy, “awkward process of protection.” In exchange for these conveniences, women took on a new kind of challenge. The concept of memory entered in to the experience of contraception and became the explicit prerequisite necessary for the successful use of the Pill. Replacing the relatively bulky diaphragm or condom, which provided a concrete, physical barrier to conception, the “thin while tablet” and the ability to remember to take it properly occupied the minds of women and the physicians who instructed them in adhering to the regimen. The thin white tablet was imbued with power both through its diminutive size as well as through its invisible mechanism of action. Since the tablet’s power existed only through a woman’s ability to take it correctly, the dispenser was able to take on the same importance and cachet as the pill itself.

**Counting the Days of the Cycle**

Prior to the oral contraceptive and its associated compliance packages, there was a well-established history of women keeping track of their menstrual cycles for the purposes of family

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32 Ibid., 87.
33 Ibid., 89.
planning. Research into the rhythm method, and later the Pill, helped to facilitate the process of making physicians and patients aware of the possibilities of controlling the menstrual cycle.

In the 1920s, independent studies by physicians Kyasaku Ogino in Japan and Herman Knaus in Austria revealed that the time of ovulation was in the middle of the menstrual cycle, specifically about 12 to 16 days before the subsequent menstrual period. Once popularized and disseminated, this information made it possible for women to time intercourse so as to decrease or increase the chances that they would become pregnant in a given cycle. Ogino and Knaus did not adapt their findings on the time of ovulation to be used as a method of birth control, as they did not believe it would be effective or accurate enough to be useful. Instead, Jan Smulders, a Dutch physician, acquainted Ogino and Knaus with one another’s work and adapted their theories into “a revamped method of periodic abstinence”.

In the United States, the Catholic physician Leo John Latz first disseminated the theory in 1932. Latz took the technique described by Smuthers and helped popularize it, coining the new term “rhythm method.” News of the new method was spread in Latz’ book *The Rhythm of Fertility and Sterility in Women: A Discussion of the Physiological, Practical and Ethical Aspects of the Discoveries of Drs. K Ogino (Japan) and H. Knaus (Austria) Regarding the Periods When Conception Is Impossible and When Possible.*

Though Latz wrote the book on rhythm, the Boston physician John Rock was a leader in promoting the rhythm method and he opened the first clinic dedicated to teaching the method.

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36 Ibid., 5.

37 Ibid., 253.

Rock’s Boston clinic was the nation’s most prominent devoted to teaching the rhythm method, but it was just as renowned for treating infertility. Rock was equally concerned with meeting the needs of the over-fertile and the infertile couple. By seeing the two problems in relation to one another, he was able to apply his research findings. Rock’s interest in promoting the rhythm method was multifaceted. As a practicing Catholic and a physician deeply concerned with his patients’ wellbeing, he felt an obligation to help couples that could not use any “artificial” methods of birth control. Ironically, it was precisely his expertise in infertility that gave him the knowledge and skills to become known as one of the “fathers” of the Pill through his involvement with the clinical trials, and one of its leading proponents.

Although the rhythm method was associated with the Catholic Church, and was known by detractors as “Vatican Roulette,” it was not discovered or initially promoted by the Church. John Rock believed that the rhythm method would be acceptable to the Church based on the logic that even if the purpose of intercourse was to produce children, intercourse was not prohibited during times when a woman could not conceive such as during pregnancy or menopause. Rock also believed that the Church would eventually deem the birth control pill acceptable since it was merely a variant on the rhythm method that regulated the menstrual cycle and extended the “safe period” using the same hormonal mechanisms found in nature. Rock thus promoted a “rationale for Catholic contraceptors.” Despite Rock’s widespread influence and a Catholic majority that agreed with him, he was famously wrong and the Pill was never officially sanctioned.

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39 Marsh and Ronner, The Fertility Doctor, 139.
40 Ibid., 204.
41 Tone, Devices and Desires, 241 on "Vatican Roulette"; Viterbo, “The Promise of Rhythm,” 5.
42 Reed, From Private Vice to Public Virtue, 352.
Rhythm Method Devices

Some women doubted the rhythm method’s efficacy because physicians’ earlier advice about the so-called “safe period” in the middle of the menstrual cycle was completely ineffective.\textsuperscript{43} Though the rhythm method was based on new information about the timing of ovulation, it was not a simple or foolproof solution to fertility control. Women had cycles of different lengths and there was no telltale sign that could identify when ovulation occurred. The rhythm method was also difficult because complex calculations were necessary to identify the fertile period in the middle of the cycle. Despite the complication of the rhythm method, and even perhaps because it was tedious and required medical counsel, the rhythm method gained credibility as a medical method.

Latz offered booklets as well as consultation to women by mail and free of charge.\textsuperscript{44} Similarly, Planned Parenthood would later run a Rhythm Method Service which allowed women to send their “menstrual dates in each month and have their safe and fertile periods calculated by experts.”\textsuperscript{45} The service was carried out by mail, so women could avoid nosy inquiries and doctor’s visits, while conveniently translating their menstrual cycles into a series of dates to be entered on a calendar. For those who preferred to keep track of their own cycles, a variety of devices were developed in order to help women use the method. A device called the Deluxe Rhythmeter from 1944 represented the height of this technology.\textsuperscript{46}

\textsuperscript{43} Tone, \textit{Devices and Desires}, 72.
\textsuperscript{44} Viterbo, “The Promise of Rhythm.”
\textsuperscript{45} Planned Parenthood-World Population Instructions for Volunteers at the World’s Fair, Representative Questions and Observations Reported by Booth Attendants (World’s Fair- April 21- June 10, 1965), PPFAII, Box 112, Folder 17, SSC.
The Rhythmeter was a complex device that took into account both the inconsistencies in the lengths of the calendar months of the year, and in the lengths and characteristics of women’s menstrual cycles. It was clear that these two ways of counting, calendar days and cycle days, did not match up as each cycle and each month contained different numbers of days. Variations in each system of counting potentially led to errors, which would become further compound when moving between the two systems. In order to attempt to correct for these variations, there were settings for regular months, short months, and of course, “corrections” that needed to be made for the shortest and most difficult month due to the leap year, February. In controlling for variations in the menstrual cycle, there were settings to account for irregular days, missing days, and adjustable settings to account for the shortest and longest cycles.
The Rhythmeter’s design was cramped and cluttered. The device was designed in order to integrate as much information as possible, reflecting the increasingly precise knowledge about the menstrual cycle. The expanded knowledge incorporated into the dial, however, came at the expense of clarity and legibility. While containing relatively little information other than “fertile” and “safe” days, the Deluxe Rhythmeter’s precursor, the “Scientific Prediction Dial” of 1936, was simple, streamlined and elegant. In lieu of boxes and arrows, the Scientific Prediction Dial was adorned with the image of a graceful, nude female figure.47

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Another rhythm method device, the Gynodate clock, is noteworthy because it bears some stylistic similarities to the birth control pill compliance dispenser that would come in the 1960s.
The Gynodate clock was a rhythm method aid that at first glance resembled a sturdy, finely made brass table clock indicating the date and time precise down to the second hand. Upon removing a hinged cover, the user could find indicated, “in a discreet manner,” the infertile days, fertile time, time of ovulation, and menstrual cycle. What really set this device apart from the other methods of counting days was that the Gynodate was actually an alarm clock, capable of alerting the user to the beginning of the fertile period. Like the Gynodate, the birth control pill compliance packages purportedly took a more active role in reminding the user. The birth control pill compliance packages were also designed to be attractive and discreet, often appearing indistinguishable from common makeup compacts, mirrors and lipstick dispensers.
The rhythm method was formative for many reasons. One the level of medical research, an understanding of the hormonal regulation of menstrual cycle and ovulation was necessary before the Pill could become a possibility. Knaus’ work on the corpus luteum, which produced progesterone, was crucial to oral contraceptive research. Rock acquired valuable information about fertility and infertility that situated him as the premier physician to organize the human trials on the Pill. Finally, the rhythm method demonstrated that for the sake of contraception, women could and would be able to keep track of the days of their menstrual cycles and think of them as something that could be matched up to a calendar.

Much like the rhythm method devices, birth control pill compliance packages assumed that women needed assistance in keeping track of the days of their menstrual cycles. A diverse array of devices and instructions were devised in order to make the contraceptive pill regimen seem easy, normal and natural to women. There was little consensus, however, on exactly what the contraceptive pill regimen should look like or what would be convenient for women to follow. Each new variation represented a trial and error attempt to construct a regulated, mechanized version of the “natural” cycle. These regimens provide a rich source of information about how physicians and pharmaceutical manufacturers pictured the menstrual cycle, and how they imagined that women pictured their cycles. Many books and pamphlets promoting contraception in the 1960s lamented that women and men were woefully uninformed about reproduction. This lack of information, attributed to guilt, shame, or immaturity, extended to knowledge of the menstrual cycle as well.48

Despite the clear conceptual and medical connections between the rhythm method and the Pill, the longstanding existence of the rhythm method devices did not directly influence the

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48 The rhythm method gave way to newer methods that used biological indicators such as a change in body temperature to indicate ovulation, rather solely relying on calendar devices.
initial design of the contraceptive pill dispensers. The development of contraceptive pill dispensers lagged behind, and did not build off of rhythm method device designs. Instead, the first contraceptive pills followed the conventions for other types of prescription tablets in that they were initially released in a simple glass bottle.  

This meant that a woman had no way of easily knowing how many pills she had left to take or if she had missed one. In the early Pill regimens, there were not a set number of days in each cycle. Instead, women were told to count the beginning of their menstrual flow as “Day 1,” and then begin taking the first pill on “Day 5.” Since a number of days elapsed between the last pill

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49 The Percy Skuy Collection, Dittrick Medical History Center, Case Western University (CWRU).
and the beginning of the next menstrual flow, this meant that the total number of days between cycles varied. An early set of instructions from Planned Parenthood for taking Enovid read:

Mark the first day of your flow on a calendar. Count out 20 pills and keep them in a box. If you can’t remember whether you took your pill look at the calendar, count the number you have left over and see if it tallies with the number you were supposed to have taken. If in doubt, it is better to take an extra pill than to make the mistake of missing a day.  

The regimen for taking Parke Davis’ pill Norlestrin also did not rely on the menstrual cycle being a uniform number of days long. Instead, the instructions explained that the user should “Take one tablet daily for 20 days, with a meal or at bedtime, starting on the fifth day (Day 5) after menstruation begins, and to continue though the twenty-fourth day.” Though the number of pills was fixed at 20, ending on Day 24, there were an unspecified number of days at the end of the menstrual cycle between Day 24 and the beginning of menstruation. According to a 1964 package of Norlestrin, menstruation should start “about three days after you have taken the last tablet,” whereas a 1967 package allows a “few days.” The instructions for what to do if “no menstrual flow occurs” were also not set in stone. If no flow appeared, a new series of 20 tablets could be started on “the 7th, or not later than the 8th day after taking the last tablet.”

In addition to the problem of not knowing how many pills were taken and how many were supposed to be left, some pill packages arranged the pills in arrangements that did not correspond to the days or weeks of a calendar. The Norlestrin tablets were arranged in four rows of five tablets each.

50 Directions for Taking Enovid, Mount Vernon Planned Parenthood, PPFA II, Box 111, Folder 25, SSC.
51 Parke-Davis Norlestrin 1964, American College of Obstetricians and Gynecologists Contraceptive Collection.
52 Parke-Davis Norlestrin 1967, American College of Obstetricians and Gynecologists Contraceptive Collection.
53 Parke-Davis Norlestrin 1967, American College of Obstetricians and Gynecologists Contraceptive Collection.
Figure 6 Norlestrin 1967

From the Ralph W. Hale, MD, History Museum at the American College of Obstetricians and Gynecologists

Though superficially resembling a calendar, these rows did not match up to the seven days in a week, nor to the number of days in the variable menstrual cycle. The instructions recommended that women keep track of days, but the “calendar” provided with the package was a simple row of boxes corresponding to neither calendar weeks nor months. The need to for a package that allowed the day of the week to be adjusted to correspond to the correct pill became clear, but arriving at a solution was complicated by technical and legal concerns.
David Wagner and the invention of the Dialpak

Historian and Smithsonian curator Patricia Peck Gossel chronicled the invention of the contraceptive compliance dispenser. Gossel conducted extensive interviews with the compliance pack’s inventor, an Illinois engineer named David P. Wagner. Wagner found that “there was a lot of room for error in whether ‘the Pill’ was actually taken on a given day,” and that he was “just as concerned as Doris [his wife] was in whether she had taken her pill or not.” Wagner recalled that his wife became irritated with him constantly asking about whether she took her pill or not, and to resolve the problem, he arranged the pills on a piece of paper with the days of the

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54 Gossel, Patricia Peck, “Packaging the Pill.”
week on their dresser. Wagner’s arrangement of his wife’s pills did “wonders” for their relationship, but it was only “about two or three weeks until something fell and scattered the pills and the paper all over the floor.” Wagner then started sketching out ideas for a pill container that would prevent the pills from spilling, even if his wife carried them in her purse. Using simple materials, Wagner made some models of his dispenser, and filed for a patent with the help of a friend who was a patent attorney. The patent covered dispensers in which the pills were retained in a pattern and they could be adjusted in relation to an element having day-of-the-week identification.

![Figure 8 David P. Wagner Square Prototype](image)

*Figure 8 David P. Wagner Square Prototype*

_Wagner Collection, Division of Medicine and Science, National Museum of American History, Smithsonian Institution_

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56 Ibid., 106.
This dispenser fits 20 pills arranged in rows of 6, necessitating a system by which a piece of paper with the days of the week written out in rows of 6 had to be adjusted to match up to the correct pill.\textsuperscript{57} In retrospect, it seems strange that the pills are in rows of 6 instead of 7, since there are 7 days in a calendar week, but such an assumption highlights the extent to which the pill regimen was not initially seen as something natural or tied to the calendar. There was also another variation of the patent in which the pills were arranged in a circular pattern rather than a rectangle.\textsuperscript{58}

\textbf{Figure 9 David P. Wagner Patent 1964}
\textit{Wagner Collection, Division of Medicine and Science, National Museum of American History, Smithsonian Institution}

\textsuperscript{57} Prototype Pill Dispenser from Wagner Collection, Division of Science and Medicine, National Museum of American History, Smithsonian Institution.

\textsuperscript{58} See examples from Percy Skuy Collection, Dittrick Medical History Center, CWRU and Wagner Collection, Division of Science and Medicine, National Museum of American History, Smithsonian Institution.
Soon after Wagner applied for the patent in July 1962, he took his models and visited the Director of Advertising at the nearly headquarters of G.D. Searle. As Wagner recalled, Searle “felt basically my pill box was a good idea, but at that particular time they were preoccupied with establishing a market and overcoming some adverse publicity” concerning Enovid and blood clots.\textsuperscript{59} Wagner also sent Ortho pharmaceuticals one of his models since he knew that they too were working on a contraceptive pill. Wagner never heard back from Ortho. However, when Ortho’s first pill, Ortho-Novum, was released in early 1963, it came in an attractive dispenser called a “Dialpak” that resembled the claims on Wagner’s patent.\textsuperscript{60}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{Figure10.Dialpak.png}
\caption{Dialpak}
\textit{Wagner Collection, Division of Medicine and Science, National Museum of American History, Smithsonian Institution}
\end{figure}

\textsuperscript{59} Gossel, Patricia Peck, “Packaging the Pill.”
\textsuperscript{60} Ibid.
Wagner was able to secure a payment of $10,000 from Ortho in return for an agreement not to sue.61 Ortho used the distinctive “Dialpak” dispenser as a marketing device, and meanwhile Wagner took advantage of Ortho’s success to try to encourage Searle to re-examine his design. Searle again rejected Wagner’s dispenser, arguing that the company “did not feel the need for promotional devices.”62 But, when Searle released its new lower-dose product called Enovid-E in 1964, it came in a memory dispenser called a “Compack” that infringed upon Wagner’s patent.

61 Wagner Collection, Division of Medicine and Science, National Museum of American History, Smithsonian, and Ibid.
62 Ibid., 108.
Searle was not shy about using the dispenser as a marketing tool. When Joseph P. Bond, the Sales Manager at Searle, sent a brochure about the Compack to the Planned Parenthood Federation, he wrote

The introduction of the new Enovid-E Compack has created a tremendous impact on the oral contraceptive market. It has been received enthusiastically by both the medical profession and the women who have used it, as a very simple, attractive and effective “reminder package.”

![Figure 12 Searle Compack](image)

*Figure 12 Searle Compack*

Planned Parenthood Federation of America Records (PPFA II), Sophia Smith Collection, Smith College

Thus, although both Ortho and Searle outwardly rejected Wagner’s design, they both enthusiastically used it and paid royalties only to avoid the threat of lawsuits.

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63 Letter from Joseph G. Bond, Jr., Sales Manager at Searle, to Staff Members, All Planned Parenthood Affiliates, April 2, 1965, PPFA II, Box 68, Folder 71, SSC.
To give a sense of how novel this package was in 1964, it helps to look at examples of packages from competing companies. Wagner’s solution was not merely a matter of numbering pills and putting them in a package. Since there were 20 pills and women started taking them on a potentially different day of the week each month, the user was expected to keep track of the days using a calendar. This case was essentially just a row of boxes with the tablets arranged in four rows of five tablets each. Syntex’s Norinyl used blister packaging to separate and number the Pills, and included a calendar that could be used to match up the pill number with the day of the week. There were many variations of these designs, but none of them really caught on except for Wagner’s design.

Figure 13 Syntex Norinyl-1
From the Ralph W. Hale, MD, History Museum at the American College of Obstetricians and Gynecologists

See examples from Percy Skuy Collection, Dittrick Medical History Center, CWRU and Wagner Collection, Division of Science and Medicine, National Museum of American History, Smithsonian Institution.
Gossel argued that the various pill package designs were not merely cosmetic, but they had a significant pharmacological effect as newer designs increased the number of hormone-containing pills in the regimen. After Wagner realized that Ortho and Searle were copying his design, he threatened to sue. This encouraged Searle and other companies to come up with creative new designs that allowed them circumvent the patent. Searle initially released the pill Ovulen in a circular dispenser that infringed upon Wagner’s patent. After paying royalties, Searle then decided to circumvent the issue by re-issuing the 20 pills in Ovulen as Ovulen-21, and Enovid-E as Enovid-E 21.

Figure 14 Enovid-E 21
Wagner Collection, Division of Medicine and Science, National Museum of American History, Smithsonian Institution

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65 Gossel, Patricia Peck, “Packaging the Pill.”
66 Ibid.
Increasing the number of pills from 20 to 21 was an important innovation and the most enduring design solution. 21 pills could be easily arranged in 3 rows of 7 pills each, and thus the user could start the pills on any day. Alternatively, the pills could be placed in a circle, allowing the user to start at any day of the week at a chosen location on the circle. The irony, of course, is that in seeking to evade a patent, Searle came up with a much more simple and elegant solution.

After Searle added an additional pill, other companies used this tactic to develop regimens that would stand out from the competition. Organon Laboratories in the UK went one step further and released the oral contraceptive Lyndiol with 22 pills. Advertisements for

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67 Ibid., 114.
Lyndiol reasoned that the regimen would ensure “maximum patient reliability” when the regimen began and ended on the same day of the week.68

Mead Johnson’s pill Oracon-28 added in placebo pills so that the total number of pills was 28.69

Adding placebo pills simplified the patient instructions for taking the pills since a single pill could then be taken every single day. Advertisements explained that taking a pill everyday would eliminate the “problem of forgetfulness”70 and eliminate the need for placebos, “days, off,” and “memory gadgets.”71 Patients were to expect a period when they took the placebo pills, and they were to begin taking the new package of pills the day after they completed the previous package. The introduction of the placebo pills was an interesting issue because it challenged the

68 Ibid.
69 Contraceptive Collection, Division of Science and Medicine, National Museum of American History, Smithsonian Institution.
70 Serial 28 Now you can give her a “pill” that really counts for her, Syntex Collection of Pharmaceutical Advertising, Archives Center, National Museum of American History, Smithsonian Institution.
traditional definition of a placebo. Usually, for a placebo to work, a patient had to be unaware that she was taking a placebo. In the case of the Pill, however, the placebo served a psychological function and was often clearly labeled as a “reminder pill.” Instead of acting covertly, patients understood that the purpose of the placebo was to help them remember to take their pills every day, through maintaining a pill-taking habit and keeping track of the pills in the pack.\(^{72}\) The very existence of a break between packs was maintained based on women’s expectations, rather than physiological or pharmaceutical necessity. As one popular book explained:

> The purpose of stopping the Pill is to make the woman feel she is still undergoing her normal hormonal functions. If she didn’t feel the habitual need to menstruate once a month, she could take a Pill every day and never bleed at all.\(^{73}\)

The purpose of the withdrawal bleeding was to make the woman feel like she was still “undergoing her normal hormonal functions,” even if the normal functions in question were completely overridden by the synthetic hormones she was taking. Thus, the withdrawal bleeding was not “real menstrual period” and performed no function other than satisfying a perceived feeling or need.\(^{74}\) In sum, the variations in the pill regimens, and especially in the number of pills, were not initially justified by medical indications or reasoning, but were explained purely as a matter of what pharmaceutical companies thought patients would find convenient and easy to remember.

The compliance packs also represented a stark departure from the uniform, indistinct pharmaceutical packaging that had previously been standard. Most prescription drugs came in simple, plain glass bottles, and the biggest recent innovation in the early 1960s had been

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72 I have not found any research or attention to the question of whether or not women actually took the placebo pills.  
73 Westoff, *From Now to Zero: Fertility, Contraception and Abortion in America*, 90.  
74 Ibid.
switching from glass to plastic as it was lighter, easier to ship, and resistant to breaking. "New Role for Plastics in Drugs," *Modern Packaging* 37, no. 5 (January 1964): 1000–10003.

Though Ortho and Searle did not believe they needed what they considered promotional gimmicks, customized packaging quickly became a ubiquitous and very profitable marketing tool. Pharmacy owners were also becoming sensitized to the newly recognized importance of presentation and appearance in pharmaceutical sales. A headline in the trade journal *Drug Topics* read “Impressive Rx Display Shelves Build Prestige and Customers’ Confidence.” In the article, a De Pere, Wisconsin pharmacy owned named Robert A. Franken was quoted as saying “Prescription department remodeling has built both prestige and confidence of customers for the Franken Drug Store….I feel proper display of drugs and pharmaceuticals is an important public relations factor we often overlook.”

**Advertising Pill Packages to Physicians**

The interest in presentation was not limited to pharmacy owners and marketers aiming to impress patients. Advertisements promoting the compliance dispensers made frequent appearances in medical journals read by obstetricians and gynecologists. Thus, while the compliance dispensers were supposedly designed with the patient in mind, the content in the advertisements was designed with the physician in mind. Many of the advertisements for the compliance dispenser promoted mechanical or behavioral readings of the package, suggesting that the package could watch over and even perform the work that the absent physician might wish that he could perform from afar. The language surrounding the dispensers imbued the devices with a sense of agency, allowing them to stand in for the physician. In the


76 See examples of packaging in the Drug Topics Collection, American Institute for the History of Pharmacy, University of Wisconsin, Madison.
advertisements directed towards physicians, many ads took on a reassuring tone, convincing the physician that the pill package was overseeing or caring for the patient. The text of an Enovid-E advertisement from Searle illustrated the functions of the Compack in detail, explaining that it performed duties that served both the physician and the patient:

The New Enovid-E Compack tablet dispenser DESIGNED WITH HER IN MIND

Many years of physician experience with ENOVID and ENOVID-E have demonstrated the need for a better method of insureing strict adherence to the recommended dosing schedule. The New ENOVD-E Compack dispenser package has been developed to assist your patients in following your instructions.

The highly feminine, highly fashionable ENOVID-E Compack suits the fancy of your patients. Easy to understand and use, yet appropriately inconspicuous, this new dispenser is clearly designed with her in mind.

For you, there is the added assurance that your patient will take the medication as directed. The Compack removes the guesswork, makes the dosage regime “unforgettable,” by providing a completely automatic record of her cycle and her “pill” days. Push-button ease, crush-proof, individually sealed tablet protection, a built-in “memory” mechanism plus the look and feel of a fashionable compact are the important reasons why you should specify Compack when you prescribe ENOVID-E.

The text of the advertisement explained how the dispenser would help the patient avert just about anything that could go wrong with taking the Pill- it was even “crush-proof.”

Never to be outdone by Searle, an advertisement for the Ortho-Novin Dialpak 21 illustrated many of these same common themes. First, the advertisement mentioned that the Dialpaks “remember for her” and there were no doubts because when the patient took a pill, “the day is recorded.” The ad also claimed that the packaging would insure that the patient would not miss any tablets as the “Dialpak dosage insure the 100% method!” The ad showed an image of the pink Dialpak “for her,” but there was also a device intended for the physician himself. A “watchstrap calendar keeps the date always to hand,” so while the patient had control over her

77 Letter from Joseph G. Bond, Jr., Sales Manager at Searle to Staff Members, All Planned Parenthood Affiliates, April 2, 1965, PPFA II, Box 68, Folder 71, SSC.
regimen with the Dialpak, the physician was also metaphorically overseeing the cycles of his patients by keeping his calendar in his control.  

![Ortho-Novin Dialpak 21 advertisement](image)

*Figure 17 Ortho-Novin Dialpak 21 advertisement*

*Syntex Collection of Pharmaceutical Advertising, Archives Center, National Museum of American History, Smithsonian Institution*

A similar ad for Ortho-Novin also promoted the concept that the Dialpak was doing something for the physician with the text, “Your prescription cares for her when you prescribe Ortho-Novin.”

An Ovulen advertisement went one step further and suggested that the Pill could work as a tool to bring patients back to the physician. The text of the ad suggested that the physician:

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“Prescribe with 5 Refills to bring your patient back on time for her six-month check-up.”\(^{81}\) Not only was the dispenser meant to regulate the patient’s pill-taking behavior, but it was also a mechanism to regulate her visits to the doctor. The need for a “six-month check-up,” of course, originated with the Pill, and the number of refills acted to bring the patient back on time. The desire to obtain a prescription refill served as a powerful enticement to make another appointment and undergo additional breast and pelvic examinations. The need for regular check-ups presented an opportunity for gynecologists to not only increase business at their practices, but to expand the boundaries of their profession.

Convenient and easy to understand packages also meant fewer questions from patients and less work for physicians. Wyeth capitalized on physicians’ annoyance resulting from patients calling with questions about the Pill in an advertisement for Ovral. The text read “Questions Questions Questions… Oral contraceptives may prompt so many questions they’ll give you ‘telephonitis.’”\(^{82}\) All of the advantages of the drug were presented as assets because they would prevent patients from calling with questions. A similar 1969 advertisement reassured physicians that the product would work even if a patient made mistakes, misunderstood directions, was confused by withdrawal intervals, or failed to recognize Day 1.\(^{83}\) An advertisement for the British pill Volidan 21 also shared this theme by asking doctors, “Remember her? She was the one who asked all those questions,” suggesting that the simplicity of the Pill would save the physician from having to field annoying questions.\(^{84}\)

\(^{81}\) Patricia Peck Gossel files, Division of Science and Medicine, National Museum of American History, Smithsonian Institution.  
\(^{82}\) Wythe Ovral advertisement in *Fertility and Sterility*, 1967.  
\(^{83}\) Advertisement in *Fertility and Sterility* 1969  
\(^{84}\) Volidan 21, Syntex Collection of Pharmaceutical Advertising, Archives Center, National Museum of American History, Smithsonian Institution.
There were many variations among companies seeking to make their products unique. In 1965, Eli Lily introduced C-Quens, the first sequential pill on the American market, which was supposed to more closely mimic a woman’s natural shift in hormones throughout the month. Sequential pills included estrogen-only pills in the first part of the cycle, but this was a short-lived enterprise since estrogen-only pills caused increased side effects. In lieu of an innovative package design, the sequential regimen was pictured with flowers, marketed as being closer to nature. Because many users had suspicions that the Pill was in fact unnatural, framing one formulation as more natural than others was an asset. An advertisement for Oracon, a sequential birth control pill from Mead Johnson Laboratories, stated that it was “so close to nature that it simulates the natural menstrual pattern.” 85 The 1965 patient instructional booklet that pharmacists dispensed with Oracon read, “Your physician prescribed this product because it permits your body to closely simulate the normal menstrual cycle.” 86 These advertisements focusing on the Pill as natural countered concerns about precisely the opposite; that using “synthetic hormones to deceive the body into thinking it is pregnant” was unnatural. 87

To allay fears and personalize the Pill, a number of advertisements tried to provide semi-personal portraits of hypothetical patients, providing examples like the young housewife, or the busy wife with children.

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85 See advertisement in *Fertility and Sterility*
86 Oracon Pills, American College of Obstetricians and Gynecologists Contraceptive Collection.
87 Westoff, *From Now to Zero; Fertility, Contraception and Abortion in America*, 90.
Figure 18 Norlestrin for Newlyweds

Figure 19 Justifiable Confidence

Syntex Collection of Pharmaceutical Advertising, Archives Center, National Museum of American History, Smithsonian Institution

Figure 20 for a thousand times twenty thousand wives

Figure 21 Ortho advertisement with diamond ring

Ortho Advertisements in Fertility and Sterility (1965 Left, and 1972 Right, detail)
Other advertisements addressed the issue of how the Pill fit in with nature and women’s traditional roles. An ad for C-Quens asked “Can Sara be herself on C-Quens?” The answer, of course, was a resounding “yes,” as Sara was shown on the next page smiling at home with her son. This advertisement presented a comforting, domestic picture that showed birth control as part of the domestic fantasy of the wife and mother fulfilling her roles; an image of domestic security so crucial during the cold war years. Along with being traditional and domestic, the birth control pill was also construed as natural. Other ads describe the Pill in terms of daily chores. A British advertisement for Parke-Davis’ Norlestrin 21 read, “Many women have a regular and orderly existence. The pattern of their lives is governed largely by the demands of their families—meal times, domestic chores, shopping, to name a few.” An ad for Ovulen-21 from 1969 presented a more peaceful view of motherhood, showing a mother resting with a baby accompanied by the text “Ovulen-21 gives her time” so that she can care for her baby, her husband, and herself. Another Ovulen-21 advertisement used the slogan “Ovuen-21 works the way a woman thinks by weekdays… not ‘cycle days,’” and shows thought bubbles emanating from a woman’s head, illustrating which chores she associates with which days of the week.

An Australian advertisement explained that: “The young housewife with children and the working wife are typical examples of busy women who have enough to think about without having to pay special attention to taking the pill.” The advantage for the physician was that if there was less for the patient to remember, then there was less for the physician to explain.

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89 Examples from Division of Science and Medicine and Syntex Collection of Pharmaceutical Advertising, Archives Center, Smithsonian National Museum of American History, Smithsonian Institution.
90 See *Fertility and Sterility* v. 20 no. 5 (Sept-Oct 1969).
91 Ovulen-21 advertisement from Patricia Peck Gossel files, Division of Medicine and Science, National Museum of American History, Smithsonian Institution.
same theme of the harried, overwhelmed young housewife was also used in ads for psychotropic medications. Matthew Hersch has shown how Smith Kline & French’s antipsychotic Stelazine was marketed and successfully used to treat institutionalized patients diagnosed with schizophrenia, and at lower doses, the “worried well.”93 Smith Kline & French advertised the use of Stelazine for regular, “everyday” patients in a brochure entitled Stelazine in Everyday Practice. The brochure illustrated a variety of regular patients, which Hersch describes as “archetypes of superlative normality.” One such archetype was “the young mother.”94 Overwhelmed by “bills to pay, children to feed, house to clean,” the young woman was overwhelmed and “afraid of another pregnancy.”95 Such a hypothetical patient might walk away from the physician with not just a prescription for Stelazine, but an oral contraceptive as well. An article on Stelazine’s uses suggested that general practitioners might also prescribe the drug to pregnant women facing “apprehension, anxiety and fears” associated with their upcoming deliveries.96 Womanhood and motherhood in general, and fear of pregnancy in particular, became conceptualized as potentially pathological categories.

Also drawing upon the theme of domesticity, a British advertisement for Parke-Davis’ pill Norlestrin 21 read, “Many women have a regular and orderly existence. The pattern of their lives is governed largely by the demands of their families- meal times, domestic chores, shopping, to name a few.”

94 Ibid., 142.
In addition to routine housework, the ad also hinted at the woman’s sexual role as another one of the family “demands” that governed and shaped her life. The woman in the ad was pictured at home ironing in a frilly, lacy housedress with a bow in her hair and her head tilted provocatively to the side. Next to the flirtatious housewife were the lyrics to an English folk song about a man whose heart was stolen by a woman ironing her linen, “dashing away with the smoothing iron.”

The advertisement mentioned that the poem had been recited for years, highlighting both the repetitiveness of women’s reproductive cycles as well as the repetitive nature of housework and

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97 Norlestrin 21, Syntex Collection of Pharmaceutical Advertising, Archives Center, National Museum of American History, Smithsonian Institution. Thanks to Hannah-Louise Clark for identifying this folk song, helping me understand the context, and pointing me to a recording.
women’s duties in their families. In 1968, with speculation that the Pill was fueling the sexual revolution, it was significant to place the Pill in the context of tradition and housework.

Surely, forgetting to take the Pill was a real problem that women faced, but the way the compliance package imagery was utilized suggests that it was perceived to hold a greater appeal to the physician. The forgetfulness imagery was embedded in representations of women’s lives, transitions, and identities, representing women in specific female roles such as the “newlywed,” the working woman, the busy mother, or the “housewife.” Thus, the conflict of remembering to take the Pill was presented to doctors not as a singular problem, but as embedded in the activities and meanings of women’s roles. These deeply nuanced and contextualized scenarios presenting women’s forgetfulness were compelling not because they represented the problem of remembering to take a pill, but the problems surrounding the complexities of what the Pill symbolized. They represented the uncertainties women and physicians were facing and with which they were struggling to come to terms. The problem of taking the Pill was not just about remembering, but about the enormous individual and cultural changes represented by the Pill.

Patient Instruction Booklets

While advertisements directed towards physician made great use of the problem of forgetfulness, the instructions for women on how to take the Pill took this issue much more literally. Pill packages generally came with instructions on how to take them, while individual clinics and popular writers presented more general recommendations on pill-taking. Not only did these materials emphasize the importance of taking a pill every day, but they focused specifically on the time of day that the pill should be taken. Taking the pill at the same time every day was seen as important for the medication’s effectiveness, but it was also crucial for
integrating the Pill into the patterns of everyday life and promoting the concept of a compliant pill-taking patient. These materials became increasingly involved and elaborate towards the end of the 1960s and especially after 1970 when physicians were supposed to provide patients with a package insert on health risks.

Materials directed towards patients usually emphasized the pill’s effectiveness. In fact, the Pill was usually called 100% effective, and most pregnancies were assumed to be failures on the part of the patient to take the tablets correctly. Therefore, pill packages walked a fine line between reassuring the woman that the product was effective, while simultaneously warning her that if the product failed, it was her fault. For example, a package for C-Quens read, “This product has been found to be highly effective- but only when taken as directed. So do not fail to take each daily dose and keep a daily record.”

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An instruction sheet for users of Enovid written by the Mount Vernon, NY Planned Parenthood Center was even more explicit. “To obtain 100% protection you must follow these instructions EXACTLY. Please do not try to make your own rules.” These instructions seemed to suggest, in an amusing way, that the Center had experience admonishing patients who interpreted the rules in a creative fashion.

A 1970 booklet from Searle entitled “Planning Your Family” was also rather explicit in explaining the need to take the pill “regular as clockwork,” and “faithfully every ‘pill day’!” The booklet read:

Take your pill at about the same time every day! You are probably wondering why the same time of day is important. By taking your pill at the same time every day it becomes a good habit and you are much less likely to forget. You may wish to keep your pills in the medicine cabinet near your toothbrush as a reminder to take them when you brush your teeth at night.

Similarly, A Concept of Contraception, a 1967 book for a general audience by a physician, encouraged patients to establish a daily “pill habit.” It did not matter if it was “8 p.m. on Friday night and 3 a.m. the following night,” or even a daily habit in the morning or at lunch. The firm establishment of a habit was more important than the exact time.

The directions from the Mount Vernon Planned Parenthood Center also suggested that it was possible to take the Pill at any set time, “but most women find it convenient to take it before retiring.” The instructions were framed in terms of what “most women” found convenient, thus showing the premium Planned Parenthood placed on normalizing the concept of taking a

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99 Planned Parenthood, “Directions for Taking Enovid,” PPFA II, Box 111, Folder 25, SSC.
100 Searle “Where ‘the Pill’ Began” booklet, American College of Obstetricians and Gynecologists Contraceptive Collection.
101 Neubardt, A Concept of Contraception, 45.
102 Ibid.
103 Planned Parenthood, “Directions for Taking Enovid,” PPFA II, Box 111, Folder 25, SSC.
daily pill. The recommendation to take the Pill after eating or before going to sleep, however, probably did not originate from the experience of what “most women” found convenient. Rather, the recommendation probably originated from the Planned Parenthood Medical Department. Physicians believed that taking the Pill at night would reduce the chance of nausea. At the 6th International Conference on Planned Parenthood in 1959, Pincus cited research indicating that nausea was often “psychogenic,” and that it occurred just as frequently with placebos. Still, in order to circumvent the problem, suggesting that patients took the Pill at night meant that they were likely to sleep through any discomfort anyway.

Compliance Research

The struggles surrounding patients’ adherence to treatment regimens was not going unnoticed by medical researchers and medical sociologists in the 1960s. In fact, the concept of “compliance” was becoming a unique pathological entity and a community of researchers concerned with non-compliance was beginning to stabilize. Several historians and social scientists have focused on the concept of patient “noncompliance” as a construction, ideology, or category that increasingly became a concern of physicians and a subject of research.

Historian and physician Jeremy Greene provides a compelling analysis of how the concept of a non-compliant patient became a “resonant category” and research priority in the period from 1955 to 1975. Though the concept of difficult patients not following doctors’

104 Planned Parenthood, “Directions for Taking Enovid,” PPFA II, Box 111, Folder 25, SSC.
105 Draft of entry on oral contraceptives in The Medical Letter, 1962, PPFA II, Box 111, Folder 26, SSC.
directions was certainly not a new one, noncompliance did not “emerge as a viable research subject” until the 1950s. Greene links the development of the concept of compliance to a variety of trends, including a new pharmacopeia geared toward the treatment of chronic diseases as well as a Cold War “ideology of social control” that allowed physicians to use the concept of noncompliance as a convenient way to shift blame to their patients.109 A focus on the ideology of patient compliance was used to bolster a “flagging sense of physician authority” as the movements for informed consent and patient autonomy emerged.110

The concept of noncompliance was also appealing to a younger generation of doctors beginning their careers after 1960, when the skills of epidemiologists were becoming more and more specialized and divergent from those of clinicians. In the 1950s and 1960s, methodological reformers persuaded medical researchers to adopt the techniques of double-blind randomized controlled trials, and the dominance of statistics facilitated a revolution that called for accurate and reliable data.111 Though reform in the ethics and methods of clinical trials promised purer results that were better able to assess the safety and effectiveness of new drugs, medical knowledge still relied upon the cooperation of the patient.

According to sociologist Samuel Bloom’s 1963 study of the doctor-patient relationship, physicians had a tendency to judge patients as “good” or “bad” based on how cooperative their behavior seemed.112 Bloom found that during the course of medical school, physicians learned to “judge patients on a moralistic basis,” and these judgments stood in the way of

109 Ibid.
110 Ibid., 341.
111 Marks, The Progress of Experiment.
“understanding based on fact and reason.” Getting beyond moralistic judgments could improve compliance to medical regimens, such as diabetes treatment, and uncover the underlying reasons why “understanding and compliance on the part of the patient” was not always reliable. Bloom’s observation that physicians often made judgments about their patients was not limited to any specific context. Other social scientists have noted that the concept of patient compliance was problematic and loaded with value judgments. Anthropologist James Trostle has argued that compliance was essentially an ideology geared towards promoting the authority of medical professionals, emerging from the struggle of physicians to maintain control over infant feeding technology.

Compliance research on family planning in the 1960s exemplified these themes. Researchers concerned with population dynamics shared clinical researchers’ desire for reliable data, but their efforts to produce compelling data were plagued by value judgments and a lack of clarity about the terms and subjects of study. As such, statistics about patient compliance to Pill regimens were widely divergent. Elizabeth Whelan, a consultant for the Population Council, published a review of research on compliance with contraceptive regimens for the International Committee on Applied Research in Population. Whelan found that comparing the results from different patient compliance reports was problematic because there was no single operational definition of noncompliance, and demographic differentials between the study

113 Ibid., 36.
114 Ibid., 44.
populations also made comparison difficult.\textsuperscript{117} Beyond the challenges to compliance that plagued all medical regimens, there were additional characteristics unique to contraceptive compliance. Contraceptive “acceptors” received no “ongoing reinforcement” as they might if they had been taking an antibiotic to cure and infection, and furthermore, Whelan cited the “general agreement” among psychologists and psychiatrists that “decisions relating to pregnancy involve ambivalence.”\textsuperscript{118} Whelan also identified another challenge to compliance that resulted from the very existence of a choice of contraceptive methods. Knowledge of the existence of other methods of contraception made patients uncertain as to whether they chosen the correct method, and this uncertainty was a cause of noncompliance.

The rates of noncompliance varied dramatically across the large array of published studies on patient acceptance of the Pill. On the highly compliant end of the spectrum, the Child Spacing Clinic of The Mount Sinai Hospital found that only 3.1 percent of an ethnically and religiously diverse “indigent urban” population was taking their tablets incorrectly.\textsuperscript{119} These patients received “precise and demanding” individual instruction lasting for 15-20 minutes, followed by a question-and-answer period. Failure to follow the regimen was considered to result from a lack of motivation, rather than an inability to understand, as the instructions “readily comprehended by even the simplest patient.”\textsuperscript{120} Of the 259 patients who started on oral contraceptives in the Mount Sinai Child Spacing Clinic study, 105 discontinued the method for a variety of reasons, thus making the 3.1 percent figure sound much less definitive. On the other

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\textsuperscript{117} Elizabeth M. Whelan, “Compliance with Contraceptive Regimens,” \textit{Studies in Family Planning} 5, no. 11 (November 1, 1974): 349–355. Whelan cited a few studies from as early as the 1930s, but the bulk were from the 1960s and early 1970s.


\textsuperscript{120} Ibid., 841.
\end{flushleft}
end of the spectrum, a study of women in Pakistan found that only 53 percent of women took the pills regularly, despite careful instruction and visits from a well-respected “Lady Health Visitor” from a local clinic.\textsuperscript{121}

Studies of patient compliance were conducted in a haphazard fashion so that results were difficult to compare, and different results could be deployed where it was politically useful. Though the results from studies of patient compliance were inconsistent, the studies were united by a desire to identify the characteristics of non-compliant patients, and to understand why some patients were more compliant than others.\textsuperscript{122} Young women, the most common users of oral contraceptives, were seen as already at a high risk of non-compliance by virtue of their age and sex,\textsuperscript{123} but again, without a clear way to measure compliance, psychological factors were persuasive explanations. Psychological theories such as “willful exposure to unwanted pregnancy,” ambivalence, and immaturity were used as explanations.\textsuperscript{124}

\textsuperscript{121} See for example Cobb, “Oral Contraceptive Program Synchronized with Moon Phase.”


Theories of compliance were understood to be specific to particular populations and also linked to the pill-taking regimen. John C. Cobb, a professor of Public Health at the School of Hygiene at Johns Hopkins University and a group of researchers from the Medical Social Research Project in Lahore, Pakistan and conducted a program in which hundreds of women were given their monthly contraceptive pills on a schedule intended to correspond with the moon phase. The researchers accomplished this by starting the women on a short course of 12 pills so that their withdrawal bleeding would occur during the “dark of the moon.” The women then began taking one pill a day from a bottle with 22 pills, beginning on the first day of the new moon. The visiting health worker kept track of missing pills by counting, but there was no explanation of whether or not these women generally associated their menstrual cycles with the moon, or how following the phases of the moon would help them keep track of the Pills. Any association between the moon and the menstrual cycle was implicit, and there was no rationale or cultural explanation underlying the program. The implication is that the researchers saw these women as primitive and animalistic. When Alan Guttmacher visited the village where Cobb was conducting his study, he dramatized his disgust at the poor and crowded conditions. Guttmacher described a grubby, dirty town, teeming with flies, disease, and children, the “excreta of animals and humans carpet[ing] the crooked, rutted dirt lanes.” Guttmacher identified population density itself as a marker of social pathology, citing the antisocial behaviors exhibited by rats in overcrowded conditions.

In this destitute setting, Cobb and his team believed that following the moon would be an effective strategy for illiterate women who could not use a calendar, but the definition of literacy

was also unclear. Cobb did not explain why literacy was necessary to keep track of a calendar, and women who were “only able to read the Quran” were still counted as illiterate.\textsuperscript{128} The researchers did not address the issue of why it seemed that counting was more difficult than reading, and this episode points to Trostle’s conclusion about compliance as an ideology describing the proper roles of patients and physicians.”\textsuperscript{129} Researchers could have theorized all patients as potential non-compliers, but instead, most research on compliance “hypothesizes that there are non-compliant types of people, and that with sufficient ingenuity their traits can be identified.”\textsuperscript{130} Of course, in Cobb’s case, the non-compliant women were identified by virtue of being from Pakistan, with its associated poverty and illiteracy, as opposed to many of the U.S. based studies that searched for psychological characteristics in addition to social class as markers of likely noncompliance.

**Tuberculosis and the Radioactive Pill Clock**

Though Cobb’s study was just one of many cursory attempts at constructing evidence pointing to the Pill’s appropriateness or unsuitability in different contexts, his work was linked to research on the acceptability to pharmaceutical regimens of a different sort. In 1956, the US Public Health Service had just recently taken over public health services from the Bureau of Indian Affairs, and many young doctors came to work on Indian Reservations.\textsuperscript{131} According, to Cobb, the Korean War draft figured prominently in many of these young doctors’ decisions to

\textsuperscript{128} Cobb, “Oral Contraceptive Program Synchronized with Moon Phase,” 560.
\textsuperscript{129} Trostle, “Medical Compliance as an Ideology,” 1299.
\textsuperscript{130} Ibid., 1306.
\textsuperscript{131} Transcript, John C. "Jock" Cobb. M.D.,M.P.H. Oral History Interview, 1994, by H. Henrietta Stockel, New Mexico Health Historical Collection, University of New Mexico Health Sciences Library and Informatics Center Online: http://hsc.unm.edu/library/spc/oralhist/cobb.shtml (last accessed 12/16/2011)
Young doctors decided to come to the Navajo Reservation to avoid the Army or Navy, and these doctors had little or no training in the problems facing the Navajo, which were primarily pediatric problems, and especially diarrhea and tuberculosis. Cobb was enlisted to travel across the broad swath of reservations in the Southwest and to train the doctors in treating the public health problems facing people on the reservations.

Tuberculosis was easily spread because large family groups slept together in single room structures with minimal air circulation, and many children were sent away to boarding schools where up to 100 children could be crowded together to sleep in a single room. Navajo health aides tried to convince families to send those sick with tuberculosis to sanatoriums where they could receive treatment, but families resisted this intervention. As an alternative to institutionalization in sanatoriums, researchers from Cornell developed a project called Many Farms, in which they enlisted Navajo Health Aides to support patients in the self-administration of antibiotic treatment from home.

Many Farms was one of the most involved compliance studies of the late 1950s and early 1960s. Walsh McDermott and his team of medical researchers from Cornell University saw that tuberculosis was rampant and causing great suffering on the Reservation, so they were quick

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132 Incidentally, Cobb cited his experience as an ambulance driver during World War II as a reason for his own decision to enter medicine. Cobb realized that physicians “were the only people that were putting things back together and everyone else in the world was tearing it all apart.” Cobb then wrote to his father, a Harvard Medical School professor, who got him admitted so he would not have to “waste” his life in public health. (Cobb oral history transcript page 1).

133 Transcript, John Cobb Oral History, p. 5

134 Cobb had an interest in Navajo traditional medicine, and a particular interest in medicinal plants used for birth control. However, Cobb’s engagement with traditional medicine was tentative at best. Cobb found that psychosomatic disorders were best handled by medicine men, where ceremonies provided patients with support from the community. Still, Cobb recalled that if a patient in a tuberculosis sanatorium seemed to be near death, he would often go home for traditional treatment, and come back much healthier. Transcript, John Cobb Oral History, p.9.

to try a promising new antibiotic called isoniazid. While the antibiotic streptomycin was available to treat tuberculosis starting in 1944, isoniazid made outpatient therapy practical starting in 1951.  

Previous antibiotic formulations involved daily injections or unpleasant side effects that made treatment difficult or impossible in an outpatient setting. Isoniazid treatment could be administered on an outpatient basis, but McDermott did not know if patients would take isoniazid faithfully enough to cure their infections. Regardless of what the researchers thought of the Navajo as patients and the likelihood of their taking the pills, physicians and anthropologists working with McDermott acknowledged that the faithful “daily ingestion of a pill appears to be strangely difficult in any society.”

Isoniazid posed a great conflict for the researchers. They possessed a powerful technological solution; an antibiotic that they believed might finally cure a deadly, communicable disease. However, social factors, such as “patients’ seeming inability to take their medicines regularly” posed a limitation on the power of the drug. McDermott “sought to deploy the technology of antibiotics against the social disease of tuberculosis,” while simultaneously “deploying the technology of surveillance against the social problem of non-compliance.” Antibiotic resistance was a problem early on, lending urgency to the issue of compliance. Physicians also believed that noncompliance was becoming more important as medicines were becoming more effective, and this was clearly recognized to be true in the cases of antibiotics and oral contraceptives.

137 Ibid., 280.
138 Ibid.
139 Ibid.
Physicians working in outpatient tuberculosis treatment programs used much of the same terminology that would later be repeated in oral contraceptive advertisements. Physicians spoke of “foolproof” administration and “patient error.” In the 1960s, tuberculosis was no longer common in middle and upper class communities, but it persisted in poor and marginalized populations, so the socio-economic backgrounds of tuberculosis patients promoted physician anxieties over compliance, much as it did with the Pill. Not only were marginalized populations assumed to be less compliant than middle-class patients, but physicians also assumed that these patients would not have sought treatment on their own.

After experimenting with an array of creative and novel approaches to see if a medication had been consumed, McDermott eventually settled on a round “pill clock” designed by physician Thomas Moulding. The pill clock only allowed the patient to rotate the dispenser in one direction and remove one day’s dose at a time. The patient was unaware, however, of the fact that the dispenser contained a radioactive emitter and photographic film that allowed the physician to see if the patient took the pills regularly. Since each point on the film corresponded to a different day, overexposed areas indicated that the dispenser was not advanced, whereas the days that were subsequently skipped in order to catch up registered as unexposed sections on the film. Thus, the film in the dispenser left a visual record of the patient’s irregularity and introduced a new element of secrecy into the doctor-patient relationship.

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140 Ibid., 285.
141 Ibid.
142 Ibid., 312.
143 Ibid., 297.
144 Jones points out, “this regime of distrust and surveillance emerged during the height of the Cold War” (300).
While the Dialpak went on to become perhaps the most iconic pill dispenser in history, Moulding’s invention did not spread far beyond the initial trial. Wagner’s first model was dated May 15, 1962, which was the same month that Moulding published his description of the rotating pill clock. There is no evidence that Wagner was aware of Moulding’s design. The innovators came up with similar models simultaneously. While Wagner’s invention was intended to help patients remember to take their pills, it did not record the patient’s behavior, which was so important to Moulding. The contraceptive compliance dispensers also carried an additional function, which was to conceal the pills. Whereas the contraceptive compliance dispenser was designed to look like a makeup compact or lipstick tube when closed, dispensers designed for tuberculosis were supposed to be displayed in the home with the hopes that a patient’s family would help remind the patient to take the pills. Despite these differences, Moulding recognized the connections. In 1971, he published an article in the *American Journal of Obstetrics and Gynecology* with results from a study on the use of a medication monitor for studying the self-administration of oral contraceptives. The design of the monitor included a radioactive source and film, and was quite similar to the device he developed for isoniazid. Whelan’s review of contraceptive compliance prepared for The Population Council noted that Moulding’s device “might prove useful in large-scale oral contraceptive compliance studies.”

Conclusion

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146 One version of Mead Johnson’s Oracon was in a dispenser completely indistinguishable from a Ponds lipstick tube, according to an interview with Percy Skuy, founder of the world’s largest collection of contraceptive devices and retired pharmaceutical executive, personal communication, 6/10/09
147 Whelan, “Compliance with Contraceptive Regimens,” 350.
As the locus of control in medication administration moved from doctor to patient, physicians turned to technologies of surveillance. This shift was promoted as one that increased patient autonomy. Forcible detention of tuberculosis patients was legal in 31 states in 1960, so any technology that allowed patients to take their own medications independently increased the possibilities for freedom. During the same time period, care for the mentally ill followed the same trajectory as residential mental health institutions were closed as part of the move towards deinstitutionalization. In reality, mental health services that were discontinued were rarely replaced with alternative forms of care. Regardless of the results of these policies, the trend toward patients medically managing themselves was a pervasive one.

Contemporary discussions of compliance and surveillance are almost invariably influenced by Foucault. The compliance package calls to mind Foucault’s work on panopticism since the packages were marketed as enabling doctors to watch over their patients, although in actuality no such observation generally occurred. The fantasy of control from afar might well have been appealing to doctors, but there is no clear evidence that patients saw the packages this way. Patients might have seen missed pills as a failure to adhere to their prescribed regimen, but this does not mean they necessarily connected their own pill-taking behavior to their doctor’s power. Still, a Foucauldian analysis is not far off. Since patients were frequently assumed to have missed pills if they experienced side effects or unwanted pregnancies, it is possible that women could have linked their pill-taking behavior to their physician’s power and chastisement or praise. The compliance package fits more strongly into Foucault’s model when considered as

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part of the broader means of disciplinary power. If the compliance package is read as an instrument of disciplinary power, then it represents “a normalizing gaze, a surveillance that makes it possible to qualify, to classify, and to punish.”\textsuperscript{150} Under this gaze, women managed their adherence and the attendant responsibilities and risks of the Pill.

\textsuperscript{150} Michel Foucault, \textit{Discipline & Punish: The Birth of the Prison}, 2nd ed. (Vintage, 1995), 184.
As patients managed their pill-taking at home and physicians developed new conventions for overseeing their patients, expectations for doctor-patient relationships shifted. The compliance package was not the only innovation shaping these interactions. Physicians struggled over the safety and moral implications of providing access to increasing numbers of patients. In the context of the sexual revolution, the calculus of risks and benefits to both individuals and to society was actively debated. While doctors claimed responsibility over the social implications and risks of the Pill, women declared their own ability to live with its risks.

The Pill’s role in the social changes of the 1960s has been a focal point of interest among historians. While historians such as Elizabeth Watkins have discounted the popular myth that the Pill was responsible for causing the sexual revolution, this idea was persuasive to some in the 1960s and it has been further promoted by various journalistic accounts. Watkins shows how the origin of this misconception about the Pill resulted from looking at two different audiences. “In the 1960s and early 1970s, demographers focused on the contraceptive habits of married women to document the contraceptive revolution, while sociologists surveyed the sexual

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1 Parts of this chapter were presented as: “Healthy Patients and Annual Exams: The transformation of gynecology and the post-pill patient in the 1960’s.” Berkshire Conference of Women Historians, University of Massachusetts at Amherst, Amherst, MA, June 2011.

2 Journalistic accounts of the history of the Pill have remained active debating this issue, and the question was frequently raised in the Pill’s 50th anniversary publications in 2010.
attitudes and practices of unmarried women to study the sexual revolution.” The sexual
revolution among college students was characterized by increased premarital sexual activity,
though the Pill was not freely available to these women until the end of the decade. The Pill
was adopted largely by married women in the 1960’s, while in Watkins’ account, “journalists
combined the two contemporaneous changes and developed the lasting image of the pill as
symbol of the sexual revolution; scientists and the public accepted and promoted this
interpretation of the pill.”

Elaine Tyler May also argues strongly against the idea that the Pill itself sparked major
changes in behavior. Women were making more autonomous choices about sex, marriage,
childbearing, education, and work, and the Pill encouraged this trend, but it did not create it. May argues that “those who were not engaging in sex were unlikely to do so simply because the Pill” was available, though the Pill had a great impact on married women. Effective
contraception played a role in the sexual revolution, but historical evidence does support the idea
that it was causative.

Other social scientists have weighed in as well. Sociologists and demographers have
assessed the Pill’s impact on contraceptive behavior, while political economists have provided
econometric analyses of the “power of the pill” to change the calculus of women’s career,

4 Carol Sachs Weisman, Women’s Health Care: Activist Traditions and Institutional Change (Johns Hopkins
University Press, 1998); Beth Bailey, “Prescribing the Pill: Politics, Culture, and the Sexual Revolution in
6 Elaine Tyler May, America and the Pill (Basic Books, 2010), 73. May draws heavily from Watkins, On the Pill: A
History of Sexuality in America (University of Chicago Press, 1988); Stephanie Coontz, The Way We Never Were:
7 May, America and the Pill; May cites Gloria Steinem, “The Moral Disarmament of Betty CoEd,” Esquire LVIII,
education and marriage decisions.\textsuperscript{8} Polls and sociological studies are unable to make definitive statements about the role of the Pill in the lives of single women in the 1960s because usage was inconsistent due to legal and practical barriers to access.\textsuperscript{9} While these demographic studies can convey a sense of the Pill’s impact on large-scale, widespread changes in behavior, the cultural history of the sexual revolution is best characterized as a change in attitudes and ideas, and for this reason, the Pill’s role as a symbol for these changes is most important.

Historian Beth Bailey helps to explain this point in the historiography of the Pill. By the mid-1960s, “talk of the sexual revolution inevitably turned to talk of the Pill,” as experts of every stripe weighed in on the impact of the Pill.\textsuperscript{1} Beyond noting the role of the Pill in inspiring the commentary of pundits, theologians, and advice columnists, Bailey explains that in order for the Pill to have had any impact on the sexual behavior of single women, these women first needed to find a way to get the Pill.\textsuperscript{10} Since the Pill was not available in the free marketplace, it had to be prescribed. In the early 1960s, most physicians, following American society as a whole, believed that it was wrong for unmarried women to be engaged in sexual intercourse, and physicians made it difficult for unmarried women to access the Pill. By the end of the 1960s, this had changed, and while opinions about "morality" differed, unmarried women's use of the Pill was taken as a given. Analyzing the historiography of the Pill, Bailey concluded: "Somewhere between the story of the development of the pill and discussions of its importance to the young single women who lived the revolution, a historical step is missing. How did these

\textsuperscript{9} Ibid., 731.
\textsuperscript{10} Beth L. Bailey, \textit{Sex in the Heartland} (Harvard University Press, 2002).
young women get the pill?” Bailey begins to fill this gap by analyzing the institutional changes that allowed for single women to access the Pill, and placing these changes in cultural context.

While it is clear that many physicians who did not prescribe the Pill in the early 1960s were doing so by the late 1960s, other questions remain unanswered. How did physicians conceptualize their place in the sexual revolution? Did they have a responsibility to their patients, or to society in general? This chapter explores the question of how physicians came to see their role in prescribing the Pill, and how their sensibilities regarding the Pill and their patients changed over the second half of the 1960’s. The Pill encouraged physicians, and obstetrician-gynecologists in particular, to develop and articulate broader conceptions of their professional roles as they managed the risks of the Pill.

The first part of this chapter addresses the internal debates that physicians were engaged in, focusing on the concerns and controversies over the place of family planning programs and the need to address the twin problems of global overpopulation and the moral issues raised by the Pill and the emerging sexual revolution. Physicians and policymakers were concerned about keeping the Pill out of the hands of unmarried women, while vigorously promoting birth control to others. Though these goals were contradictory on a basic level, controlling access to contraception helped obstetricians/gynecologists and related experts promote and construct a professional language of “social responsibility.” The second part of the chapter considers how physicians examined and conceptualized their changing social roles in the late 1960s. Calls to expand the doctor’s role and the role of family planning led to the introduction of sexuality into the medical school curriculum. Physicians also struggled to understand their relationships with patients as some patients began to challenge and demand more from their doctors. In the context

11 Bailey, “Prescribing the Pill,” 827.
of change, physicians reframed their expertise on sex and the family in order to preserve their authority in the late 1960s.

The Social Responsibility of Obstetrics/Gynecology

Despite widespread interest in the promises of the Pill, the late 1960s were not seen as a particularly triumphant time for obstetrics/gynecology (ob/gyn) as a field. Clayton Beecham’s 1968 presidential address to the American Association of Obstetricians and Gynecologists questioned the competency of “too many gynecologists” who kept their journals “neatly bound but not read,” and called for the re-examination of physicians every 5 years after passing the Boards to guard against “an air of satisfied complacency.”12 Several years later, an address at the American Gynecological Society lamented that throughout the 1960s, fewer and fewer “bright young men” were training in obstetrics/gynecology, and the recruitment of students to the field, “talented or not,” was regarded as a “pathetic failure.”13 The number of medical graduates entering obstetrics/gynecology residency programs had declined, leading to a deficit that in 1961 had been a concern, but by 1971 had become a disaster.

Using such addresses and other historical sources, sociologist James Zetka has argued that obstetricians and gynecologists maintained a “dishonored position within the medical division of labor” due to competition with surgeons and other specialists, and that they sought to restructure the division of labor in order to become women’s primary care physicians.14

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primary care physicians, obstetrician/gynecologists aimed to exploit the shortage of primary care physicians while controlling the pattern of patient referrals from one physician to the next. As the number of physicians entering specialty practice had quickly risen in the postwar years to nearly 90% by the late 1960s, obstetrics/gynecology did not follow this trend.\textsuperscript{15} When many physicians were abandoning primary care for additional training, status, and compensation as specialists, ob/gyns went the opposite direction to seek out the primary care role, and while subfields were becoming increasingly specialized, ob/gyn sought to expand the bounds of the discipline to cover an ever-wider range of issues. This chapter shows how obstetricians and gynecologists adeptly took advantage of the Pill in order to strengthen their positions as primary care gatekeepers, sex educators, and social and moral experts. Ob/gyns worked to frame reproduction as a social issue that responsible medical experts needed to manage, and controlling access to the Pill was critical to this enterprise.

According to Alan C. Barnes, the Director of the Department of Gynecology and Obstetrics at the Johns Hopkins University School of Medicine, obstetricians and gynecologists were central to addressing the social problems of the time, though they had not sought out this role intentionally. At a 1965 conference of prominent physicians and public health professionals at the Johns Hopkins Hospital, Barnes called it a “historic accident” that obstetricians and gynecologists found themselves in the position where “many of the problems which seriously concern our society” were related to their discipline.\textsuperscript{16} The field of obstetrics and gynecology


expanded in such a way that it intersected with society’s attempts to examine “the cause and cure of our threats and ills.”\textsuperscript{17} Among the many issues addressed at the conference, the “quality” and “quantity” of the next generation were central, followed by discussions of the agencies, laws and individual players involved in issues of reproduction. The conference included talks on the population crisis, divorce, abortion, motivation problems in family planning, the pregnant “school girl,” cervical cancer screening, the psychologic and family impact of disease, and finally, physician education. Since so many social problems linked back to issues of population, it seemed that society was “asking for help and many of the weapons which are needed are to be found in the therapeutic armamentarium” of obstetrics and gynecology.\textsuperscript{18} The perceived importance of the population problem was a strong impetus for obstetrician/gynecologists to consider their roles and responsibilities, leaving them unable to “flee the responsibility” implied by their fateful place in the crossroads of social ills and the possibility of controlling reproduction.\textsuperscript{19}

**The Population Explosion**

In writing about the future, population experts of the 1960s adopted a tone that went beyond idealistic or eugenic visions for improvement, often betraying a feeling of pure panic. Population planners and demographers generally saw a disaster unfolding which terrified them and it was only more worrying that few other people seemed to care. At the social responsibility conference, Robert C. Cook, the president of the Population Reference Bureau in Washington, DC, imagined a future “within a few hundred years” in which every “man, woman and child on

\textsuperscript{17} Ibid., xi.
\textsuperscript{18} Ibid.
\textsuperscript{19} Ibid.
the face of this earth will have one square yard to occupy.”

The only global problem that seemed to hold anything near the same gravity was the possibility of nuclear war, and both threats were often mentioned in the same breath. Cook even addressed the folly in casting war as an antidote to the population crisis, urging, “Do not ask, in a cynical or callous way, for war to save the situation…. the required remedy must be so much more drastic than warfare that it is entirely impossible that whatever we do now will be too little and too late.”

The Population Reference Bureau’s grim prognostication relied upon what seemed to be simple demographic calculations. There had been an age old “seesaw balance between many births and many deaths, which had held population growth in check since the beginning of time.” It took sixteen centuries for the population to double to a half billion, but by 1850, it had doubled again, and then tripled since. History seemed clear and reliable, and numbers did not lie to the competent demographer. “Population dynamics are simple enough. The balance between births and deaths determines the rate of population growth.”

It was not that the birth rate had climbed all of a sudden, but instead, mortality had plummeted. The wonders of modern medicine, including sanitation and antibiotics, were to some extent responsible for this revolution in life expectancy, and because modern medicine had something to do with causing the population problem, it seemed only appropriate that it would also offer a “magic bullet” solution. The power of new technology seemed to be right at the heart of population change, for better or for worse. Population control experts claimed that “family planning” could help spur economic

23 Ibid., 5.
growth, even though historically, birth-rate declines have been the consequences, rather than the causes, of economic growth.\textsuperscript{24}

Paul Ehrlich’s best-selling book \textit{The Population Bomb} came out in 1968, taking an environmentalist perspective and warning of mass starvation due to overpopulation. The term “population bomb,” however, originated in 1954 when Hugh Moore, inventor of the Dixie Cup, used his fortune to initiate mass mailings of his pamphlet \textit{The Population Bomb}.\textsuperscript{25} The pamphlet was adapted into different forms over the years, and it was sent out under the aegis of the Campaign to Check the Population Explosion in the 1960s. Moore framed the issue in dire and alarmist Cold War political terms, explaining that the world was on the brink of the biggest famine in history and a population of starving people was a threat to peace. “Hunger brings turmoil—and turmoil, as we have learned creates the atmosphere in which the communists seek to conquer the earth.”\textsuperscript{26} The pamphlet considered many possible remedies to the problem of starvation such as improving food production, increasing foreign aid through such programs as “Food for Peace,” and providing education with the hopes of increasing the standard of living in poor countries. According to those concerned with the population explosion, none of these more moderate solutions would be nearly enough, and drastically reducing the birth rate was the only answer. As for how to do this, the Campaign to Check the Population Explosion acknowledged that there were many reliable contraceptives available in developed countries, but they were “still too complex or too expensive for wide use in the less developed countries.”\textsuperscript{27} The pamphlet

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\item \textsuperscript{24} Linda Gordon, \textit{The Moral Property of Women: A History of Birth Control Politics in America} (University of Illinois Press, 2002), 283.
\item \textsuperscript{25} Connelly, \textit{Fatal Misconception}, 162.
\item \textsuperscript{26} This is from a 1960s version of the pamphlet called “The Population Bomb Keeps Ticking...” from The Campaign to Check the Population Explosion, n.d., p. 3, Patricia Peck Gossel files, Division of Medicine and Science, National Museum of American History, Smithsonian Institution.
\item \textsuperscript{27} Ibid., 11.
\end{itemize}
mentioned the Pill, but explained that a reduction in price or government subsidies would be needed to spread its use to poor countries.

In general, the Pill was conspicuously absent from discussions of global population control; written off as being simply too expensive, too complicated, and too difficult to use. If affluent women in the United States, under the direct care and supervision of competent doctors had a high rate of discontinuation and side effects, family planners saw little chance of the Pill solving the population problem in rural India. The gravity of the population problem, though, was great enough that it lent importance to the issue of family planning in contexts very far removed from the coercive sterilization programs of the Third World. As a result, even a physician seeing patients in a suburban practice could feel that by providing his married patients with the diaphragm or Pill, he was keeping pace with the social responsibilities of his profession.  

The idea that husbands’ and wives’ feelings about contraception influenced their ability to use it successfully was not limited to those steeped in population control. The Consumers Union guide to contraceptive methods, prepared in the simple and utilitarian style of the editors of Consumer Reports, began a chapter on how to use contraception successfully with a discussion of how thoughts and beliefs influence use. Since contraception was “self-medication” and required more effort than a “simple vaccination,” the way a husband and wife thought about contraception was just as important as the method they chose. Furthermore, the

28 Bailey, Sex in the Heartland. One example of such a physician was Dale Clinton, who ran the public health department in Lawrence, Kansas. His efforts to check the population explosion in a quintessential American town will be covered later.
physician’s attitude also impacted whether the couple would be happy with their chosen contraceptive. If the physician took on a “dictatorial approach” and insisted on the method he liked best, this could backfire.\textsuperscript{30} The chapter relied on population research, drawing heavily from Lee Rainwater’s work linking social class to the successful use of contraception.\textsuperscript{31} Even though the guide was for a middle class audience who presumably had the opportunity to choose a preferred contraceptive method, population control research informed concepts of using contraception correctly. Since policy-makers believed that large families stood in the way of economic development abroad, they also noticed that large family size was correlated with poverty at home. As such, the Department of Health, Education, and Welfare and the Office of Economic Opportunity’s antipoverty program began to sponsor family programs around the country in the 1960s.\textsuperscript{32}

A 1970 educational film called “Squandered Heritage,” produced by the Planned Parenthood Association of Chicago, examined the link between world population, social class, and the American family planning context.\textsuperscript{33} The film was based on a series of questions and answers exchanged over the course of a class discussion between high school students and a doctor. Painting an image of American history in which “our forefathers dreamed of building and populating an empty continent,” a student lamented that the forefathers’ “overwhelming achievement” had resulted in an overly crowded country. Crowds of Americans had rendered Yellowstone National Park, a national symbol of unspoiled wilderness, into a sea of people and

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\item[31] See: Rainwater, And the Poor Get Children: Sex, Contraception, and Family Planning in the Working Class.
\item[33] Planned Parenthood Association Chicago Area, Squandered Heritage [motion picture], 1970, History of Medicine Division, National Library of Medicine.
\end{itemize}
\end{footnotesize}
cars. The film made a strong case for why population mattered to the U.S. and was not just an abstract problem in far away countries. On a global scale, hungry and frustrated people were a threat to political stability and world peace, but “to the extent that the US is part of the world… the world’s people feel that they have a claim on us.” Though many American couples had recognized “a civic and social responsibility to limit their families to about 2.2 children,” it was not just the high cost of college that was keeping families from “questioning their right to a third child.” A voice suggested that perhaps it was a concern about the population explosion that was contributing as well.

“Squandered Heritage” directly linked social class to the average number of children per family, showing that upper class families had the fewest children, and lower class families had the most. The “poor and uneducated” were not blamed for their predicament, but were “too busy and too tired” to care for their children, and “either don’t understand birth control or can’t afford it.” Framing family planning as an aspirational ideal facilitated the marketing of the Pill as a lifestyle product. The discussion of the problems of delinquent, unwanted children functioned as a segue to an explanation of Planned Parenthood’s services, including information on how to become involved as a volunteer or donor. Planned Parenthood’s public message linked the abstract problem of world population to the issue of how many children an American family might desire, all the while showing how “social objectives” mattered to medicine.

To companies manufacturing the Pill, it did not matter as greatly who the customer was as long as somebody was buying the product. In the pages of the Syntex Laboratories’ promotional publication *The Family Planner*, stories of successful family planning programs in

34 This was a statement from one of the students represented in the film.
the United States were mixed with occasional features on programs abroad.\textsuperscript{35} One of the more unusual features was about a 25-year-old female elephant that accompanied health workers “visiting isolated Indian villages dispensing birth control pamphlets and contraceptives.”\textsuperscript{36} The elephant was draped in a cloth with a red triangle, the emblem of the Indian government’s family planning program, and four happy faces, indicating a “size-approved” family with two children. Though Syntex was in the business of selling synthetic progestin for birth control pills, it was unclear if the elephant’s owners were concerned with spreading birth control pills or simply recruiting villagers for voluntary sterilization. Thus, to onlookers in the U.S., the family planning and international population control movements were not always clearly defined, and could be easily conflated or misinterpreted by supporters of one or the other. Still, the inclusion of such material in a pharmaceutical company’s marketing materials demonstrates the appeal of linking the domestic introduction of the contraceptive pill to the global struggle to fight overpopulation.

Ultimately, the promise of the Pill as a panacea to dramatically reduce the rates of unwanted pregnancies and population growth was not achieved. There was no easy solution, technical, medical or otherwise, for these perceived problems. Whereas the Pill was deemed acceptable only to patients with a high degree of responsibility and self-control, the IUD was much better as a technology of compliance. Since the Pill was often seen as too complicated and risky for widespread use in illiterate populations, family planners preferred the IUD and voluntary sterilization.\textsuperscript{37} But these methods had major problems. Early IUDs often caused

\textsuperscript{35} Syntex was a producer of synthetic progestin used in various birth control pills.
\textsuperscript{36} Trunk Full of Family Planning for India’s Villages, Syntex Laboratories, March 1969, Gossel files, Division of Medicine and Science, National Museum of American History, Smithsonian Institution.
\textsuperscript{37} A number of researchers sought to measure contraceptive acceptance in different countries. See Cobb, “Oral Contraceptive Program Synchronized with Moon Phase”; Gavin W. Jones and W. Parker Mauldin, “Use of Oral
infections leading to sterility and many were far from easy or painless to insert. Finding candidates for voluntary sterilization was never easy, and often only occurred as a result of coercive campaigns. In his exhaustive history of the failed project of population control, Matthew Connelly chronicles a grim and disturbing story. Connelly described the projects of organizations such as the International Planned Parenthood Federation and Rockefeller’s Population Council as ultimately eugenic projects that aimed to plan other people’s families and prevent poor people from having children. In the United States, the country’s own history of eugenic sterilization meant that the family planning movement of the 1960s had to rhetorically distance itself from the past and constantly manage skepticism from many segments of the population, especially African Americans. After the concern with overpopulation reached its peak, population control lost out as a compelling strategy because of its association with eugenics and other social engineering projects, despite efforts to disassociate them. Many women rejected population control and moral rhetoric, instead opting for the language of women’s rights.

**The Unmarried**

The population bomb was not the only social problem concerning obstetrician/gynecologists. When it came to their private practices and government-funded family planning clinics, they faced the dilemma of how to deal with demand from the wrong people. Social responsibility meant encouraging family planning for some while keeping the Pill, and its invitation to promiscuity, away from others. Many women received a great deal of

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Contraceptives: With Special Reference to Developing Countries,” *Studies in Family Planning* 1, no. 24 (December 1, 1967): 1–13; Fawcett, *Psychology & population*.

38 Connelly, *Fatal Misconception*.

39 Kluchin, *Fit to Be Tied*. 
scrutiny and were not guaranteed a prescription. These categories of women included unmarried women, engaged women, single college women, and even “unexamined” women who had not received a pelvic exam. Screening patients to regulate safety was certainly an issue, but part of the process of prescribing the Pill was a process of regulating and surveying the patient, insuring that only the right type of woman received the Pill.

Physicians were quick to repeat that they would not prescribe the Pill to just anybody, and it was a matter of careful consideration. In a 1967 “survey of experience with oral contraceptive pills” conducted by the American College of Obstetricians and Gynecologists, 6,733 obstetricians and gynecologists shared their thoughts on prescribing the Pill. 17.2% of those surveyed prescribed oral contraception for single women frequently, 39.1% occasionally, 29.6% rarely, and 12.9% never. The survey suggested that since most physicians did prescribe oral contraceptives to unmarried women at least occasionally, the concern about unwanted pregnancy outweighed other risks. The ill-effects that most concerned these physicians were an “increase in extramarital sex relations” and an increase in “venereal disease.” The ACOG survey showed that in many ways, the issue of single women using the Pill cut right to the heart of the physician’s role. On the one hand, physicians were concerned with a sense of morality and social responsibility which meant restricting access to single women and weighing the extent to which the Pill was unwittingly promoting suspect activities. On the other hand, concern over population had started to reframe the debate over morality, and preventing unwanted children was becoming recognized as an end unto itself.

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41 Ibid., 4.
42 Ibid.
Sure enough, the language of responsibility surfaced in the comments on the survey written by ACOG’s Committee on Public Education. The committee wrote, “the social responsibility of the obstetrician-gynecologist in an age of changing mores is given consideration in the reports of use of the pill for the single woman.”

The committee reiterated that the Fellows had “primary concern for the unwanted pregnancy” but they were “mindful” of what they believed would be the unintended behavioral consequences of the Pill.

Regular physical examinations were also highly valued. 45.2% of the physicians reexamined their patients twice a year, and 46.8% called for examinations once a year including a complete physical, pelvic exam, breast exam, and Pap smear. Women were for the most part willing to comply with these exams, and for this reason the Pill “surely hastened the modern trend toward the annual office visit to the gynecologist.” Before the Pill, healthy women rarely went to the doctor, so these frequent visits were regarded as just one of the Pill’s “side effects.” Clinicians also believed that the extra visits and cancer screenings would compensate for the potentially dangerous effects of women seeking out additional sexual partners.

Gynecological exams were obviously not new to the 1960s, and the Pap test predated the Pill by decades. Encouraging women to have regular Pap tests was a public health initiative that was difficult to implement in the 1940s and 1950s, despite the best efforts of public relations firms, the American Cancer Society and the Women’s Field Army. In 1963, only 15% of the adult female population was examined, and the Assistant Commissioner of Health in New York City characterized the process of winning public acceptance for the Pap test as “like pulling

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44 Ibid., 6.
teeth.\textsuperscript{48} The Pill and the Pap smear depended on similar developments in reproductive endocrinology and they both became standard practice concurrently.

During the initial pill trials in the mid 1950s, researchers were interested in finding out if the Pill increased rates of cancer, so the administration of the Pill was linked to the Pap smear early on. Over time, public health experts argued that the Pill was not carcinogenic but that it would save lives by bringing women into the doctor’s office every 6 months. Thus, physicians saw women coming to get the Pill as an opportunity to encourage a culture of regular preventive examination and sex education. Clinicians saw the extra visits the Pill assured as a check against one of the most feared side effects, which was that their newly sexually liberated patients would go out seeking additional partners.

Though the Pill did have some very real and dangerous side effects such as blood clots and strokes, these were not problems that physicians could screen for or monitor through the pelvic and breast exams they administered. Instead, the exams were aimed to monitor sexual activity and compliance to the Pill regimen. Though the Pill was seen as a potential cause of danger and disease, and the Pap smear a precaution against it, the Pill might have been just what the Pap smear, and gynecology in general, needed to stay relevant and attract patients. This system was reflected and reinforced by the conventions of Pill prescriptions, refills and especially packaging that determined how many pills were dispensed at once. Thus, women on the Pill received greater scrutiny from their physicians, encouraging and reflecting women’s greater scrutiny of their own bodies in light of concerns over the Pill’s multitudinous physical and psychological side effects.

\textsuperscript{48} Ibid., 86.
The same concerns about unmarried patients that shaped medical practice in the offices of ACOG’s fellows had surfaced earlier in the clinics of Planned Parenthood. Irving Weiner, the chairman of the Medical Advisory Committee of Planned Parenthood of Orange County wrote to Alan Guttmacher that he was “reluctant to advocate the use of Enovid in our clinics for fear that the tablets may reach the wrong hands,” meaning that every women should have a “thorough pelvic evaluation” before receiving a prescription. Weiner wondered how it would be possible to “guard against the indiscriminate use by the unexamined.”^49^ Medical director Mary Calderone responded that to safeguard against the pills reaching the wrong hands, only two months’ pills were prescribed at a time.\(^50\) Though this inconvenient policy was short-lived, it showed the extent to which Calderone believed that the clinics had a responsibility to monitor usage. While the procedures surrounding the prescription of the Pill were initially based on uncertainty, concern and a lack of consensus on risks and side effects, the procedures for obtaining the Pill were built around controlling and surveying who had access to the new technology. Many women were not opposed to such measures. In fact, plenty of women were just as strongly in favor of stringent restrictions as their physicians.

Planned Parenthood commissioned a “major marketing and motivational research firm” to produce an exhaustive survey of attitudes towards contraception.\(^51\) The research firm National Analysts interviewed a representative sample of women in focus groups and asked them questions about sources of birth control information. Family planning clinics were seldom mentioned. According to the report, “the only time such clinics were mentioned in this context was when an upper socioeconomic status woman reacted with surprised horror when another in

49 Irving Weiner to Alan Guttmacher, December 1, 1961, Box 111, Folder 25, PPFA II, Sophia Smith Collection (SSC).
50 Mary Steichen Calderone to Irving Weiner, September 6, 1961, Box 111, Folder 25, PPFA II, SSC.
her discussion group suggested that Planned Parenthood clinics might offer advice to unmarried girls. The group consensus reaction was decidedly negative with regard to this possibility: it was felt that the proffering of such information was not only unlikely at such clinics, but undesirable. It was not until 1972 that a Massachusetts law prohibiting the sale of contraceptives to unmarried people was struck down by the Supreme Court in *Eisenstadt v. Baird*.

Keeping family planning in the context of marriage meant that it could be associated with the longstanding concern of making better, happier, stronger families. Already in 1963, the Science Service released an enthusiastic press release announcing that “surveys show oral contraceptives contribute to happier marriages.” When mothers were better able to prevent unwanted pregnancies, “marriages improve and the home is more harmonious.” The happiness the Pill afforded improved the relations between husband and wife as well as the emotional stability of the children. Though the 1963 press release mentioned that the Pill increased libido, understood to be an important component of a healthy marriage, framing the birth control pill as part of a project to improve the family helped to partially camouflage its association with illicit sexuality.

Women pill patients and doctors cooperated in forging tighter, more intrusive relationships, but there were voices of dissent. Some physicians pushed back against the assumption that it was their business to prescribe contraception at all. Jesse Caldwell, writing in the North Carolina Medical Journal, believed that physicians were inappropriately “caught in the

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52 Ibid., 31.
55 Ibid.
middle” of the disagreement about the Pill. Dedicated advocates were “ecstatic about it,” the “foundations of the Roman Catholic Church” were shaken by it, and physicians were faced with “citizens” demanding the “‘right’ to get pregnancy when they want to.” Despite his obvious moral reservations, Caldwell relied upon his logic as a physician by citing side effects and medical concerns as his primary reason for doubting whether physicians should be prescribing the Pill. Caldwell argued that contraceptives were not a “medical service,” since “no disease or pathological condition” was being treated. Providing contraceptives inappropriately cast “the role of the physicians as a sociologist or as a panderer to the women in his practice.” These concerns about the impact of market pressures on medical practice, and the medicalization of reproduction were also emerging concerns for women’s health advocates, though their motivations and reasoning were entirely different.

**The Pill and College Students**

In the early to mid 1960’s, it was common for middle-class married women to be the subjects of psychological interpretation, but once the Pill became more accessible to younger, unmarried women, these women too were subject to scrutiny. College campuses, in particular, were hotbeds of debate on the issue of Pill use by unmarried students. While some considered contraception basic healthcare, others believed that students requesting contraception were really “asking that universities express an opinion on the new morality,” and dispensing the Pill would

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57 Ibid., 372.
58 For a comprehensive account of the contraceptive revolution on campus, see Heather Munro Prescott, *Student Bodies: The Influence of Student Health Services in American Society & Medicine* (University of Michigan Press, 2007).
“undoubtedly be interpreted by students as an administrative sanction to sexual freedom.”  

Even those who saw contraceptives as a medical issue, and not a moral issue, still maintained that a doctor might steer a student to “psychiatric help” if her own moral standards were not deemed to be “mature and consistent.” In fact, psychiatric services on campuses were expanding concurrently along with contraceptive services, and the two movements were intertwined.

In 1964, extensive mental health services were already available at elite universities such as Columbia, Yale, and Harvard, and the trend of expanding campus health services to include contraceptive counseling as well as psychiatric help expanded to dozens of universities across the countries in the second part of the 1960s. In 1967, almost half of college health services offered contraceptive pills, but very few did so for students who were not married or engaged. This requirement dissolved quickly in the next few years as many colleges and universities moved towards a policy of providing contraceptives to all students through their health services. Demand for psychiatric and counseling services on campuses grew just as student health services became involved in contraception. According to Seymour L. Halleck, psychiatrist at the University of Wisconsin, new sexual attitudes and freedoms were causing pressures on young women that were “leading to promiscuity, guilt, personal devaluation, and

even mental illness.” 64 Halleck described the stresses and worries over sexual relationships that plagued some of his patients, calling these women “casualties of the sexual revolution.” 65 The permissive atmosphere of “highly publicized sexual freedom” allegedly pressured women into unhealthy relationships that quickly led them into a maladaptive “trap of promiscuity because of loneliness and lack of self-confidence.” 66 Deans and psychiatrists alike believed that “discipline” and “less permissiveness” were necessary, even if it meant that students would protest. 67

In 1967, Dr. Marjorie Nelson, the head of Barnard’s Health Service, explicitly linked mental health issues to the college’s policy on contraceptives. Barnard did not give “contraceptive information to unmarried girls” because there were “too many anxious and unsure girls who should find themselves first.” 68 In addition to her belief that her students were not mature enough for sex, Nelson blamed “sexual problems” as the reason explaining why Barnard’s counseling service was proportionally larger than Columbia’s service. 69 Criticizing the health service under Nelson, a student gave the telling description of care; “If it hurts above the neck it’s your wisdom tooth. If it’s below, you’re pregnant. If it’s neither, it’s ‘in your mind’.” 70 Staying away from a student health service that would inform a student’s parents if she were found to be pregnant, Barnard students knew where to obtain contraceptives, and many found them at Planned Parenthood and other local clinics. Just five years later, Barnard was cited as a case where the introduction of a program providing birth control and abortion referrals

64 Joan Beck, “Sex And The College Girl.”
65 Ibid.
66 Ibid.
67 Fred M. Hechinger, “Couch on Campus: Psychiatric Experts Find Danger in Bright, Immature Students.”
68 Ronnie Friedland, “Sex and the Barnard Girl.”
69 Ibid.
met with little resistance, and a new director of the health service said that she would rather give the students accurate information than have them search on their own.71

Controlling Access

Physicians framed access to the Pill as an issue of social importance that required expert supervision. Several historians have considered the question of how women’s access to the Pill was managed in a range of different settings. Taking a expansive view, Leah Aronowsky and Laura Stark assess that “state-mandated gate-keeping mechanisms, such as prescription requirements” have been used throughout the 20th century to either aid or encumber women’s access to contraception.72 With the FDA approval of Enovid, physicians gladly took on the role of mediating women’s access to the drug while building their practices and promoting profit for pharmaceutical producers. Since barriers to access impact certain kinds of women more than others, Stark and Aronowsky conclude that the practices of mediating access to contraception act as a mechanism “through which states accentuate gender disparities and socioeconomic inequality.”73

Taking a closer look at a specific case, historian Beth Bailey provides a study of what it was like to obtain birth control in her history of the sexual revolution in the small university town of Lawrence, Kansas. Bailey charted the trajectories of three separate clinics, showing the shifting and sometimes contradictory visions of what was at stake in providing the Pill to patients. The easiest and most affordable place to get birth control pills in Lawrence, Kansas was the public health department. Funded by the Kansas State Department of Health, the

71 Jane E. Brody, “Colleges Expand Modern Psychiatric Aid.”
73 Ibid., 37.
clinic was started by the director of Lawrence’s public health department, Dr. Dale Clinton, in 1966.\textsuperscript{74} Using government funding for contraception was still a relatively new concept. In 1965, President Lyndon B. Johnson was the first sitting president to announce any support for birth control when he pledged in his State of the Union address “to seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources.”\textsuperscript{75} Inspired by population concerns, Clinton’s goal was to dispense contraceptive pills to any woman who requested them without requiring the “ordeal” of an exam, which was highly unusual.\textsuperscript{76} Since most of the women who permanently lived in Lawrence were married and could obtain contraceptives from their private family doctors or gynecologists, the vast majority of the women who attended the public health office clinic were students.

Clinton’s philosophy clashed both with the University of Kansas health service’s approach and with Planned Parenthood, which operated a clinic in Lawrence from 1967 to 1970. Like most college campuses, the University of Kansas did not offer any gynecological services or contraceptives to unmarried students, and Planned Parenthood would only prescribe the Pill after counseling, education and an exam. With the University unwilling to take on the issue of birth control and the Planned Parenthood clinic resources already overwhelmed, it was not surprising that students went to the public health clinic where they could quickly and anonymously get the Pill.

In 1972, the Kansas State Department of Health cut funding from Clinton’s program because he ignored the mandate that required doctors follow a specific procedure for prescribing

\textsuperscript{75} Bailey, \textit{Sex in the Heartland}, 109.
\textsuperscript{76} Ibid., 114.
the Pill including a complete physical exam and laboratory tests. Adamant that public health departments were not appropriate sites for comprehensive medical care, Clinton believed these services were merely a mechanism to divert birth control funding, and roadblocks that stood in the way of women accessing contraception. Clinton argued that requiring examinations would be “using birth control as a carrot (or a whip),” referring to the popular idea that women would only voluntarily undergo examinations if they were doing so with the promise of access to the Pill held out in front of them like a carrot. Clinton’s opponents accused him of being condescending and irresponsible for making no attempt to educate women about the Pill, but after his program’s funding was pulled, women voted with their feet. After the loss of the federal grant, the clinic accepted small donations in exchange for services, and ran a $10,000 surplus. If this situation is read as a sort of unintentional experiment, then it was clear that many women preferred access to birth control pills without counseling and examinations, though most were willing to submit to the new regime of the examination if there was no easy alternative. After opposition led by Petey Cerf, a local woman of an older generation not involved with the feminist movement, Clinton was forced to close his program and resign in 1973. Though Clinton’s authority was challenged, it was not under the guise of women’s rights. Bailey’s work, in addition to Aronowsky and Stark’s paper, show how state interests, among many others, shaped access to the Pill. The interests of women, physicians, and the state converged and diverged as the political valences of the Pill shifted. While many women desired easy access to the Pill, some requested the very same sorts of mediation that others resisted.

77 Ibid., 130.
78 Ibid.
79 Ibid., 131.
The Premarital Exam

As a comparison to the Kansas case, a study of North Carolina college students indicated a strong desire for contraceptive information and examination in the context of a “premarital examination.” In 1969, North Carolina, along with 43 other states, required that all applicants for a marriage license produce a “medical certificate certifying freedom from venereal disease” as well proof that the applicant did not have tuberculosis or uncontrolled epilepsy, and was “not an idiot, imbecile, mentally defective, or of unsound mind.” The patients who were interviewed in the study, however, had little knowledge of what the law required, and what the premarital exam entailed.

Ethel Nash from the Department of Obstetrics and Gynecology at the University of North Carolina School of Medicine noted that “the present generation of American young people has grown to adulthood during a century which has seen significant national shifts in attitudes towards sexuality.” Nash described the “repressive asceticism” of the generation’s parents, writing, “coitus was the price a woman must pay for bed, board, the status of ‘Mrs.,’ and those wonderful blessings: babies.” In contrast to the older generation, young people were eager for more information about sexuality and sexual adjustment in marriage if only they were not too shy to ask. Nash believed that communication difficulties were standing in the way of open communication between the “then” and the “now” generations, and physicians needed to take the initiative to ask questions. The key issue was that young people were generally too embarrassed to bring up the issues they most wanted to discuss, and they instead waited for the physician to broach the issue. “Most desired by all respondents, black and white, male and female, is

81 Ethel M. Nash and Lois M. Louden, “The Premarital Medical Examination and the Carolina Population Center.”
82 Ibid., 2368.
information about methods of contraception.” Nash noted that many patients wrote-in statements such as “‘I want the doctor to offer information about contraception without my having to ask.’” Patients were concerned about “the importance of determining reproductive potential and correcting any conditions that could make the initiation of coitus difficult.” Thus, Nash supported the resolution passed at the 1969 American Medical Association annual meeting supporting the inauguration of “support programs of health education” including “family life and sex education.”

Not only would this education prevent unwanted pregnancies, but it would also improve the quality of marriage and prevent divorce. Though such promotion of sexuality education made sense in the context of the sexual revolution, in the minds of those concerned with family planning, it was also perfectly coherent with early Cold War era ideas about the importance of stable marriages, and the place of healthy sexuality within them. Explaining the importance of sex in terms of biology, rather than pleasure, Nash wrote “coitus is the foundation for ‘biological peace’ between a married couple.”

The premarital pelvic exam became a common prerequisite for a marriage license in the 1950s and 1960s as part of an state-mandated effort to curb venereal disease, but it also was used as an opportunity to educate the couple about healthy heterosexual adjustment. Historian Carolyn Herbst Lewis has shown how these exams were an important part of how physicians constructed their role as sexual counselors and experts on psychosexual development. A sexually fulfilling marriage was deemed the basis of a healthy family, and therefore a secure

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83 Ibid.
84 Ibid.
85 Ibid., 2367.
86 Ibid., 2369.
87 Ibid.
nation. Lewis describes how during the pelvic examination, the physician would “monitor a woman’s response to penetration and thereby estimate her ability to experience vaginal orgasm.” When “a passive and receptive vaginal orgasm [w]as the hallmark of a well-adjusted and normal femininity,” leaving the job of “defloration” to a “bungling’ bridegroom” was simply not a risk worth taking. With divorce rates on the rise and “frigidity” cited as a common reason, the premarital exam was an important point of intervention to set the stage for a happy wedding night and a peaceful marriage. This also set the stage for doctors advertising the Pill to women before their weddings with the promise of a period-free honeymoon.

The premarital pelvic exam was necessary to test women’s acceptance of their femininity and provide medical intervention when necessary. Such intervention could take the form of either psychiatric counseling, or the physical use of vaginal dilators or hymeneal surgery. Many couples were eager for such education and believed that guidance from a physician would ease a bride’s anxiety about her wedding. In Nash’s study, upwards of 95% of the female respondents “hoped for a pelvic examination.” These women had made the correct assumption that "since

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91 Mary Calderone to I.L. Epstein, Chairman, Medical Advisory Committee, Planned Parenthood of Queens, NY, March 20, 1962, PPFA II, Box 111, Folder 26, SSC. For recommendations on starting birth control before a wedding, see The Consumers Union Report on Family Planning: a Guide to Contraceptive Methods and Materials for Use in Child Spacing, Techniques for Improving Fertility, and Recognized Adoption Procedures, Prepared by the Editors of Consumer Reports and Alan F. Guttmacher [et Al.], 86.

the doctor is the only professional who knows the body and is allowed to touch and see it, then he must be the most reliable source of sexual information.”

While patients might have relied upon their physicians for reliable and truthful advice, textbooks instructing physicians on how to approach premarital exams did not always promote such honest communication. For example, one textbook suggested that unmarried women often deny sexual contact, and therefore physicians should place “much more reliance…on the findings of a physical examination than on what the patient has told the physician.” Since men were assumed to have already had sex before marriage, their instruction was geared towards making the groom aware of “both the psychologic and the physical differences between the former consorts of the groom and the girl he is going to marry.” Supposedly, men were having sex with “prostitutes or pickups” while their future brides were virgins, but the existence of the Pill quickly threatened this antiquated notion, and changing expectations opened up the possibility for women admit to sexual activity.

Family Planning for Nurses

Beyond doctors and patients, there were a number of interested parties in the field of family planning. In the struggle over access and responsibility, family planning nurses emerged as important intermediaries between doctors and patients. Searle, a manufacturer of several

93 Ibid., 2368.
94 J Greenhill, *Office Gynecolgy*, 9th ed. rev. and enl. (Chicago: Year Book Medical Pub., 1971), 17. Comparing the 1965 and 1971 editions of this book, the text was almost identical, but the drawings and diagrams were more realistically rendered in the 1971 edition.
95 Ibid., 327.
popular brands of the Pill, produced a manual for nurses intended to provide them with helpful, educational information. The manual served not only to provide nurses with information, but it was also designed to manage their concerns about the Pill. In fact, much of the manual was concerned with convincing nurses that family planning was important and that they in fact had the authority to encourage family planning.

The manual explained that the National Council of Churches, American Medical Association, and new government funding streams such as Medicare and the Economic Opportunity Act all favored responsible family planning. Though there were many conflicting points of view on the subject, most agreed that uncontrolled fertility was a hazard for individuals, families, and societies. In order to encourage nurses to think of family planning as part of their purview, the manual emphasized that family planning concerned everyone, even though “motivations” may differ. For some, the motivation was “physical or mental health: that is, preventing the breakdown of maternal health through too many and too closely spaced pregnancies; and preventing the birth of children who through lack of love and proper care will fail to develop healthy minds and bodies….Still others are trying to reduce welfare rolls, or deal with other urban problems such as overcrowded schools or housing, juvenile delinquency and crime…”

One reason why it was so critical to make sure that nurses had a positive attitude toward family planning was that their attitudes were easily passed onto patients. If a nurse was relaxed about family planning, this would relieve tension in her patients and she would be able to effectively communicate accurate information. If the nurse was embarrassed, she would

98 Ibid., 38.
“embarrass her patient, too.”99 Since many women had never been to a family planning clinic or had a pelvic examination, nurses needed to ease the fear of the unknown with factual accounts of what happened at such a visit.100

The pamphlet also helped the nurse to identify who might be a good candidate for family planning information. Women confined to the hospital after childbirth were a captive audience. The structure of maternity care in hospitals meant that many women were already attending classes led by nurses during their maternity stays, and family planning information could be easily integrated into existing educational sections. Patients could learn about various contraceptive methods, express their preferences, and then receive a “promise” that when they returned to the hospital for a postpartum check-up, they would receive instructions and supplies for the method that they chose.101 This arrangement was convenient for women planning to use a birth control method postpartum, and it also brought women back to the hospital for preventive care. As the manual noted, “hospitals making this offer have found that the percentage of patients returning for the postpartum examination has climbed spectacularly- a sequel highly gratifying to their physicians…”102

While offering a mother family planning information in conjunction with a child’s birth might have been a matter of convenience and practicality, other situations required more judgment on the part of the nurse. A low-income family might seem like an obvious target, but only if they had children already.103 Another situation that involved some discretion on the part of the nurse was the case of the newly-wed or engaged couple. With marriage rates falling in the

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99 Ibid., 43.
100 Ibid.
101 Ibid.
102 Ibid., 44.
103 Ibid.
early 1960s, even young married couples having children too soon became a concern. “Marrying at an early age, many young couples lack the maturity and financial resources for responsible parenthood. A baby coming along too soon can even wreck the marriage.”\textsuperscript{104} While nurses were not usually in a position to discourage teenage couples from marrying, they could at least help young brides who were not already pregnant avoid pregnancy for a few years. Even more controversial than teenage marriages were unmarried mothers. Providing such women with contraception was considered controversial, but social aims increasingly trumped moral concerns. The goal was to prevent the birth of another presumably “unwanted child” and “avoid the hazards implicit in out-of-wedlock pregnancies.”\textsuperscript{105}

Though nurses played a key role in family planning, it was important to note that their role was limited. Though physicians were in charge, the nurse needed to carefully negotiate her place because the “general public still tend[ed] to look to nurses for advice on health.”\textsuperscript{106} Particularly in the setting of a gynecologist’s office, nurses were necessary intermediaries between male doctors and female patients, and in hospital settings, they had unique insights into patient care.\textsuperscript{107} The manual cast nurses as properly reluctant to take on the role of doctor, and explained that they must frequently remind their patients to consult their doctors. The emphasis on this issue indicated that the division of labor and authority between nurses and physicians was a perceived area of tension. The manual aimed to allay nurses’ fears that they could be overstepping their bounds and threatening doctors, while reassuring doctors that allowing nurses to do family planning work would not threaten their own authority. Also, Searle would not want

\textsuperscript{104} Ibid.
\textsuperscript{105} Ibid.
\textsuperscript{106} Ibid., 38.
family planning to be construed as something that could be taken so lightly that it could be entirely relegated to nurses. Searle and the other major players with much to gain had worked hard to promote contraception as a legitimate medical issue and they wanted to promote it as a respectable part of a physician’s job.

Teaching Family Planning to Medical Students

In 1966, a group of physicians met at a conference in New York City to discuss the emerging practice of teaching family planning to medical students. The attendees were deans and professors from the country’s most prestigious medical schools, including quite a few professors of obstetrics and gynecology, and they intended to form a syllabus that medical schools could adapt to integrate family planning into medical education. In the rapidly changing context of the 1960s, physicians found that the traditional doctor-patient relationship, as they had known it, had become obsolete. There was an imperative to train the next generation of physicians to manage the challenges associated with shifting structures of authority, in addition to the moral challenges brought upon by public perceptions of the sexual revolution and population explosion. Popular interest in the contraceptive pill, in particular, brought these issues to the fore and served as a lightning rod for tensions over the role of physicians in society, the management and supervision of women’s sexuality, and the context of contraception access.

At the conclusion of the conference, John Z. Bowers, the president of the Macy foundation for health and medicine, summed up the major problems facing medical education.

Aside from the basic fact that physicians needed to learn more about family planning, a lack of coordination between departments resulted in major deficiencies in teaching. Bowers suggested that coming up with a family planning curriculum would necessitate bringing together the basic science departments, clinical departments, especially Obstetrics and Psychiatry, and social sciences such as sociology. The result would be a “‘crash’ program to strengthen the teaching of family planning in medicine.

At the time, medical schools spent surprisingly little time teaching family planning. Physicians at the conference recognized that family planning was not receiving the attention it deserved, and material went untaught because nobody was certain who should take responsibility. For example, one school might relegate an aspect of fertility regulation to the department of environmental medicine, while another medical school might include this information within the department of obstetrics and gynecology.

Using data compiled from 70 schools, Schuyler G. Kohl, an obstetrics and gynecology professor at SUNY Downstate Medical Center, concluded that 80 percent of medical schools spent “less than four hours of lecture time, during the four years of medical school” on fertility regulation, while, 50 percent “gave less than two hours of lecture time to this subject matter.” Clinical experience time was “perhaps three hours or fewer.” Much of the practical experience that medical students received was in post-partum clinics. Patients often received information about fertility control, prescriptions or IUD insertions at these visits. Reflecting the

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110 Ibid., x.
111 Ibid.
113 Ibid., 11.
114 Ibid.
115 Ibid., 12.
well-entrenched professional hierarchy evident in Searle’s family planning manual for nurses, Kohl said “if we can train nurse midwives to insert IUD’s, I think the medical student is potentially as adept and intelligent.”

While sometimes the lack of communication between the medical disciplines meant that family planning was left out, in other instances, close collaboration was the rule. John Romano, chairman of the department of psychiatry at the University of Rochester, emphasized the interdisciplinary nature of medical education at his institution. Romano credited the level of interaction and exchange to the departments’ close physical proximity, and throughout his talk, Romano mentioned the departments of psychiatry, obstetrics and preventive medicine frequently in relation to one another. Romano’s comments also offered some insight into why psychiatry was so heavily represented in family planning literature. Even among patients deemed perfectly normal and psychologically healthy, the loaded emotions and weighty issues surrounding reproduction and sexuality meant that psychiatry was never far away.

In order to explain the degree of interaction between obstetrics and psychiatry, Romano used the example that Rochester never even needed to set up a “formal hospital committee to study and judge each application for therapeutic abortion.” Approval for therapeutic abortion often required a psychiatrist and obstetrician/gynecologist appearing before a hospital review board, so such cases required collaboration between the two disciplines. A low therapeutic abortion rate was a measure of a hospital’s prestige, and this was perhaps aided by good communication between the departments.

116 Ibid.
Romano pinpointed obstetrics as the branch of medicine where patients most frequently came for “educational health purposes and for guidance in their marriages.” He continued, “they come to insure the proper conduct of their pregnancies, and when non-pregnant, for periodic and preventive examination. They come because of their concern with menstrual problems, for premarital and marital counseling, and for advice about contraception and sterility.” Also, to help medical students gain firsthand experience with contraceptive methods, they were given an opportunity to be placed at the local Planned Parenthood Clinic.

While students studying obstetrics might learn about family planning through teaching their patients about contraception, psychiatry students came to study the same issues from a different angle. During their clinical assignments in psychiatry, students had ample opportunity to see patients facing difficulties, struggling with “anxiety, shame, and guilt…related to sexual behavior and marriage problems.” Psychiatry students saw “unwed mothers following suicidal attempts, persons in homosexual panics, unmarried and married women who [we]re considering or requesting therapeutic abortion or sterilization, and postpartum psychotic reactions.” Romano also mentioned that students learned “something about the range of acceptance and conflict about the use of contraceptive devices.” This indicated that sex and reproduction loomed large as core issues that brought patients to psychiatrists for help. As sex education became part of medical education, the disciplines of obstetrics/gynecology and psychiatry were able to cooperate on areas of mutual interest.

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118 Ibid., 80.
119 Ibid.
120 Ibid.
121 Ibid., 81.
122 Ibid.
123 Ibid.
In 1966, there was growing consensus among physicians that in order to realize their “great potential as case finder and as healer,” they needed to learn more about sexual practices and behaviors.\textsuperscript{124} Though gynecologists and psychiatrists were most active in this pursuit, family practice physicians were not far behind in laying claim to a position of importance in recognizing sexual problems within the family. Sufficient knowledge and training about sexual practices was necessary in order to distinguish purely somatic disorders from those arising from psychic causes and sexual disorders. Learning about sexuality was on its way towards being recognized as a necessary part of medical training.

The same year as the \textit{Teaching Family Planning to Medical Students} conference, Harold Lief presented his thoughts on the physician and family planning at the 62\textsuperscript{nd} annual Congress on Medical Education, sponsored by the AMA Council on Medical Education in Chicago.\textsuperscript{125} Lief was not an obstetrician/gynecologist, but rather another psychiatrist interested in family planning. As a passionate believer in the importance of information and education about sexuality, he advocated developing a curriculum for introducing sexuality education into the medical school curriculum. Lief’s remarks at the 1966 conference, however, focused on constructing an argument for why physicians should care about family planning in the first place, reinforcing the idea that this was a controversial point that needed arguing.

While many physicians worked out rationales for why family planning lay within their purviews, Lief advocated a different strategy. He promoted the need to actually broaden the field of family planning and he presented a clear mandate on his vision of what family planning should include. He explained that “we cannot enlist the active support of every physician in the


land unless we broaden the concept of family planning to include, in addition to contraception, such items as the timing of marriage, the timing of the first child, child spacing, the total number of children in the family, and, most importantly, the sexual and general marital adjustment for the parents.”

Lief’s vision was not entirely new. Though his views of sexual morality were decidedly liberal, he borrowed from the field of family life education, which had strong institutional and ideological support during the 1950s. Based on middle class ideals, family life education supporters sought to "raise the standards of home life” and enable people to live more constructively.

Influenced by the success of Family Life Education, Mary Calderone founded the Sexuality Information and Education Council of the United States (SIECUS) in 1964. As Calderone maintained her belief that a fulfilling marriage was the ultimate goal for women and men, she was “profoundly ambivalent” about the sexual revolution. For those who saw the value of the Pill in strengthening families and marriages, the Pill’s association with the sexual revolution was problematic. Despite Calderone’s traditional moral leanings and distaste for promiscuity, conservatives accused her of trying to eliminate inhibitions and taboos. Separating the Pill from the sexual revolution was often in family planners’ best interests.

In Calderone’s colleague Alan Guttmacher’s assessment, new contraceptives played a part in the sexual revolution, but the “elimination of legalized prostitution, a single sex standard accruing from the emancipation of women, the steady date pattern, unchaperoned use of automobiles, coed campuses,” were all just as important. He observed patterns of gender

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126 Ibid., 128–9.
128 Ibid.
129 Ibid., 165.
130 Ibid., 182.
relations in flux in a whole range of arenas. In an article with the definitive headline “Sex Revolution Not Due to Pill,” Guttmacher remarked, “people want to tar and feather us because they feel the pill is the responsible agent for the whole thing,” but he maintained that “the rapid change in the sex habits of American youth” began prior to the introduction of the Pill.131 Though Guttmacher was right that teenage sex increased in the 1950s as births and marriages among teenage women peaked, historians contextualize this trend as indicative of the postwar baby boom rather than the sexual revolution.132 Guttmacher aimed to separate the Pill from its association with sexual liberation and frame it as a means to strengthen the institution of marriage by protecting young couples from “unwise and unplanned pregnancies” that caused resentment, divorce and ruined career ambitions.

Though Lief’s reasoning was similar, he took a developmental approach to the issue. “At this time in their lives, young people are attracted to one another for maladaptive reasons; to obtain illusory security, status or sexual pleasure, to make a pregnancy legal, to rebel against parental wishes, to overcome loneliness, to become one of the crowd, to attain independence” among others.133 To Lief, the physician’s responsibility was to postpone pregnancy and marriage to protect young people from making irreparable mistakes.134 Providing contraception and information about sexuality was ultimately part of the bigger and more important job of helping the patient start a healthy family and build a strong country as a result. Over the next few years, Lief went on to further the cause of improving sexuality education by starting the

Center for the Study of Sex Education in Medicine at the University of Pennsylvania where he advocated for medical student education and training in marriage counseling.

Lief’s vision for family planning was also in line with the way that gynecologists were reconceptualizing their own field. In 1968, gynecologist Richard Burman popularized the concept that gynecologists should serve as primary care physician for women in an address to the Section on Gynecology of the Southern Medical Association.\(^\text{135}\) Burman argued that the “true woman’s physician is actually, other than her husband, the most intimate man in her life” because he needed to be able to discuss population control, marriage, sexuality, and other personal matters.\(^\text{136}\) While the patient’s presumably employed husband was sent by his “business firm, or by his Board of Directors” for an annual checkup, women were generally excluded from this practice.\(^\text{137}\) Thus, gynecologists were poised to become women’s physicians, and to claim “family life and its components” under their jurisdiction in addition to encouraging twice annual gynecological exams.\(^\text{138}\) Using the pretext of women’s frail emotional states as a justification for the importance of “women’s physicians,” Burman continued, “So often I have heard young men say, ‘She needs a psychiatrist,’ when all the patient needs is her doctor, the gynecologist.”\(^\text{139}\) Burman’s statement indicted gynecologists for failing to attend to the “emotional factors” particular to women patients.\(^\text{140}\) Neglecting to provide the comprehensive care that the “‘gals’” expected represented a lost opportunity and breach of trust.\(^\text{141}\) While


\(^{137}\) Ibid., 392.

\(^{138}\) Ibid., 394.

\(^{139}\) Ibid.

\(^{140}\) Ibid.

\(^{141}\) Ibid.
physicians debated their proper roles in managing the problems of their women patients, they also began to reassess themselves.

**Changing Attitudes and Students**

The focus on social responsibility encouraged physicians to turn their gaze inward and re-evaluate their roles and values. A significant portion of the *Teaching Family Planning to Medical Students* conference focused on the “changing attitudes of medical students towards family planning,” and a chapter of the resulting book was dedicated to this topic. This richly detailed section of the conference delved into a frank discussion of the construction of medical expertise, exploring how a “layperson” transformed into a doctor, and what distinguished a doctor from any other layperson of the same age and social class.

According to Theodore Fox, a physician at the Family Planning Association in London, England, the task of the medical school teacher was to “turn a layman into a doctor” by teaching him to “behave differently” and to “alter his reactions.” This meant that he needed to sensitize himself to certain things, while desensitizing himself to others. The medical student “usually start[ed] as a fairly normal person; and the normal reaction of a normal person, when he sees something horrible, such as a bad accident, is to get away.” However, through learning to be “objective,” “impersonal” and “detached,” the doctor could, up to a point, “get straight down to whatever need[ed] to be done, genuinely untroubled by emotion,” and become “more useful than other people.”

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143 Ibid.
144 Ibid., 66.
145 Ibid.
“enhance his awareness of what other people [we]re thinking and feeling.” 146 The interrelated roles of doctor and patient were crucial in such clinical interactions.

In the classical doctor-patient relationship, the patient admits ignorance and helplessness. He says: ‘O Doctor, I can’t understand what’s gone wrong, and I place myself unreservedly in your hands.’ This call on him brings out the best in the physician, who is thereupon prepared, if need be, to do far more than is expected of him. Probably the deepest satisfaction that the physician can get comes of this response, in which he gives what nobody can buy. 147

Fox remarked on the trend, however, that unless patients were in “grave distress,” they were “less and less likely to make the patient’s ‘act of submission.’” 148 Instead, Fox noticed patients treating their doctors more and more like “equals, if not inferiors.” He also detected the sense that patients had began thinking of themselves as employers, no longer “coming as a supplicant,” but looking at the physician “as he looks on the plumber who mends his pipes or the mechanic who sees his car.” 149 In Fox’s satiric interpretation, “‘Oh, John,’ they say, ‘I’ve sent for you because I rather think of trying a new remedy described in Readers’ Digest.’” 150 Since the physician’s professional expertise relied upon some degree of privileged access to information, the concept that a patient might believe that he too could make decisions based on his own information was particularly troubling.

Fox, keenly aware of the importance of the doctor-patient relationship, did not describe the problem as one of specialized knowledge or popular health information, but rather one of interpersonal relationships. To Fox, what was lost was the need to form a “personal relationship” with the physician. The patient failed to see that if he got “his way and abolishe[d]
the patient in favor of the client or customer, he will abolish the physician, too.”

Fox continued, “the physician as such does not exist without the patient: unless we get the appropriate stimulus, we do not make the necessary change into professional gear.” Without the correct stimulus, the physician was just another person, with the same prejudices and fears as anyone else. The patient’s “act of submission” was a necessary precondition for the physician to transcend the regular constraints of everyday life. Because of this, the fates and identities of doctors and patients were intricately connected and one could not change without the other.

Fox was uncommon in the level of consideration he gave to the socially constructed nature of physicians’ authority. A more common sentiment was the desire to hold on to the idea that physicians were by nature special people who were somehow exempt from having to learn the same things as everyone else. Harvard psychiatrist John Nemiah admitted to a group of medical students:

> I have always had, even since childhood, the image of the doctor (and by extension the medical student) as a very special sort of person who knew everything—even though rationally I know this is not so, somehow, I still believe it, and hate to give up the fiction.”

Nemiah’s statement indicated that despite a desire to hold onto a romantic fiction, some patients were beginning to demand a new model of the doctor-patient relationship that challenged the physician’s privileged position. Physicians, too, were just as aware that they needed to concern themselves with understanding their roles and teaching a new generation of doctors. These changes did not usually happen smoothly or in sync with one another, but the interconnectedness of doctors and patients meant that their roles were negotiated in tandem. Challenges to the

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151 Ibid., 69.
152 Ibid., 69.
traditional doctor-patient role came from other disciples as well. Law and bioethics expanded their reach into medical decision-making, introducing regulation into what had previously been more or less private encounters between doctors, patients, and their families.\textsuperscript{154}

**The Social Role of the Physician**

Fox’s description of changing doctor-patient relationships fit squarely with contemporary research in the field of sociology of medicine. Talcott Parsons, who developed the concept of the “sick role” in 1951, was considered the first sociologist to theorize comprehensive system of the roles of doctors and patients.\textsuperscript{155} Parsons considered both the rights and duties of the sick person, noting the interdependence of the physician’s and the patient’s roles. Other models of the doctor-patient relationship were believed to have emerged from Freud’s “interest in the nature of the therapeutic process” and the transference and countertransference between doctor and patient.\textsuperscript{156} These theories helped to explain a patient’s helplessness and dependence, and a physician’s privileged access and communication.\textsuperscript{157} Just as in psychoanalysis, the relationship between doctor and patient could be understood as a manifestation of the patient’s feelings towards his parents and other significant individuals. Patients challenging their roles were threats to physicians’ authority, and the gendered nature of this authority was particularly acute in the case of the Pill, where primarily male experts were struggling to maintain status as experts on the moral implications of women’s contraceptive decisions. The rhetoric of

\textsuperscript{154} Rothman, \textit{Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision-Making}.

\textsuperscript{155} Talcott Parsons, \textit{The Social System} (Glencoe, Ill: Free Press, 1951); Amasa Ford, \textit{The Doctor’s Perspective: Physicians View Their Patients and Practice} (Cleveland Ohio: The Press of Case Western Reserve University, 1967).

\textsuperscript{156} Ford, \textit{The Doctor’s Perspective}, 7.

\textsuperscript{157} For example, Burman referred to patients as “gals” and compared their relationship with their husbands to their relationship with their gynecologists.
obstetrics/gynecology further nurtured the supposed existence of an intimate, special bond between male physicians and young female patients.\textsuperscript{158}

A 1967 study on how physicians viewed their patients and practice illustrated the delicate nature of the “process of mutual role definition.”\textsuperscript{159} Through an exhaustive survey of practicing physicians in an unidentified Midwestern city, the authors, a faculty member at Case Western Reserve University School of Medicine and three clinical psychologists, tracked what physicians considered to be effective and satisfying medical practice. The study focused on how physicians saw themselves, and again, the concept of change loomed large. The study began with the familiar trope idealizing medicine’s past. “The doctor’s relationship to his patients, although it may have been simple in the past, is so no longer.”\textsuperscript{160} Beyond this, physicians recognized that patients themselves were potential experts with insight into physicians’ attitudes. Gynecologists in particular were warned that “ours is the most personal of all branches of medicine, and our patients are most expert at sizing up the ‘woman specialist’ who abstractly views them as no more than walking pelves.”\textsuperscript{161} Patients were also asking more questions. “The formerly compliant patient, better informed and more interested in medicine than ever, is asking questions Dr. Oliver Wendell Holmes would have dismissed as impertinent.”\textsuperscript{162} A formerly compliant patient asking more questions was one thing, but this misbehavior signaled an even larger relational shift. The Freudian undertones of many theories of the doctor-patient relationship signaled that gender and family roles could be coming out of alignment along with traditionally gendered medical authority. These sociological observations foreshadowed the emergence of the

\begin{footnotes}
\footnote{\textsuperscript{159} Ford, \textit{The Doctor’s Perspective}, 3.}
\footnote{\textsuperscript{160} Ibid., v.}
\footnote{\textsuperscript{161} Herman L. Gardner, “The Gynecologist and the Periodic Checkup: Presidential Address,” \textit{American Journal of Obstetrics & Gynecology} 95, no. 1 (May 1, 1966): 1.}
\footnote{\textsuperscript{162} Ford, \textit{The Doctor’s Perspective}, vi.}
\end{footnotes}
women’s health movement, which would quickly gain momentum just a few years later.\textsuperscript{163} Those who were attuned to doctor-patient interactions noticed that patients had already begun to treat doctors differently before the identification of a burgeoning activist movement.

As patients began asking more questions about medicine, physicians responded by writing books written for an educated, lay audience. Louis Lasagna used his position as a nationally prominent physician, pharmacologist and professor at Johns Hopkins to write books, and magazine and newspaper articles for the public.\textsuperscript{164} Lasagna believed that physicians, as members of a profession and as members of society, had a responsibility to write for a popular audience.\textsuperscript{165} In a newspaper review of Lasagna’s book \textit{Life, Death and the Doctor}, journalist Deborah S. Gilman wrote that Lasagna’s thesis was that “the physician must modify his traditional role as servant to the sick person and take up an additional burden as servant to the sick society.”\textsuperscript{166} With a hint of sarcasm, Gilman then added, “What, then are the mutual concerns shared by the physician and the ‘sick society’? Dr. Lasagna—father of seven children—thinks overpopulation is the most critical.”\textsuperscript{167}

One of most prominent themes to emerge from coverage of Lasagna’s work was his belief that women and their physicians needed to be aware of the dangers of the Pill. A review of \textit{Life, Death and the Doctor} that appeared in several newspapers featured the weighty quote, “Since it is my firm conviction that these pills can kill—rarely, to be sure—and that other

\textsuperscript{163} The Boston Women’s Health Book Collective and numerous other feminist activist groups would begin meeting by 1969, though the watershed publications of the movement were not be published until the 1970s. The Boston Women’s Health Book Collective, \textit{Our Bodies, Ourselves: a Book by and for Women}, 1973; Barbara Ehrenreich and Deirdre English, \textit{For her own good: 150 years of the experts’ advice to women} (New York: Anchor Books, 1978).

\textsuperscript{164} After 1970, Lasagna was at the University of Rochester


\textsuperscript{166} Deborah S. Gilman (Patriotic Ledger, Quincy, Massachusetts, August 8, 1968), Louis C. Lasagna Papers, Box 4.2, University of Rochester. The same quote was also in another article: John Dempsey, “Hopkins Physician Thrives on Controversy,” \textit{Sun Magazine}, December 8, 1968, p. 32-39, Louis C. Lasagna Papers, Box 4.3, University of Rochester.

\textsuperscript{167} Ibid.
techniques, properly used, which do not kill, are almost as effective in preventing conception, I believe it bad medical practice not to recommend mechanical contraception to those who can use it.”\textsuperscript{168} Lasagna’s statements about the dangers of the Pill were well suited to newspaper articles weighing whether or not doctors and patients were feeling “disenchanted” with the Pill.\textsuperscript{169} He produced statements that were at once bold and catchy, but also reflected the nuanced decisions that doctors and patients faced. Lasagna made headlines with the line “I personally would not give the pills to my wife,” but he also said that he would discuss them as an option, and “wouldn’t want the pill to be outlawed.”\textsuperscript{170} According to a survey on physician attitudes conducted by the \textit{Ladies’ Home Journal}, Lasagna was in the minority, as 85 percent of doctors would prescribe oral contraceptives to their wives, and 87 percent would approve them to a married patient. As was frequently the case, in coverage of the survey, Lasagna was quoted as the voice of caution against indiscriminate use.\textsuperscript{171}

In the same way that Lasagna saw himself as straddling the line between being an expert and a member of society, the theme of “social responsibility” had become a persuasive value to physicians in the 1960s. The goal of curing patients and curing society became one in the same,


and the line between the physical, the psychological and the psychosomatic were just as easily blurred. Appropriately, Alan Barnes ended the social responsibility conference with the statement:

We live in a society which is shooting at us, and the bullets strike us and our patients in almost a random fashion. We call the bullet wounds ulcers, menstrual irregularity, pelvic, pain, frigidity, psychoneurosis- and we bind up each wound as though it were an isolated medical event rather than recognizing it as always part of a larger struggle.  

The New Sex Ed for Medical Students

Harold Lief’s Center for the Study of Sex Education in Medicine at the University of Pennsylvania represented a new vision of medical expertise, revamped for the sexual revolution. At once combining elements of family life education with an unusually bold treatment of sexuality, medical students took part in the project of self-exploration and examined their own biases in class exercises.

Lief made a series of films called “Sexuality in the Medical School Curriculum: an introduction for medical educators.” Produced by Ortho Pharmaceutical Corporation’s Department of Educational Services, these films were yet another source of family planning information sponsored by a pharmaceutical manufacturer. In the films, Lief introduced himself and explained that he would show a conjoint session of sex and marriage counseling in order to teach clinicians about this work. He then staged a mock interview in order to demonstrate what might happen during the first session between a patient and a counselor, interviewing a couple about their relationship, upbringing, family, and how they met in a relaxed setting. At the end of

the mock interview session, Lief took on the role of a teacher standing in front of a chalkboard, and proceeded to go back and re-play sections of the interview interspersed with analysis and commentary, highlighting the most important stages in the clinical encounter such as building rapport, appraising the problem, and paying attention to nonverbal cues about feelings and attitudes. Calling attention to the “husband” and “wife” depicted in film, Lief instructed viewers to observe how the couple interacted and to look for the individual strengths and coping patterns that could be emphasized in counseling. Lief emphasized educating the couple to reduce the confusion, anxiety, and tension that interfered with communication.

A set of clinical encounters illustrated two complementary situations: the insecure and embarrassed “Frigid Wife,” who blamed herself for her marital troubles, and the angry and defensive “Impotent Husband,” who blamed his wife. The familiar, stereotyped behaviors of the husband and wife were perhaps played up so as to be easily identifiable to the medical student. One of the recurring themes in Lief’s analysis was his insistence that negative conditioning from childhood left women with bad feelings towards sexuality. The counselor mentioned negative conditioning as a possible source of the “frigid wife’s” problems, but the “impotent husband’s” past was not discussed. The “frigid wife” conceded that her mother probably did instill in her the idea that sex was dirty, and this was a step towards resolving her marital troubles. Helping patients identify negative attitudes was just part of the project. In order for medical students to uncover their own negative beliefs about sex, clinicians and

medical educators needed to first understand “their own attitudes and beliefs and how these stand in relation to peers and society.”

To accomplish this task, Lief developed an assessment measure called the Sex Knowledge Attitude Test. In addition to recommending that students take this test, Lief demonstrated an exercise for instructors to conduct with medical students. Together with a female facilitator, Lief showed a “sexual film” to a co-ed class of medical students. In order to help the medical students better understand their attitudes, they needed to learn about a variety of sexual behaviors. Lief believed that confrontation and reflection would lead to acceptance and comfort, and the discussion after the film was important so that the students could process the “emotional film” on an “emotional level.” Lief was clear that women should teach this course along with men, explaining that team teaching with a “man and woman provides a more comfortable atmosphere for exploration of attitudes.” He added that it was especially necessary for women to teach “in today’s sexual revolution.”

The male and female medical students had fairly different reactions to the sexual film, and this seemed to emphasize Lief’s point. A male student said the film was “somewhat different from a stag movie—it was happy,” while a female student observed that the “male was the aggressor and the female body was the focus.” The fact that these students realized that their reactions differed contributed to the educational component of the discussion and exercise. On film, the students appeared to approach the material honestly, and were interested in their

174 Harold I. Stanley Lief and Center for the Study of Sex Education in Medicine, Sexuality in the Medical School Curriculum: An Introduction for Medical Educators Reed (Ortho Pharmaceutical; National Medical Audiovisual Center, 1972), History of Medicine Division, National Library of Medicine.
175 Ibid.
176 Ibid. The “female point of view” was valued in providing education on morality and sex. Alan Guttmacher to Marsden Fox, MD, July 20, 1968, Itinerary-November/December 1968, Alan Guttmacher papers, Box 7, Folder 1, Harvard Medical Library, Francis A. Countway Library of Medicine.
177 Ibid.
reactions and the opinions of their classmates. One of Lief’s students, reflecting back on the experience, said “as a blushing first-year medical student, one of only a handful of women in classrooms full of men, I was shocked and embarrassed when we watched Dr. Lief’s documentary film with graphic video clips.”

Still, the student recognized that the training was important to her work as a doctor, and Lief’s groundbreaking work in this burgeoning field would quickly become commonplace.

Considered controversial at the time, and possibly even part of a communist plot according to the most extreme critics, Lief’s center was at the cutting edge of bringing new techniques into medical schools and sexuality into medical education. Lief was recognized as “the guiding spirit behind the development of human sexuality courses in medical schools.”

When Harvard Medical School began offering a series of sex education lectures for medical students, Lief was enthusiastically cited as the impetus for the initiative. Even when contraception was not the immediate issue that brought a patient to a counselor, or a class of medical students to see Lief, sexual adjustment was an important factor in correctly using contraception, and marital problems often manifested themselves in contraceptive problems as well. Lief’s views merged a psychoanalytic orientation, in that he believed repressed conflicts were at the heart of his patients’ sexual problems, along with the new ethos of expanded sex education for the sexual revolution. In order to achieve his vision, Lief encouraged physicians and students to reflect on their own training and values.

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In the process of trying to understand their patients and the social context surrounding them, the fields of obstetrics/gynecology and psychiatry found themselves in a situation where they needed to analyze and identify themselves. Not only were doctor-patient relationships and the conventions that shaped these interactions in flux, but so too were the relationships between physicians and nurses, and instructors and medical students. Physicians fashioned themselves as first line responders at critical developmental junctures and sources of trusted information and support for the most important personal and family problems. While physicians may have been confident in their abilities, the social problems they aimed to address were large, ever-changing and overwhelming.

The Pill was a powerful new tool, full of hope and promise, but there were deep doubts about its ability to address the problem of overpopulation. The Pill circulated in the midst of questions, too, over the sexual revolution and what this meant for society. The paternalistic sheen of the field, the doctor-knows-best mentality, had to be softened and reconfigured. As patients also redefined their roles, new theories of doctor-patient relationships and models for training the next generation of physicians emerged. Though this new approach was more collaborative and less overtly top-down, physicians and patients both participated in constructing a reflective and internalized sense of medical authority. To adhere to regulations concerning access and safety, physicians required pill users to return for regular pelvic and breast exams, at once tethering patients to the medical system and enabling them to maintain control over their reproduction. As women internalized and shaped the projects of managing their health, their marriages, and their families, a new type of patient and a new type of physician were born.
Though the medical profession had been struggling to adapt to patients’ changing expectations in the late 1960s, the pace of reform was not fast enough to appease many critics. The assumption that physicians were the best protectors of patients’ interests was swiftly being undermined. In 1967, informed consent regulations to protect human research subjects became national policy, and Senator Gaylord Nelson began an inquiry into the practices of the drug industry.\(^1\) The challenge to medical paternalism was further fueled by a number of public disclosures of unethical research practices and unsafe drugs in the early 1970s. Most notably, in 1972, the Associated Press revealed that the U.S. Public Health Service had been lying and intentionally denying treatment to several hundred African American men as part of the Tuskegee syphilis study.\(^2\) Cases of cancer among the daughters of women who took DES, a synthetic estrogen administered to prevent miscarriage, started appearing in the medical literature in 1970.\(^3\) The feminist press followed this emerging tragedy, as well as the growing concern

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about the dangers of IUDs, which as devices, were not yet regulated by the FDA. Concern about the safety of the Pill emerged in a context of distrust as women’s groups, investigative journalists, and consumer advocates questioned the ability of doctors and regulators to adequately protect patients from risk.

While the loudest opponents to the contraceptive pill in the 1960s had been social conservatives, by the early 1970s, critics of the pharmaceutical industry, and women’s movement activists, emerged as some of the Pill’s most skeptical detractors. While conservatives were concerned about morality and the impact of the Pill on sexual behavior, drug industry critics and women’s health movement activists on the left were driven by entirely different motives. These activists called for transparency and information on the Pill’s risks, focusing on women’s safety and wellbeing. As the women’s health movement gained traction, critiques of the Pill, and the pharmaceutical industry more broadly, were characterized by charges that doctors, the pharmaceutical industry, and FDA were not adequately protecting women from risk. Anti-pill critiques from this time period, epitomized by journalist Barbara Seaman’s *The Doctors’ Case Against the Pill*, illustrate this impulse. Seaman’s caution about the Pill was not driven by a resistance to social change, but by a belief that doctors were not adequately guarding women’s health. Seaman argued for greater access to health information so that women could make their own informed decisions. Women needed to pay greater attention to medical care not for the sake of empowerment, but primarily because doctors were failing to protect them.

Beginning in 1970, a more radical critique of the Pill would emerge from the women’s health movement as D.C. Liberation protested the hearings that were inspired by Seaman’s book.

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The women’s health movement would agree that women were not adequately protected from risk. In fact, they charged that women were being used as guinea pigs. But rather than shore up medical paternalism or regulations intended to watch over women more stringently, they advocated for women’s control over their own bodies through informed consent, consciousness raising, self-help clinics and promoting new forms of knowledge production. These mechanisms would ultimately construct a new psychology of women where living with risks was an inescapable part of being female.

**The Women’s Health Movement and the Pill**

Concern over the safety of the Pill obscured the fact that control over reproduction, and women’s control of their bodies more generally, was the primary goal of the women’s health movement. While Seaman relied upon psychiatry to expound upon the dangers of the Pill at almost any cost, other feminists took a broader perspective on the issue, considering safety in relation to the Pill’s overall potential to impact women’s lives. Other health feminists, such as those of The Boston Women’s Health Book Collective, considered the psychological impacts of the Pill within the broader framework of patriarchy. Though the power dynamics surrounding gender relationships and control over reproduction transcended any single birth control method, controversy over the safety of the Pill was a galvanizing force for feminists concerned with women’s health.

Women’s opinions of the Pill differed radically and the Pill itself did nothing to unite feminists. In 1969, the journalist Barbara Seaman published *The Doctors’ Case Against the Pill*,

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7 Ruzek, *The Women’s Health Movement.*
which eventually led to Senate hearings on the safety of the Pill and the role of the government in regulating the safety information that patients received from doctors. *The Doctors’ Case Against the Pill* was a hallmark of an emerging women’s health activism. Upon close inspection, much of the content of the book was derived from the sorts of psychiatric studies that declared women on the Pill irrational and immature. The portrayals of women in the book are decidedly far removed from what would be characteristic of the feminist movement. Seaman began her inquiry into the Pill with an interest in simply reforming the medical profession, but she quickly transformed into a dedicated feminist. When Seaman wrote *The Doctors’ Case Against the Pill*, the language of the women’s health movement was not yet widespread, but the book and its consequences would have long-term impact for women’s health. In 1970, women’s rights activists attended the Nelson Senate hearings on the safety of the Pill and disrupted the proceedings, leading to extensive media coverage and a “pill scare” that spurred public debate and caused many women to temporarily stop taking the Pill.

While the women’s health movement was concerned with much more than just contraception, the Pill controversy in 1970 marked a key moment. The debate over the safety of the Pill spoke to a central concern of women’s health activists, which was the question of how to deal with contradictory evidence and how to know what information could be trusted. Barbara Seaman and others, such as the members of The Boston Women’s Health Book Collective, had a complex relationship with commonly accepted medical knowledge as they simultaneously

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questioned it and also relied on it out of necessity. The ways in which the women’s health movement blended new and old new tools, techniques and ways of knowing invites the question of how these women decided who and what to trust. The women’s health movement at times borrowed from the authority of medical expertise, but also aimed to construct a new body of knowledge based on women’s experience. These forms of knowledge existed simultaneously, while contradicting each other at times, and the lines between medical and experiential knowledge were blurred.

The traffic of ideas between medicine and feminism was evident in the way that the women’s health movement analyzed the meaning of the Pill, and especially its impact on women’s bodies and psyches. In the case of The Doctors’ Case Against the Pill, medical ideas about women’s psyches were translated quite swiftly into public awareness as Seaman’s condensed evidence against the Pill from published studies and off-the-cuff remarks made by psychiatrists. In the case of the Boston Women’s Health Book Collective and other advocates of feminist “self-help,” consciousness raising activities led to a new way of understanding women’s lives and bodies as at once individual but linked through the common experiences of patriarchy.


The women’s health movement constructed its own expertise regarding women’s psyches, borrowing from mainstream medicine and challenging it in such a way that it ultimately transformed relationships between women, doctors and the Pill. The challenge helped women to become more active participants in their medical care while also allowing doctors to safely cordon off areas of technical knowledge from critique. The controversy and challenge of the women’s health movement put discussion about the Pill into the open, making it less of an unknown entity, and literally packaging it in a regulated statement of systematized risks.

Barbara Seaman

In 1969, Barbara Seaman, was working as a medical writer and a columnist at the *Ladies Home Journal*. Peter Wyden, Seaman’s editor at *Ladies’ Home Journal*, was central in “grooming” her to write the book. Wyden had recommended Seaman for a science writing fellowship at the Columbia University Journalism School, and encouraged her to “become expert in distinguishing ersatz studies from good stuff” as she questioned the “diplomatic immunity” surrounding coverage of the Pill. Though the book would come to be known as central to the women’s health movement’s critique of the medical establishment, the word “Doctors” was the most prominent word on the book’s cover, written in bold red text. The title was followed by the description “More than 100 medical specialists report how love with the pill can cripple and kill,” conflating the dangerous physical side effects of the Pill with its impact on love, and

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13 Bio, Seaman Carton 1, Folder 7
presumably sex and marriage. Seaman’s own name was typed in the smallest font on the black background.15

*The Doctors’ Case Against the Pill* was loosely organized around a laundry list of diseases and problems that women and doctors attributed to the Pill. Some of the chapters covered medical problems like cancer, sterility, strokes, blood clotting, diabetes and depression, as well as issues like irritability and how the pill can “spoil sex.” Other chapters had more sensational titles like “The Pill-Users: Why Don’t They Stop?” and “Julie Is Not a Statistic.” Seaman explained in great detail many of the most common side effects, using interviews with doctors and patients as well as scholarly and newspaper articles as her sources. Her argument was compelling because it was thoroughly researched, carefully argued, and her journalistic writing style was approachable and entertaining.

Seaman intended to provide women with the information they needed in order to make an informed decision about the Pill, since this information was not being furnished by physicians or pharmaceutical companies. In this era of increasing consumer distrust of both pharmaceuticals and authority figures, Seaman did not suggest that doctors were intentionally misleading women, but rather, took the more moderate approach that doctors themselves did not have the time to read every study, and patients needed to do their own research to stay informed. The position that the doctor was not always right became an increasingly prevalent notion as the consumer rights movement of the 1960s gained traction. The testimony in Seaman’s book communicated a powerful sense of skepticism and distrust of the mainstream medical establishment, but it also relied upon renowned medical experts, whose qualifications and praises were essential to the

15 Seaman had initially wanted to call her book *The Case Against the Pill*, but found out that another science writer had planned to use that title for a book that was never released.
legitimacy of her claims.\textsuperscript{16} Seaman extensively quoted women and their families to give the reader a portrait of how regular people, with whom the reader would presumably identify, were turning away from the Pill. By interspersing women’s experiences into a format that also valued authoritative medical knowledge, she helped to promote a new model of expertise that arose from women’s observations and experiences.

\textbf{Dear Barbara Seaman}

Seaman developed a signature style for critiquing the Pill writing her Bell-McClure syndicated column “Your Mind, Your Heart.” Seaman was able to present women’s stories through her skilled use of letters presumably written to her in which women aired their problems and asked for help. A letter began, “Dear Barbara Seaman: I am 21 years old but feel like 50. It all started last year when I went to a doctor for birth control.”\textsuperscript{17} The Pill caused this young woman to experience a cascade of health problems beginning with acne, which resulted in a prescription for antibiotics, then a strep infection, and a near death experience with antibiotic resistance. This woman concludes, “if my acne doesn’t clear up, I may not need any birth control because my face looks awful.”\textsuperscript{18}

There is a long history to this tradition of women’s advice literature, and stylistic conventions shape the letters and responses.\textsuperscript{19} While there are actual letters written by readers

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\textsuperscript{16} Many of the doctors were named, but a surprising number of claims were anonymous, or not cited fully enough to make it easy for an interested reader to track down sources. Perhaps it was a tradeoff between providing ample information for readers while keeping the book approachable, and perhaps not all physicians were willing to be named or speaking on the record.

\textsuperscript{17} Barbara Seaman Papers, 1920-1983; “Birth-Control Pill Side Effects” By Barbara Seaman with Gideon Seaman, M.D. 82-M33--84-M82, Carton 2, Folder 72. Schlesinger Library, Radcliffe Institute, Harvard University, Cambridge, Mass. (Abbreviated as Schlesinger Library)

\textsuperscript{18} “Birth-Control Pill Side Effects” By Barbara Seaman with Gideon Seaman, M.D., Barbara Seaman Papers, Carton 2, Folder 72, Schlesinger Library.

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addressed to Barbara Seaman present in her official papers at the Schlesinger Library, it is unlikely that these letters were the direct source material for the “Dear Barbara Seaman:” prompts she used to begin her columns. Seaman drafted her responses on type written pages, and the reader’s words were already typed out at the top, with no original letter attached. While the content of the actual letters and the “Dear Barbara Seaman:” letters often touched on the same themes and family problems, the style of the letters is completely different. The letters written by readers were frequently long, rambling, and despondent complaints rather than specific requests for advice, while the “Dear Barbara Seaman:” letters were short, pithy, and to the point. The published letters often pointed to a clear response that allowed Seaman to steer the column where she wanted to go.

In her book, Seaman was able to use the style of presenting women’s stories to argue that the Pill was becoming a thing of the past. She depicted the Pill as a brief trend that came on the scene very quickly, and was going out of fashion just as fast as women and doctors began to learn more and think more critically about it. In order to persuade women who might have been drawn to the Pill for its trendy, modern appeal, she made the case that going off the Pill was the new fashion for those in the know. To build her case, Seaman went to Arthur Davids, her own gynecologist to whom she dedicated the book, with a posh Fifth Avenue office in New York. According to Seaman, Davids did not like to prescribe the Pill, and he rarely did, but his waiting room was filled with “quite a few celebrities,” possibly “a readily recognizable movie or TV star

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20 It is possible Seaman discarded the original letters to maintain privacy, or there could be another reason that some of the original letters are missing.
21 Some women seemed content to write to Seaman as a way of venting, without expecting a response. One letter ended, “p.s. I don’t want this in the paper,” To Mrs. Seaman from (name redacted), Northampton, PA, December 3, 1971, Carton 2, Folder 81. Often writers commented on Seaman’s advice and whether or not they agreed. See Barbara Seaman Papers, Carton 2, Folder 81, Schlesinger Library.
or at least a society woman whose picture has appeared in Vogue or Women’s Wear Daily.”

In talking to a “celebrity, a well-known beauty,” Davids explained that he would have to provide the Pill if a patient “insisted,” but he found “the side effects grotesque and, occasionally, debilitating.” Davids then explained that many pill-takers became “water-logged, overweight, nauseated, and generally blowzy,” developing eye troubles and ugly veins. Seaman was quick to point out that Davids was able to dissuade a patient “by understanding her emotional needs and indirectly appealing to her vanity,” but of course, almost anyone would be put off by the description of these side effects. By relying on the authority of doctors to present a case against the Pill, Seaman navigated a rapidly changing space around doctors’ knowledge, patients’ knowledge, and what types of evidence were deemed persuasive to audiences.

Reviews of the book were generally positive, though some reviewers were critical of Seaman’s “emotional” tone, and medical journals were more attuned to the ways Seaman marshaled her evidence. The Washington Post called *The Doctors’ Case Against the Pill* “the best job so far of laying out unfavorable evidence in everyday language,” calling Seaman an “able and careful medical journalist.” Several reviews compared *The Doctors’ Case Against the Pill* to other books on the Pill released around the same time. A review in the Boston Globe considered Seaman’s book along with another popular paperback, gynecologist Robert Kistner’s *The Pill*. Whereas Kistner was praised for writing a “scholarly and yet easily understood book,” that could help a woman decide if the Pill was right for her, Seaman’s book merely

23 Ibid., 34.
24 Ibid.
25 Ibid.
“emphasize[d] the bad aspects of the pill.” Several years later, Seaman took part in a televised debate with Kistner, criticizing his financial involvement with pharmaceutical companies and suggesting that this compromised his objectivity. Seaman’s book compared more favorably to investigative journalist Morton Mintz’s book *The Pill: An Alarming Report*. Seaman’s account was “more comprehensive, in several aspects more up to date, and more personal in its approach,” though they both aimed to convince their readers that the Pill was unsafe.

The author of a review in the British *Times Literary Supplement* mocked Seaman for her casual style and unsubstantiated observations, which she passed off as serious research. Reviewers frequently commented on the issue of whether they considered the book too “emotional” to be authoritative. This concern indicated uncertainty as to whether Seaman was an objective authority due to her status as a non-physician and as a woman, and it was also indicative of the emotionally charged nature of the subject matter. For example, a reviewer for the *Library Journal* commented that Seaman’s “style is, for the most part, restrained and factual; in a few places she allows emotion to creep in, but there situations are ones where emotion is a realistic and necessary element.”

A letter send in to *The Medical Journal of Australia* by H.G. Wilson, presumably a physician, sarcastically remarked that he found Seaman’s logic “intellectually titillating.”

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28 Black, “The Pill: The Medical and Moral Question.”
29 Barbara Seaman, *Her TV Opponent Was Professional Expert*, January 7, 1972, Barbara Seaman Papers, Carton 2, Folder 72, Schlesinger Library.
31 Beatty, “The pill.”
35 H G Wilson, “‘The Doctors’ Case Against the Pill,’” *The Medical Journal Of Australia* 1, no. 8 (February 20, 1971): 452.
Wilson quoted an example straight from the book, explaining the case of a 23-year-old woman who had taken the Pill for a year when she was diagnosed with advanced cervical cancer. After the diagnosis she stopped taking the Pill and her doctors performed a hysterectomy. The pathology report from the hysterectomy showed no signs of malignancy. While there were many different explanations Seaman could have given for this situation, including diagnostic or medical error, Wilson highlighted Seaman’s assertion that “the cancerous condition had evidently completely reversed itself once the patient had stopped taking the pill.”

Even assuming that there had been cancer and that it did in fact disappear, Wilson critiqued Seaman’s account as a logical fallacy, since she was assuming that stopping the Pill caused the cancer to “reverse itself,” an unlikely scenario, without any evidence of causation. Still, despite these lapses in logic that might concern some readers, reviewers recommended that the book be available in libraries to be read by doctors, married couples, and those interested in women’s health. As one reviewer put it, “Her book will shake up even those who knew birth control pills were dangerous in many cases.”

*The Doctors’ Case Against the Pill* became influential in policy debates. As a best-selling book for a popular audience, many more women read *The Doctors’ Case Against the Pill* than read the academic journals where the physicians she cited usually published. In 1978, sociologist Sheryl Burt Ruzek observed, “the controversy Seaman's work engendered ranged far beyond immediate concern with the pill. The pill fiasco simply pulled out the cornerstone in women's belief that the FDA fully tested drugs prior to marketing or that physicians were truly

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36 Ibid.
38 Ibid., 316.
concerned with safety.”39 The resulting reassessment of contraceptive drugs by women, medical professionals, and regulatory agencies was “one of the most significant outcomes of the movement.”40

Because Seaman had privileged access to so many physicians through her position as a science writer, she was able to record many subtle insights illuminating doctors’ perceptions of women. Barbara Seaman’s husband, Gideon Seaman, was a psychiatrist and frequently credited as a contributor to her columns, though the extent of his collaboration is not clear. Regardless of whether Gideon Seaman was included in the byline primarily because of his medical credentials, Barbara Seaman was well connected to the psychiatrists and psychologists who made frequent appearances in her writing. Seaman did not refute psychiatrists’ preconceptions about the psychology of women or the impact of the Pill. In fact, Seaman vigorously promoted psychoanalytic psychiatrists’ views because they played an important role in developing theories about the Pill’s negative side effects. By fashioning psychiatrists’ findings in her approachable style, Seaman’s book helped to embed arguments about the psychological effects of the Pill into the literature of the women’s health movement. Seaman’s writings, and the portrait of women’s psyches painted therein, did not look so vastly different from what psychoanalytic psychiatrists had been writing about the Pill all along. Though the spirit of Seaman’s critique, rather than specific psychological interpretations, became salient to the women’s health movement, Seaman’s book provided a precedent for health feminists to critique contraception in psychological terms.

40 Ibid., 226.
Psychiatrists and Families Negotiate the Pill

One of the most prominent themes in Seaman’s research was how families dealt with women’s decisions to take the Pill. Seaman opened up the debate to include actors other than doctors and patients, showing how the Pill impacted family life. Husbands were the most frequently interested parties, but Seaman also wrote about concerned parents. Mirroring the failures of the medical profession, pharmaceutical industry, and Food and Drug Administration (FDA) to protect women from risk, Seaman documented a range of captivating, and occasionally tragic, family dramas that occurred as concerned relatives tried to promote women’s best interests. While in some cases family members made wise choices, Seaman’s narratives reflected her frustration that women’s health was trivialized.

For example, Seaman recounted the story of a woman who stopped taking the Pill because her mother-in-law’s persistent nagging. The nagging took a morbid tone and seemed motivated by selfishness rather than concern over the daughter-in-law’s wellbeing. “If anything happens to you, Marjorie,” her mother-in-law kept saying, “don’t count on me to look after the children.”\textsuperscript{41} The mother-in-law made her disdain clear as she suggested that taking the Pill was reckless not only to oneself, but to one’s children and parents as well. In order to provide insight on such supposedly immature and dangerous behavior, Seaman called upon Sandor Lorand, whom she described as “an authoritative psychoanalyst who possesses extraordinary qualifications for insight into the minds and emotions of women.”\textsuperscript{42} Seaman described Lorand as a gynecologist trained in Europe who later became a disciple of Sigmund Freud.\textsuperscript{43} Lorand’s expertise in both gynecology and Freudian psychoanalysis gave him authority as an expert on

\textsuperscript{41} Seaman, \textit{The Doctors’ Case Against the Pill}, 48.
\textsuperscript{42} Ibid., 49.
\textsuperscript{43} Ibid.
women’s reactions to the Pill. Lorand described women’s decision to take the Pill as one of immaturity, which was critical since so much psychoanalytic literature about women focused on their sexual development. In the case of the Pill, Lorand saw the Pill as obviously dangerous, and it was immature to believe otherwise. “Immature people, those with a sense of infantile omnipotence, do not weigh the consequences of taking the pill. They think it’s an easier way of pleasure.” Lorand did not characterize women taking the Pill as misinformed, or merely making a bad judgment based on their faulty weighing of risks and benefits. Instead, Lorand believed women on the Pill were infantile and destructive, seeking an easy source of sexual pleasure. The idea that psychologically immature women might look for an easy but flawed route to sexual pleasure was a simplified version of the explanation that many psychoanalysts gave for women’s complaints such as frigidity or unhappiness in their marriages. When women taking the Pill were defined as potentially immature for deciding that the risks of the Pill were worth it, reactions to the Pill could be attributed to these women’s immaturity. Thus, some psychoanalysts believed that taking the Pill made it virtually impossible for a woman to have a mature, fulfilling sex life along with the pleasures of attaining the role of mother.

In what was perceived as a dangerous move that further destabilized the family, many women dragged their daughters into the same situation. Lorand explained that, “We found numerous mothers who seemed to live in such fear that their teen-age daughters might become pregnant that cramps or the slightest irregularity were welcomed as a pretext to drag a girl off to the doctor to get a pill prescription.” In these cases, the Pill was not prescribed for the benefit of the daughter, but instead, “The pill was the mother’s own tranquilizer.” This analysis fit

44 Ibid.
45 Ibid., 52.
46 Ibid., 53.
squarely within the mother-blaming psychoanalytic ethos of the time, in which too much, or the wrong kind of maternal involvement could lead to ill health for children.\textsuperscript{47} Instead of taking a tranquilizer herself to treat her anxiety, the mother was unnecessarily medicating her daughter, to deleterious effect. Several years later, Seaman would also become critical of representations of women’s use of tranquilizers. For “those who doubt that women have cause to be angry at their doctors,” she encouraged readers to leaf through the advertisements in any medical journal. To Seaman, the message of a particular, “often irresponsibly used tranquilizer” advertisement seemed to say “Doctor, get her off your back…Get her off her husband’s back….Shoot her up and shut her up with our product.”\textsuperscript{48}

Seaman cited other evidence that a woman on the Pill was the sign of potential dysfunction in the family. Seaman interviewed Frederick Ziegler, a psychologist, and David Rogers, psychiatrist, at the Cleveland Clinic. The researchers looked at the roles of wives and husbands, determining which spouse was the “take-charge type” in the relationship.\textsuperscript{49} Ziegler and Rogers determined who was in charge based on who took care of the “ambiguous responsibilities,” which were those tasks they considered to be in the “gray area” between a husband’s and a wife’s responsibilities. While Ziegler and Rogers made no assumption about whether women or men were in charge, they found that women in charge displayed behaviors that seemed irrational and detrimental to their health. In families where the husband was in charge, wives who suffered side effects went off the Pill, which they presented as a rational and reasonable reaction to experiencing the side effects. One way of putting it, they said, was that

\textsuperscript{47} Buhle, \textit{Feminism and Its Discontents: a Century of Struggle with Psychoanalysis}.
\textsuperscript{49} Ibid., 61.
the “father-knows-best families go off the pill.” Conversely, “strong women with weak husbands tend to stay on it,” regardless of side effects. In order to explain this allegedly irrational behavior, Ziegler believed that these strong women might continue to take the Pill because they did not trust their husbands, or it “may be one more way of asserting their authority.”

Psychological experts such as Ziegler and Rogers interpreted women’s motives as often self-destructive, with women choosing assertiveness and control over harmony and health. Whether the wife took the Pill or had side effects or not, though, the factor shielding women from harm was really the “father-knows-best” husband who took control. It was the husbands of the wives, and not women themselves, who had the ability to influence women’s choices about whether or not they could tolerate the Pill. Without a strong husband, the “take-charge women” irrationally endangered their own health. While all types of couples might start using the Pill, in a family where the “father-knows-best,” the wife was more likely to go off the Pill, which was regarded as the proper, rational choice since the Pill was dangerous and the side effects were detrimental to women’s health. Ziegler and Rogers suggested that women on the Pill were pathological because they were harmed by the distribution of power in their marriages.

Other physicians argued in Seaman’s book, and again at the Senate hearings, for the importance of husbands in monitoring their wives’ behavior. Dr. Phillip Ball said that he stopped prescribing the Pill because of psychological changes. At the hearings, Ball reported that an exasperated husband once called his office and begged him to “do something” about an

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50 Seaman, The Doctors’ Case Against the Pill, 61.
51 Ibid.
52 Ibid.
ill-tempered wife.\textsuperscript{54} Ball explained that so many husbands called because women often did not recognize the effects of the pills in themselves. Not only were women not in control of their emotions, but they also lacked the self-awareness to realize their problem, and needed the paternalistic care of husbands and doctors to keep them in check.

The attitudes of Seaman’s informants were not unusual. Cheryl Burt Ruzek interpreted routine medical care as an “affront to self-determination.” Physicians treated women like children, sheltering them from unpleasant facts and relieving them of the “responsibility for decisions making, ostensibly for their own good.”\textsuperscript{55} In cancer care, physicians held the prevailing opinion that even “hopeless” patients should not be told of their condition, though on occasion a husband or other family member might be given more information.\textsuperscript{56} Physicians believed that sparing patients bad news was doing them a service because expecting the worst would only cause one’s condition to decline. Similarly, physicians argued that patients should not worry about the risks of the Pill. A pamphlet entitled \textit{Anxiety and the Pill} addressed the “particularly knotty problem” of informed consent. If relieving patient anxiety was a “proper and necessary part” of patient care, “how can we inform without arousing apprehension?”\textsuperscript{57} The pamphlet argued that patients should be allowed to take the Pill without “a constant barrage of highly colored, anxiety-producing reports in the press and other media.” Thus, the psychiatrists Seaman interviewed never suggested that women should be given more information. Instead, psychiatrists suggest that husbands should watch over their wives and somehow, by virtue of their superior judgment, know when to intervene and call the doctor when necessary.

\textsuperscript{54} Ibid.
\textsuperscript{55} Ruzek, \textit{The Women’s Health Movement}, 33.
\textsuperscript{57} Frederick W. Goodrich, Anxiety and the Pill, n.d., Vertical Files, American College of Obstetricians and Gynecologists Resource Center.
Other anecdotes from the book reinforced the notion that family members were instrumental in women’s decisions to take, or to not take the Pill. Seaman convincingly created the impression that the Pill was quickly dropping out of favor among those “within the best-informed echelons of the medical profession” since “so many doctors had persuaded their wives to stop using the pill.”  

Doctor’s wives were presumably well informed and responsible, guided by men that Ziegler and Rogers might consider take-charge physician husbands. The real trouble, according to Seaman, was doctors’ “difficulty in convincing their daughters to drop the pill, too.”  

Echoing Lorand’s findings, Seaman suggested that one source of the daughters’ resistance was “their natural tendency to rebel against authoritarian parents, just like all children.”  

“At any rate,” Seaman wrote, “there was great pride and relief in the voice of one distinguished specialist when he told us that, unlike some of his colleagues, he had persuaded not only his daughter, but also his daughter-in-law to give up the pill.”  

Those physicians who were best informed had the knowledge to make the right decision, as well as the authority within their families to convince their relatives to stop taking the Pill. The families that Seaman described were upper-class and certainly not representative of American families in general, but they provide a glimpse into the representations of family interactions that were persuasive to Seaman and those in her social circle.  

Seaman also described psychological changes, both subtle and dramatic, that resulted from the Pill. Though the source of the changes was often a subject of speculation and debate, Seaman reported that psychiatrists “did not take long to notice certain adverse reactions in their

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58 Seaman, The Doctors’ Case Against the Pill, 34–35.
59 Ibid.
60 Ibid, p.35.
61 Ibid.
wives and daughters, patients and friends.” 62 Psychiatrists, being “finely attuned to emotional feedback,” were among the first to notice subtle effects such as “increased irritability and tearfulness,” in addition to “suicidal and even murderous tendencies.” 63 Though psychiatrists were at the forefront of observing women’s reactions to the Pill, Seaman also joked that “A man doesn’t have to be a psychiatrist to make the diagnosis that his wife is less lovable on the pill.” 64 Seaman used this statement as a humorous introduction to present a newspaper story about a Toronto man who noticed a drastic change in his wife’s disposition. Sure enough, a doctor traced the change to when the wife started taking the Pill, and the husband promptly threw the pills out into the snow. 65

The reason why emotional reactions to the Pill were so widespread was that they could be attributed to so many different causes. Seaman reasoned that some pill-associated depressions were caused by “hormones alone,” while others were “triggered by a combination of hormones and psychological factors or, in still other cases, by psychological factors alone.” 66 Though the explanation of depression caused by “hormones,” seemed to indicate a biological mechanism, the exact reasoning was not explained. Seaman’s understanding of the impact of hormones on the psyche came from Francis J. Kane’s work in the Department of Psychiatry at the University of North Carolina School of Medicine. Kane studied the ways in which women reacted “to hormonal variations in the menstrual cycle, during pregnancy and in the weeks after

62 Ibid., 210.
63 Ibid.
64 Ibid., 223.
65 Ibid., 224.
66 Ibid., 218.
childbirth.”67 Kane linked emotional states to hormone levels at these different life stages, and speculated that the synthetic hormones in the Pill would have a similar impact.68

While some studies about the emotional effects of the Pill were conducted by psychiatrists and gynecologists together, indicating that they shared compatible viewpoints, there were also situations in which they clashed. A Manhattan psychiatrist told Seaman “My fights with the gynecologists began in 1963.”69 He noticed immediate and drastic changes in a patient whom he knew “perhaps better than I know my own wife.”70 Though this woman was “tough as nails,” eight days after starting the Pill, she came to her appointments sobbing and suicidal.71 As soon as the patient stopped taking the Pill she was back to her old self, but the ordeal was not yet over. The psychiatrist was then plagued by calls from the patient’s gynecologist, claiming, “‘Birth control is not a psychiatrist’s province.’”72 This type of disagreement illuminates the divisions that separated different types of doctors’ understandings of their patients’ bodies and minds. Fitting the theme of Seaman’s book, though, the disagreement did not last long and the skeptical gynecologist soon came to realize that depression caused by the pill was in fact real. The psychiatrist reported that the gynecologist began sending him his patients for tranquilizers to treat pill-caused depressions.73 Using tranquilizers to counteract pill-induced side effects further compounded these women’s problems.74

67 Ibid., 215.
68 For some of Kane’s work, see: Daly, Kane, and Ewing, “Psychosis Associated with the Use of a Sequential Oral Contraceptive”; Kane, Treadway, and Ewing, “Emotional Change Associated with Oral Contraceptives in Female Psychiatric Patients”; Kane, Lipton, and Ewing, “Hormonal Influences in Female Sexual Response”; Kane, “Psychiatric Problems Associated with Oral Contraceptives.”
69 Ibid., 213.
70 Seaman, The Doctors’ Case Against the Pill, 213.
71 Ibid.
72 Ibid.
73 Ibid., 214.
74 Ibid., 218. Seaman quoted Frank Ayd, one of the founders of the field of psychopharmacology. Ayd’s hesitance to promote tranquilizers for depression was likely due to his work for Merck. Ayd developed a list of “target
The Pill and the new morality

Another major perspective that framed Seaman’s critique was how the Pill fit in with the changing sexual mores of the 1960s. Women found that the sexual freedom the pill promised came with its own complications, disappointments and unwanted side effects. Some of the women Seaman interviewed found that the sexual freedom afforded by the Pill actually put them in situations where they had less bargaining power than before. One college student ruined a “beautiful” relationship after she cheated on her boyfriend at a sit-in. The woman said that she thought about the situation in retrospect, and she was convinced that the affair “wouldn’t have happened except for the pill.” The woman acknowledged that she “should have resisted, pill or not,” but the problem with the Pill was that she “didn’t seem to have any excuses” to turn down the affair. Consigned to the fact that men would tempt her, taking the Pill meant that this woman was in an untenable situation of not having an “excuse” to turn down advances. The woman concluded that when she fell in love again, she was “going to get a diaphragm and keep it at home.” After being constrained by the supposed freedom of the Pill, she sought more control over her own behavior through limiting her access to contraception. This woman’s story supported the interpretation that women were not able to control themselves, and needed an external force to check their behavior. The diaphragm, perceived as a simple, mechanistic, form of birth control, offered this type of constraint, whereas the Pill, a high-tech, effective solution to birth control, constrained women by complicating traditional courting scripts. Since the diaphragm necessitated “a five-minute leeway” in order to insert it, this provided women the

75 Ibid., 138.
76 Ibid.
time and space for women to assess situations, and potentially make up excuses and turn down advances.\textsuperscript{77}

Seaman was quick to point out that men took advantage of the fact that women had lost a traditionally accepted “excuse” to turn down sexual advances. Seaman quoted one man who said, “I made both my girls go on the pill.”\textsuperscript{78} This led to a situation where “Once a guy has had a taste of sex on the pill, he just won’t settle for anything else.”\textsuperscript{79} This situation further skewed the sexual power dynamic in men’s favor, so that any woman taking the Pill was potentially being duped into harming her own health for the convenience of a “spoiled” bachelor. The power of Seaman’s argument came from her ability to turn the standard narrative about the Pill’s liberating effects on its head. Seaman challenged women to consider their motives for taking the Pill, and to wonder whether they were in fact taking it with their own interests in mind.

Seaman’s was not the only “case against the pill” to consider moral and safety arguments.\textsuperscript{80} A physician writing a piece for the North Carolina Medical Journal considered contraceptive services as a dangerous reflection of “the willingness of the profession to bow to social pressures.”\textsuperscript{81} Other critics such as investigative journalist Morton Mintz focused on what he called “gross ineptitude” at the FDA, and profit hungry pharmaceutical companies that promoted the Pill as an uncontrolled experiment on women.\textsuperscript{82} Mintz’ book was followed by

\textsuperscript{77} Seaman, The Doctors’ Case Against the Pill, 141. Our Bodies, Ourselves also included a short section on sexual availability, acknowledging that the near-perfect effectiveness of the Pill and IUD put pressure on women. Rather than lamenting this fact, the book recommended women honestly explain their feelings without being “apologetic or scared.” The Boston Women’s Health Book Collective, Our Bodies, Ourselves: a Book by and for Women (Simon and Schuster, 1973), 110.
\textsuperscript{78} Ibid., 62.
\textsuperscript{79} Ibid.
\textsuperscript{80} Caldwell, “The Case Against the Contraceptive Pill.”
\textsuperscript{81} Ibid., 370.
\textsuperscript{82} Mintz, The Pill, 23. Mintz was skilled at writing exposés covering the intricacies of the FDA. See: Morton Mintz, By prescription only; a report on the roles of the United States Food and Drug Administration, the American
several other investigations of the Pill that aimed to inform the public about its history, impact and dangers.\footnote{Jules Saltman, \textit{The pill: its effects, its dangers, its future}. (New York: Grosset & Dunlap, 1970); Paul Vaughan, \textit{The pill on trial}. (New York: Coward-McCann, 1970).}

The Pill Hearings

Though Seaman’s book did not initially draw much media attention, it soon made its way to U.S. Senator Gaylord Nelson by way of a the public relations executive John Hoving, a friend of the publisher.\footnote{Seaman, “The Pill and I: 40 Years On, the Relationship Remains Wary.”} Nelson, considered a foe of the drug industry, ran the Subcommittee on Monopoly of the Select Committee on Small Business, which was concerned with the business practices of pharmaceutical companies. Since the approval of Medicaid and Medicare in 1965, the federal government was spending over half a billion dollars each year on prescription drugs.\footnote{Elizabeth Siegel Watkins, \textit{On the Pill: A Social History of Oral Contraceptives, 1950-1970} (The Johns Hopkins University Press, 2001), 106. Watkins’ account is the most thorough and authoritative history of this event. A number of scholars have drawn from Watkins’ work in their own histories of pharmaceutical regulation, including Daniel Carpenter, \textit{Reputation and Power: Organizational Image and Pharmaceutical Regulation at the FDA}, 1st ed. (Princeton University Press, 2010).} Nelson identified several problems with the drug industry. Since pharmaceutical companies provided information to both the Food and Drug Administration (FDA) and the medical profession, there was no disinterested source of scientific information for federal regulators.\footnote{Tobbell, \textit{Pills, Power, and Policy}.} In fact, the drug industry and the medical profession resisted government regulation, and joined forces to oppose the authority of the FDA to regulate pharmaceutical practice.\footnote{Ibid.} Second, drug companies were responsible for conducting tests and clinical trials, so
the urge to bring a drug to market “compromised the quality of new drug evaluations.”

Nelson also wondered whether physicians could make intelligent decisions at all because they were receiving so much information through industry-sponsored medical publications, promotional literature and free samples from detailmen. Throughout the 1950s and 1960s, pharmaceutical marketing products served as physicians’ “primary source of information about new drugs and new dosage regimes.”

Seaman’s critique of the Pill cut right to the heart of these issues. The adverse effects of the Pill caused Seaman to wonder if the Pill was tested thoroughly enough, and whether physicians and women had enough information in order to make informed decisions. Though Seaman collected much of the information on the Pill that came to Nelson’s attention, she was not chosen as a witness. Neither a single woman scientist nor woman who had taken the Pill was chosen to testify. A local feminist group, D.C. Women’s Liberation, noticed these omissions. Unlike Seaman, these women did not consider the lack of available safety information about the Pill a mere oversight, but an act of “sexist-racist-imperialist” suppression. Members of the organization attended the hearings and were moved to ask questions, at first spontaneously, and later, organized as part of an ongoing protest. As Barbara Seaman explained the story retrospectively in an interview with historian Elizabeth Watkins:

All of a sudden, these women started standing up and yelling… I heard my name, “why isn’t Barbara Seaman testifying?” And then somebody else was saying

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88 Ibid., 106.
89 Greene, “Attention to ‘Details’.”
90 Tobbell, Pills, Power, and Policy, 142. Tobbell uses testimony from the Kefauver hearings to support this point, and observes that there is little evidence that pharmaceutical promotion materials became less prominent afterwards.
91 Ibid., 107.
93 Sigal, “Politics of the pill.”
“why isn’t there a pill for men?” And someone else was saying “why aren’t there any patients testifying?”

This represented a transitional moment for Seaman, as she was at the hearings on assignment as a journalist. The women of D.C. Liberation pointed out the irony that many of the experts who testified at the hearing appeared in Seaman’s book, but Seaman herself was not included.

According to Ben Gordon, the staff economist for the Senate Committee on Small Business, who played an important role in the hearings, Seaman was not considered a “primary source,” and he explained the omission of women by saying that Senator Nelson “wanted to keep the hearings on a high level.”

Feminist activists kept arriving each day and disrupted the hearings with questions intended to point out the absence of women’s testimony. Ironically, as Watkins has noted, the feminists agreed with Nelson on the major issues that doctors and patients needed more information in order to be able to make informed decisions. Doctors argued that mandating what information a physician had to provide interfered with the doctor-patient relationship, and that medical information would scare and confuse women, who were not able to understand scientific language. In Seaman’s words, “many technically qualified physicians” were still “fence-sitters on the subject of the doctrine of informed consent, meaning that they used their own judgment in determining how much information to provide.” On the other side of the debate, feminists and consumer rights activists believed that the pharmaceutical industry was standing in the way of informed consent, and that poor communication between doctors and patients meant that doctors could not be trusted to provide women with adequate information. While the FDA publically

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94 Ibid., 108.
96 Seaman, The Doctors’ Case Against the Pill, 15.
urged physicians to make sure their patients were informed, the FDA, physicians, and the press also wanted to reassure women that their physicians were “in the best position to determine the extent” to which they needed to discuss and understand the material.\footnote{Charles C. Edwards, Commissioner of Food and Drugs, signed a letter to doctors and hospital administrators, taking into account the report of the Food and Drug Administration’s Advisory Committee on Obstetrics and Gynecology, quoted in Harold M. Schneek, Jr., “F.D.A. Bids Doctors Tell Of Risks in Birth Pill Use,” \textit{New York Times}, January 20, 1970. For more on the debate see Victor Cohn, “Dr. Ley Urges Full Data for Pill’s Users: Dr. Ley Says Birth Pill Users Must Have More Information,” \textit{The Washington Post, Times Herald}, December 22, 1969.}

The 1938 Food, Drug, and Cosmetic Act mandated that pharmaceutical manufacturers had to make information about their products available to physicians, but not to patients, so in 1970, when the FDA announced that Pill prescriptions would come with a leaflet to supply the patient with facts, it set off debate over the question of how much information to include. In the controversy that followed, there were debates over the erosion of the doctor-patient relationship, and whether information would scare women. This debate among policymakers reflected physicians’ concern with this issue. In the words of policy makers, this issue was one of scaring women with too much information, but in the psychiatric literature, the issue of psychosomatic complaints had plagued the Pill from its inception. In one of the most famous quotes to come out of this testimony, Senator Bob Dole said:

\begin{quote}
I think we probably have terrified a number of women around the country… I would guess they may be taking two pills now— first a tranquilizer and then the regular pill- because of our erudite investigation.\footnote{U.S. Congress, Senate Subcommittee on Monopoly, \textit{Competitive Problems in the Drug Industry} (Washington D.C.: U.S. Government Printing Office, 1967), 6151. Cited in Watkins, 110.}
\end{quote}

In actuality, the investigation was not particularly erudite since it was essentially a regurgitation of existing knowledge from a select group of experts. Nevertheless, Dole’s quote was telling in that he drew a connection between women’s use of contraceptives and tranquilizers, labeling women’s supposedly irrational worries over the safety of the Pill as just
another problem to be cured by “mother’s little helper.” Dole’s statement was intended to be humorous, and it was likely perceived as such because it blatantly said out loud what was usually only suspected.

Elizabeth Connell, a gynecologist at New York City’s Metropolitan Hospital, described the prevailing attitude. When asked which risks she mentions to her Pill patients, she replied:

Oh, usually the thrombophlebitis [blood clotting disorders] and not too much else. They don’t understand anything else. You scare the heck out of them. We tell her that in case of anything abnormal she is to call. You don’t have to outline it for them and make trouble. You don’t have to plant seeds about what they’re going to call about. If you tell them the symptoms they’ll have them by the next day.100

Though Connell worked in “impoverished Harlem,” she pointed out that the same would apply the same standard in a middle-class practice.101 Connell would later be called to testify in the second round of Pill hearings, where she, as an accomplished physician and mother of six, would talk about the elevated position to which women should aspire.102 Connell also discussed findings from her practice, which confirmed her suspicions that women should not be told of the risks of the Pill. In February of 1970, she said “we are just beginning to see the first of the pregnancies of women who panicked in January, stopped using their pills and did not seek or use another means of birth control.”103 In an interview with The New York Times, she elaborated “we’re getting into the dozens, that I know of, and there probably are many more who have

99 Herzberg, Happy Pills in America; Metzl, Prozac on the Couch; Tone, The Age of Anxiety.
100 “The Doctors’ Case Against The Pill,” 11; Lyons, “Panic and Pregnancies Linked To Senate Inquiry on Birth Pill.”
101 Ibid.
103 Lyons, “Panic and Pregnancies Linked To Senate Inquiry on Birth Pill.”
stopped using the pill, become pregnancy and not come back to our clinics” after becoming “frightened.”\(^{104}\)

A Gallup Poll taken in February of 1970 also confirmed that the hearings had “a profound effect on the views of American women regarding the safety of oral contraceptives.”\(^{105}\) The survey found that about two thirds of American women believed that that the Pill was dangerous to a person’s health, whereas a survey three years earlier in 1967 found that two thirds believed the pills were safe. Women in their twenties and those with a college education were more likely to believe the pills were safe than those who were older and did not attend college.\(^{106}\) A study in family planning prepared by the Population Council suggested that the effects of the publicity from the hearings was fairly short lived.\(^{107}\) The Population Council used data from the National Fertility Study, which looked at married women under the age of 35, and was much more extensive than the Gallup Poll. A graph of the percentage of married women using the Pill showed a steep and steady increase until it reached a plateau of about 31 percent in 1967. In early 1970, there was a “small but perceptible decline” from 31 percent to less than 29 percent, which was enough for the author, Norman Ryder of the Office of Population Research at Princeton, to “presume that this decline was associated with the unfavorable publicity for oral contraception in the Senate hearings on the pill.”\(^{108}\) The “aggregate consequence of the negative publicity may have been transitory” as the proportion of women using the Pill quickly rose back to over 30 percent by the end of 1970.\(^{109}\)

\(^{104}\) Ibid.
\(^{106}\) Ibid.
\(^{108}\) Ibid., 234.
\(^{109}\) Ibid.
their patients on oral contraceptives dropped from 75% to 62% at the height of the Nelson hearings, but quickly returned to 75% by the end of 1970.110 As one feminist journalist lamented, “women are left with enough evidence to scare them, but not enough to convince them to give up the miracle Pill and go back to the old methods.”111

Seaman’s Transformation and Women’s Liberation

The women’s movement was decentralized and prone to schism, as groups frequently formed and splintered to pursue their own agendas.112 Though Seaman called herself a feminist, she identified with mainstream groups, such as Betty Freidan’s National Organization for Women.113 Seaman described her transition from a moderate “uptown” feminist, literally from the upper west side, to a “downtown” feminist when she met the more radical Alice Wolfson of D.C. Women’s Liberation.114 Seaman learned that her book helped inspire D.C. Liberation to demonstrate, and she and Wolfson would go on to form the National Women’s Health Network in 1975.115 When thinking back on the events, Seaman remarked:

I thought yes, yes, why didn’t I see it this way, why didn’t I understand it this way all along? But of course, if I had seen it that way, I wouldn’t have been suitable to write for the Ladies’ Home Journal or to write the kind of book I wrote. So in the scheme of things, it’s just as well that I saw it from my particular lens up until that moment in January 1970, when I met Alice.116

114 Ibid.
115 Ibid.
In retrospect, *The Doctors’ Case Against the Pill* might not have been as influential had it not been written in the approachable style of a health journalist. Because the book was accessible it played an important role in speaking to multiple audiences and arguing for the benefits of blending different types of evidence.

The tension between appealing to a broad audience, on the one hand, and remaining true to her feminist consciousness on the other, was evident in Seaman’s syndicated column, “Your Mind, Your Heart.”[^117] Seaman explored this theme through her answer to a letter exploring whether “extremists in women’s lib” were helpful to the average woman. The letter writer explained that she was a widow working hard to support her four children. Though this woman was “all for equal pay for equal work,” she believed that the women’s lib “‘crazies’” were hurting the cause as they turned “people off with their shrieking” and wasted time on issues “like beauty contests, and burning bras.”[^118] Seaman first sympathized with the writer, agreeing that for someone struggling just to keep a family together, “some of the women’s lib extremists must seen quite destructive and laughable.” However, Seaman continued, “we think they may have accomplished a great deal by dramatizing the issues.”[^119] Seaman’s response then considered the Civil Rights Act of 1964, explaining that it prohibited job discrimination based on sex, and also encouraged women to bring class action suits against employers who had been barring women from job promotions.

Seaman tried to convince her audience that even if they did not identify with women that they perceived to be loud and misguided “women’s libbers,” they “should be grateful for what

[^117]: Extremists in Women’s Lib Harmful to Average Woman, December 8, 1971, Barbara Seaman Papers, Carton 2, Folder 72, Schlesinger Library. Seaman was referring to the 1968 Miss America Protest in Atlantic City, NJ, organized by the New York City based radical feminist group Redstockings.

[^118]: Ibid.

[^119]: Extremists in Women’s Lib Harmful to Average Woman, December 8, 1971, Barbara Seaman Papers, Carton 2, Folder 72, Schlesinger Library.
Seaman drew a parallel between the more radical members of the women’s movement to Ralph Nader’s work as an advocate for auto safety and consumer’s rights. “Most of us are grateful to Ralph Nader for the efforts he has made to improve auto safety, and yet we are nowhere near willing to forgo cars altogether.” The connection to Nader illustrated the new, consumerist mentality concerning healthcare. The pharmaceutical reform movement was part of a broader public interest movement, and consumer advocates aimed to lower drug prices by reducing physicians’ reliance on brand names, and restricting pharmaceutical marketing practices.121

**Expert Distrust and the Move Toward Self-help**

As different types of experts continued to debate the impact of the Pill, women interrogated expert knowledge, and also created their own models of expertise. A reaction to what was considered a patriarchal medical system, women’s health movement activists advocated a new doctor-patient relationship that aimed to equalize the power distribution between healthcare providers and patients.122 The women’s health movement also advocated new pathways towards achieving and valuing knowledge about the body. Learning from one’s individual experiences, and sharing experiences with other women were deliberately promoted as methods of making new types of knowledge of the mind and body through consciousness raising. Knowledge itself was construed as a form of power to women’s health movement

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120 Extremists in Women’s Lib Harmful to Average Woman, December 8, 1971, Barbara Seaman Papers, Carton 2, Folder 72, Schlesinger Library. For examples of the radical feminism that Seaman was referring to see: Kate Millett, *Sexual politics*. (Garden City, N.Y.: Doubleday, 1970); Shulamith Firestone, *The dialectic of sex; the case for feminist revolution*. (New York: Morrow, 1970); Robin Morgan, *Sisterhood Is Powerful: An Anthology of Writings from the Women’s Liberation Movement* (Vintage, 1970).

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feminists, and the process of constructing this knowledge led to new understandings of women’s minds and psyches.

Although medical information was difficult for non-physicians to access, women’s health movement activists were savvy at collecting and pooling their knowledge through networks and organizations. Despite aiming to remove the power differential between health care provider and patient, most health feminists never entirely eschewed mainstream sources of medical information, techniques and tools. Screening for breast and cervical cancer were promoted as ways of reclaiming and learning about one’s body, and midwives and homebirth advocates challenged hospital childbirth procedures. The boundary of what was considered medicine, and what was considered lay knowledge, however, was critical.

In what became a foundational event in the history of the women’s health movement, Carol Downer, founder and leader of the Feminist Women’s Health Center in Los Angeles, was arrested and charged with practicing medicine without a license by the State Board of Medical Examiners. Downer had treated a yeast infection with yogurt, and successfully defended herself by claiming that she did not diagnose the condition herself, and had merely applied a “home remedy.” The egalitarian and empowering care provided by Downer and others came to be known as self-help gynecology. The self-help movement arranged and performed underground abortions in organized networks, operated clinics without licensed medical providers, conducted

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123 For more on lay expertise and patient activism see Steven Epstein, Impure Science: AIDS, Activism, And the Politics of Knowledge (University of California Press, 1998).
124 Kline, Bodies of Knowledge.
125 “Physicians and Feminist Patients: Conflict Grows” Medical Tribune, November, 1973, in BWHBC Records, Carton 102, Folder 3, Schlesinger Library. Self-help advocates also linked menstrual extraction to traditional “folk” medicine, calling menstrual extraction “Grandma Bessie’s technique” and comparing it to a Chinese technique performed by women “folk” doctors in “The Self Help Clinic” by Colette Price, Feminist Women’s Health Centers, BWHBC Records, Carton 102, Folder 3, Schlesinger Library.
studies of the menstrual cycle, and taught women to examine their own cervixes in numerous
self-help groups around the country.126

The emergence of self-help gynecology signaled a shift from the late 1960s, when
advocates such as Seaman complained of the failure to protect women from risk, to the 1970s,
when women sought to control their own bodies and manage risks themselves. The "invention"
of self-help gynecology more than any other event transformed health and body issues into a
separate social movement.127 Downer offered informational sessions, presenting slide shows
about the female reproductive system, instruction on how to identify common complaints, and
demonstrations on how to perform a preventive self-help examination. As journalist Ellen
Frankfort described an encounter with self-help: “An old church basement, a long table, a
woman, a speculum—and pow! In about five minutes you’ve just about destroyed the mystique
of the doctor.”128

Because dispensing contractive pills required a replenishable source of prescriptions, the
self-help movement was not well equipped to provide the Pill. Instead, menstrual aspiration,
used to routinely shorten the menstrual cycle and provide a method of contraception, was the
most contentious, yet characteristic procedure of self-help.129 Proponents worked to maintain an
ambiguous space surrounding the procedure, so it could not be defined as illegal abortion, but

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126 “Physicians and Feminist Patients: Conflict Grows” Medical Tribune, November, 1973, in BWHBC Records,
Carton 102, Folder 3, Schlesinger Library. Also see Elizabeth Fishel, “Women’s Self-Help Movement,” Ramparts
BWHBC Records, Carton 102, Folder 3, Schlesinger Library.
127 Ruzek, The Women’s Health Movement, 53.
129 “The Self Help Clinic” by Colette Price, Feminist Women’s Health Centers, BWHBC Records Carton 102,
Folder 3. “Statement on Menstrual extraction,” December 1974, BWHBC Records Carton 102, Folder 3,
Schlesinger Library.
somewhere between contraception and simply a convenient way to avoid a menstrual period.\textsuperscript{130} The procedure required materials that were reusable and relatively easily to acquire so the technique could be taught and performed by trained self-help practitioners. Though perhaps simpler to administer, the Pill was relatively difficult to obtain, and a less frequent feature of self-help.

\textbf{Differing Feminist Views on Birth Control}

While the Pill might have served to unite women in appreciating the possibility of more freely determining their reproductive lives, the Pill was deeply divisive to many women, including feminist activists. These divergent views illustrate how women increasingly sought out information about birth control, made their own decisions, and lived with the consequences. Sadja Goldsmith, a physician who was active in advocating for abortion rights and access to contraception for teenagers, wrote “To Freud’s classic question, ‘What does woman want?’ these new feminists are likely to respond, ‘Complete control over our own reproductive destiny—whether and when to have children—and options to pursue a full range of life styles: homemaker, bricklayer, astronaut.’”\textsuperscript{131} However, beyond this relatively straightforward desire for control over reproduction and career choices lay complex contradictions and disagreements.

\textit{A Life} magazine article by Sara Davidson, a woman who described herself as combining “marriage with a career in journalism,” presented an outwardly sympathetic view of women’s

\textsuperscript{130} “The Self Help Clinic” by Colette Price, Feminist Women’s Health Centers, BWHBC Records, Carton 102, Folder 3, Schlesinger Library.

\textsuperscript{131} Sadja Goldsmith, “Review: Birth Control and the New Woman,” \textit{Family Planning Perspectives} 3, no. 2 (April 1, 1971): 64–66. Family Planning Perspectives, published by the Guttmacher Institute, which was then a new publication focusing on reproductive health. Goldsmith covered some of the most important texts on women’s liberation to come out in 1970, including Millett, \textit{Sexual politics}; Firestone, \textit{The dialectic of sex; the case for feminist revolution}; Morgan, \textit{Sisterhood Is Powerful}. 
liberation groups, while still vigorously maintaining her status as an outsider.\textsuperscript{132} Davidson was warmly welcomed into the homes of some women’s liberation groups, while others were hesitant to allow her at meetings and “ranted” at her “as a member of the ‘‘corrupt, bourgeois press.’” While the article featured a demonstrator “attacking the ‘plight of the American woman, who functions as a breeding machine,” by protesting abortion laws, the birth control pill was listed as an inspiration to the women’s liberation movement, along with civil rights, radical activism, and the black liberation struggle. Contraception was mentioned as the sort of issue championed by moderate women’s groups such as the National Organization for Women, but it was not the main concern of radical feminists.\textsuperscript{133} Even in sources intending to provide a supposedly unbiased view of feminism, radical feminist groups were often mocked or cited as examples of why feminism seemed “militant” and “too radical and far removed” from many women’s lives.\textsuperscript{134} Thus, while most feminists agreed that control over reproduction was critical, the social and scientific controversies surrounding birth control resulted in sharp disagreement and contradictory beliefs within the women’s movement.\textsuperscript{135}

Some feminists, such as Kate Millett, saw gender relations as an issue of power. The historical “sexual politics” of men controlling women was deemed no longer acceptable as

\textsuperscript{132} Sara Davidson, “An ‘Oppressed Majority’ Demands Its Rights,” \textit{Life Magazine} (1969). Describing the experience of learning about women’s liberation groups, Davidson wrote, “Overexposure to women's liberation leads, I found, to headaches, depression and a fierce case of the shakes. A friend of mine retreated to her kitchen after a weekend of meetings to lose herself in an orgy of baking pies. I stayed home for three days and stopped answering the phone. But women's liberation was accelerating each day.”

\textsuperscript{133} For example, the Chicago Women’s Liberation Union created an index of articles covered in their Womankind newspaper from between 1971 and 1973. Issues like abortion, childcare and labor legislation showed up repeatedly, while contraceptive pills only showed up once in relation to gallbladder disease. The Redstockings Manifesto focused on broad issues of power between men and women, rather than raising specific demands about reproductive health.

\textsuperscript{134} “Consciousness Raising in a Cellophane Package,” no date, but probably between 1970 and 1973, when Seaman was at Family Circle, in Barbara Seaman Papers, Carton 2, Folder 65, Schlesinger Library.

women refused to support patriarchy.\textsuperscript{136} Other feminists bordered on technological determinism, indicating that effective contraception and safe abortion were absolutely necessary for feminists to make any real gains. Some argued that "without the full capacity to limit their own reproduction, a woman's other 'freedoms' are tantalizingmockeries that cannot be exercised….the older movements for women's liberation could not go beyond hollow token gains; medical technology had yet developed effective contraception and safe abortion techniques."\textsuperscript{137} Meanwhile, others were quite suspicious of the fact that most family planners emphasized female methods of birth control, mainly the Pill and IUD. These methods also required the intervention of physicians, who were primarily male and “presumed to be unsympathetic to the liberated woman.”\textsuperscript{138} Goldsmith concluded that almost "Without exception, the feminists regard birth control as absolutely fundamental to their full liberation."\textsuperscript{139} However, their opinions about contraceptive methods, population planners, and other issues varied considerably, and were often contradictory.

The issue of birth control was particularly divisive for African American women. Legal scholar Dorothy Roberts has pointed out that “the politics of the pill doesn’t fall into a simple liberal-conservative dichotomy,” but rather, black women recognize birth control’s “potential for both liberation and oppression.”\textsuperscript{140} Some in the black liberation movement were against the Pill because it was seen as a tool to limit the black population and this created a rift between women and men. Author Toni Cade criticized men in the movement for arguing that women’s greatest

\textsuperscript{136} Goldsmith, “Review,” 64. Referring to: Millett, Sexual politics.
\textsuperscript{137} This quote is from Lucinda Cisler’s piece in Morgan, Sisterhood Is Powerful.
\textsuperscript{138} Goldsmith, “Review,” 65.
\textsuperscript{139} Ibid.
contributions should be to give birth and raise children, finding such reasoning both sexist and naïve.\textsuperscript{141} Black women were generally supportive of family planning. When a mobile clinic in a black neighborhood in Pittsburgh was closed due to threats of fire bombings and riots, seventy black women unsuccessfully protested to have the clinic reopened.\textsuperscript{142} These women, as part of a local Welfare Rights Organization, circulated a press release with the opinion: "We think a mother can better care for her family if she can control the number of children she bears, and we think that a mother deserves the opportunity to decide when her health and well-being is better served by preventing conception."\textsuperscript{143}

Other black women’s groups expressed similar sentiments. Patricia Robinson, a leftist African American social worker organized a group in Mount Vernon, NY, that composed a position statement responding to the black nationalist condemnation of birth control pills. Robinson’s group did not dispute family planners’ genocidal motives, but instead called for black women to decide about birth control for themselves, and fight back out of their own “experience of oppression.”\textsuperscript{144}

Roberts argues that “race completely changes the significance of birth control to the story of women's reproductive freedom.”\textsuperscript{145} While privileged white women in America have viewed birth control as “an emblem of reproductive liberty,” for black women, “the movement to expand women's reproductive options was marked by racism from its very inception.”\textsuperscript{146} Black women’s understandings of birth control were shaped by the history of coercive sterilization.

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\textsuperscript{143} Ibid.
\textsuperscript{146} Ibid., 56.
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practices that were still occurring in the 1970s.\textsuperscript{147} Since for many years, sterilization was the only form of government-funded contraception available, many blacks were also wary of government-funded family planning clinics, and especially clinics run by white staff members in black neighborhoods. In many cases, there was no pretense of consent at all, and doctors performed unnecessary hysterectomies in order to provide medical residents practice performing the procedure. Women’s health activists realized that hysterectomies were also being wildly over-performed on white women, though the motivation to perform the costly and unnecessary surgery was financial.\textsuperscript{148} Women were especially vulnerable to inappropriate care because their roles of “dependency and uninformed reliance on physician’s authority” made it difficult to communicate honestly with their physicians.\textsuperscript{149}

\textbf{Psychology Constructs The Female}

In addition to the activists and lay experts of the self-help movement, a number of feminists working in medicine and psychology critiqued these fields, and constructed new models of women’s psychology. In 1968, Naomi Weisstein, a Harvard trained psychologist, and founding member of the Chicago Women’s Liberation Union, wrote the widely redistributed manifesto \textit{Psychology Constructs The Female}.\textsuperscript{150} Weisstein argued that psychology’s embrace of “the most superficial and stultifying media conceptions of female nature” had strangled the

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\textsuperscript{147} Roberts, \textit{Killing the Black Body}; Kluchin, \textit{Fit to Be Tied}. \\
\textsuperscript{148} Margaret A. Campbell, \textit{Why Would a Girl Go Into Medicine?}, 1973, 71; Kluchin, \textit{Fit to Be Tied}. Seaman refers to unnecessary hysterectomies as “Hip-Pocket Surgery” since the only beneficiary is the physician’s wallet. Michael Seiler, “Author Calls Gynecologists ‘Piggish’,” \textit{Los Angeles Times}, August 8, 1973. Seaman expands on this point in her article Barbara Seaman, “Do Gynecologists Exploit Their Patients?” n.d., Barbara Seaman Papers, Carton 2, Folder 102, Schlesinger Library. \\
\textsuperscript{149} Campbell, \textit{Why Would a Girl Go Into Medicine?}, 71. \\
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discipline, rendering it “relatively useless in describing, explaining, or predicting humans and their behavior.”\textsuperscript{151} By looking at social context rather than “somatic design,” Weisstein argued, psychology might be able to contribute to a science that could truly liberate men and women.\textsuperscript{152} Weisstein’s hope was that a more rigorous experimental understanding of social context would enable “true” liberation.

Historian Ellen Herman has traced the “curious courtship” of psychology and women’s liberation, finding that feminists “declared war on the sexism of psychological experts,” while also appropriating “those aspects of psychological theory and practice perceived as potentially liberating for women.”\textsuperscript{153} Herman traces the psychological construction of 1960s feminism to Betty Freidan’s best-selling \textit{The Feminine Mystique}, where Freidan claimed that Freudian theories of femininity were partially to blame for women’s dissatisfaction with their limited roles, famously known as “the problem that has no name.”\textsuperscript{154} Consciousness raising groups, which originated with New York Radical Women in 1967, also had a psychotherapeutic sensibility, with women sharing emotions and other experiential testimony.\textsuperscript{155} Though psychology was frequently considered “a trap for women,” the possibility of reforming it also offered the possibility of a way out.\textsuperscript{156}

As part of the feminist move to reform psychology, women’s health movement activists turned their attention to medical education in order to understand the “psychological

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\textsuperscript{151} Ibid.
\textsuperscript{153} Herman, \textit{The Romance of American Psychology}, 302.
\textsuperscript{154} Ibid., 290; Friedan, \textit{The Feminine Mystique}.
\textsuperscript{155} Herman, \textit{The Romance of American Psychology}, 297.
\textsuperscript{156} Ibid., 303.
\end{flushright}
groundwork” which prepared doctors for their roles as experts and women for their roles as submissive patients. Based on the work of feminist sociologists studying the depictions of women in gynecology textbooks, it seemed inevitable that even if a medical student started out as a “nice kid, he [was] bound to be a screwed-up sexist by the time” he finished. As many more women began to enter medical school in the 1970s, some bridged the divisions between self-help and medicine. Carol Kellogg, a Wayne State University student in Detroit, led a group that trained over 100 women as self-help teachers, but she also planned to go to medical school. Kellogg aimed to “work from within the profession to change what she considered a terrible series of injustices perpetrated on women” Barbara Seaman also bridged the gap between popular and academic audiences, presenting a paper for the 79th annual American Psychological Association called “The Pill and Sex” as part of a symposium called “Feminists View Birth Control and Health Care.”

In 1973, writing under the pseudonym Margaret A Campbell, a doctor wrote a report called Why Would A Girl Go Into Medicine?, an exhaustive compilation of the discrimination faced by women students in U.S. Medical schools. Campbell surveyed 146 women medical students, asking them to complete an open-ended questionnaire, and she compiled the results in a report published by The Feminist Press. Though Campbell wrote from the perspective of a recent medical school graduate, by the time the book was published she was already a dean at

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158 Seaman, “Dear Injurious Physician.” This argument was based on Scully and Bart, “A Funny Thing Happened on the Way to the Orifice.” Also see Laura Green, “Woman as Patient,” Health Rights News (September 1971).
Harvard Medical School. Though the students described dehumanizing and disrespectful treatment from their teachers and peers, Campbell believed that the report would enable women to more effectively respond to discrimination. Informing and encouraging “women medical students of the past, present and future” would “promote radical change in medical education and in the care of patients.”

Campbell recognized the condescending and sexist attitudes that male professors and doctors displayed towards women patients, as well as women medical students.

In lectures, women’s health concerns were glossed over or simply not addressed. Women’s complaints were belittled as being trivial, or otherwise discounted due to their psychogenic nature. Campbell saw a direct connection between the fact that women’s complaints were regarded as less serious than men’s complaints, and women’s complaints being regarded as psychosomatic. Campbell found that “hysterical women” was frequently used as a “self-explanatory category,” thus making it a “constant problem for medical management” that physicians needed “to learn how to handle.” Labeling women as neurotic or hysterical was merely a way out of taking the patient seriously.

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161 The typewritten booklet was distributed from Barbara Seaman’s New York apartment, where women could mail two dollars and receive a copy in exchange. Seaman recounted that she ran off most of the copies of the books from the photocopy machine at Family Circle magazine, where she still worked. Gary Null and Barbara Seaman, For Women Only: Your Guide to Health Empowerment (Seven Stories Press, 2003), 919.

162 Campbell, Why Would a Girl Go Into Medicine?.

163 Campbell’s observations were supported by the letters of women medical students who wrote to the Boston Women’s Health Book Collective for information. A first year medical student from New York City to BWHBC, February 10, 1972, Carton 52, Folder 15. Also see another letter from an enthusiastic first year medical student written the same day at the University of Wisconsin-Madison, February 10, 1972, Carton 52, Folder 15, BWHBC Records, Schlesinger Library.

164 Campbell, Why Would a Girl Go Into Medicine?, 73.

165 Ibid., 74.

166 Campbell clearly locates the sources of women’s denigration and oppression in the sexist attitudes of men in such a way that was consistent with other feminist writers in the early 1970s. Other publications by The Feminist Press listed at the end of Campbell’s pamphlet included Barbara Ehrenreich and Deirdre English, Witches, midwives, and nurses: a history of women healers (Old Westbury, N.Y.: Feminist Press, 1973); Charlotte Perkins Gilman, The yellow wallpaper (New York: Feminist Press, 1973).
Our Bodies, Ourselves

Other women were also reacting to the types of treatment Campbell described. The Boston Women’s Health Book Collective (BWHBC) began in 1969 after a group of women met in a workshop called “Women and Their Bodies” at a feminist conference in Boston. These women were initially inspired to learn more about their bodies, and the group continued meeting after the realization that there was no good, unbiased source of information on health.

Furthermore, when the group tried to arrange a “gyn referral setup,” they never received any suggestions of reasonable doctors. The best they could offer was “a choice of lesser evils.” Only three percent of the members of the American College of Obstetrics and Gynecology were female, and there were “male chauvinists among women doctors too.” In their quest to learn more about women’s bodies and to reclaim what was “‘reserved’ for lovers and doctors” as their own, there was no single source of information or authority that the group could trust. The few female doctors they encountered were not necessarily any more kind and caring than male doctors, and the sense of alienation with the medical profession ran deep. As these women met and shared their experiences with one another, they noticed certain commonalities, and these unities sometimes led to sudden realization that sexism lay at the core of their struggles.

A number of historians have written about the importance of the Boston Women’s Health Book Collective both in the U.S. and internationally. The group created a series of publications starting in 1970 with the handwritten and typed booklet Women and their Bodies: A Course, followed by many editions of the more extensive and commercially published manual

167 Esther Rome to reader, April 11, 1972, BWHBC Records, Carton 52, Folder 15, Schlesinger Library.
168 Seaman, “Dear Injurious Physician,” 35. In 1970, the total percentage of women physicians and ob/gyns was approximately seven percent. See: Weisman, Women’s Health Care.
169 The Boston Women’s Health Book Collective, Our Bodies, Ourselves: a Book by and for Women, 26.
170 For example see Kline, Bodies of Knowledge; Davis, The Making of Our Bodies, Ourselves.
Our Bodies, Ourselves. Historians have focused on the way Our Bodies, Ourselves, was translated into languages and cultures beyond the U.S. as well as the particular group dynamics of the members as the manual went through the controversial transformations that turned the small “movement publication” into a mainstream bestseller. Our Bodies, Ourselves has been considered U.S. feminism’s “success story,” selling 2.5 million copies before 1976 and appearing on the best seller lists of the New York Times and fourth on the Chronicle of Higher Education’s list of best-selling books on college campuses.\(^{171}\)

The political imperatives and interpersonal dynamics of the members made for a passionate and dynamic collective invested in learning and improving their course and materials. The book is filled with the group’s reflections on their process of learning about women’s bodies and of writing the book. Many of these reflections are quite personal and emotional as the women critically reflected on their bodies and lives. While the first publication Women and their Bodies: A Course was laid out in such a way that it could be used as a course manual, later versions were filled out with extensive quotes from women, using their own words to provide examples. The book was arranged into chapters that included general health topics like nutrition and exercise, but there was a strong emphasis on sexuality, birth control, reproduction, and childbearing. Detailed information on each topic was integrated with practical recommendations and multidimensional analysis.

When the group moved from publishing with the New England Free Press to the much larger and more commercial Simon and Schuster, many women from self-help clinics and other women’s groups wrote in to complain. Many women, including one who worked as a pregnancy counselor at a women’s health clinic in Portland, Oregon, did not trust capitalist publishers, and

doubted that women would have a transformative experience if they came upon *Our Bodies, Ourselves* in a mundane setting such as a “supermarket” or “drugstore.” \(^{172}\) This woman’s clinic in Portland operated on donations, and gave out copies of *Our Bodies, Ourselves* free to those who could not pay. Women who visited the clinic had an “experience which puts them, sometimes for the 1\(^{st}\) time touch with their own bodies; they want to read the book out of an initial excitement and curiosity that comes from an encounter with women who help them in their health problems in a new way.” \(^{173}\)

In response, Boston Women’s Health Book Collective member Esther Rome justified the decision to go with a larger publisher offering wider circulation of the book. To those women who expressed alienation that the book would be circulated beyond the reaches of those involved in the women’s movement, Rome asked “Another question—Who is the Movement? I think I see it as much broader than what the Free Press or you are defining it now. It seems to us that it should include all the women, including the ones in the suburbs. In fact, one good reason for including the women in the suburbs is that working class people identify very strongly with the ideals of the middle and upper class suburban.” \(^{174}\) Rome suspected that “a great many” of the readers were upper and middle class, and a larger distribution scheme was necessary for the book to reach more hands. \(^{175}\) Many of the women who wrote to the collective were already involved in the women’s movement, or they recently joined after consciousness raising experiences.

Though the collective aimed to show diversity among women’s experiences, they nevertheless relied upon certain commonalities in order to construct a vision of what

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\(^{172}\) Dear Sisters from Esther Rome, April 24, 1972, BWHBC Records, Carton 52, Folder 14, Schlesinger Library.

\(^{173}\) Dear Sisters from a pregnancy counselor at a women’s health clinic in Portland, Oregon, BWHBC Records, Carton 52, Folder 14, Schlesinger Library.

\(^{174}\) Dear Sisters from Esther Rome, April 24, 1972, BWHBC Records, Carton 52, Folder 14, Schlesinger Library.

\(^{175}\) Dear Sisters from Esther Rome, April 24, 1972, BWHBC Records, Carton 52, Folder 14, Schlesinger Library.
womanhood meant to them. The body was central to their understanding of female experience.

One reader explained her reaction:

> Your book really got me where it meant most; with our bodies being the center of our existence male domination becomes obvious when the methods are illustrated in the contest of our bodies. I had always thought there was something wrong with me that made men act so abusive. Now I realize that all I have to be is female in order to be treated less than human.¹⁷⁶

This reader’s response illustrated the impact of consciousness raising, in that the book caused her to reframe her individual experiences as symptoms of the larger problem of male domination. Women’s problems were reframed not as individual or unique failures, but systemic issues resulting from societal inequalities and sexism. Another reader from Colorado wrote in to tell the Collective that her book arrived on “one of her bluest days as a housewife,” but that she suddenly “began to fell like a real live person.”¹⁷⁷ Many women wrote similar letters, and the collective often responded that they would work on adding more information and perspectives with each revision, making the book longer and longer over the years.

The Collective was adept at questioning authority while also reflexively questioning their own claims to authority. In the course introduction, the collective wrote that they were “excited and nervous (we were just women; what authority did we have in matters of medicine and health?)”¹⁷⁸ The Collective seemed to be grappling with the knowledge that even though they were not recognized as authorities on health, they were quickly becoming respected authorities and role models. This realization registered as excitement, which was evident in their honest and enthusiastic tone. The positive tone, tempered with skepticism of the medical establishment,

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¹⁷⁶ To BWHBC from a reader in Brooklyn, Iowa, 1971, BWHBC Records, Carton 53, Folder 13, Schlesinger Library.
¹⁷⁷ Dearest Ladies from a reader, February 12, 1972, BWHBC Records, Carton 52, Folder 15, Schlesinger Library.
¹⁷⁸ The Boston Women’s Health Book Collective, Our Bodies, Ourselves: a Book by and for Women, 3.
made the book a source of inspiration to the many readers who actively participated in the movement by lending out and distributing copies, contributing content and writing in letters.

The Collective eventually came to be recognized as a resource for gynecologists interested in improving communication with their patients. An attempt at a collaboration on a conference panel between the Collective and gynecologists at an American College of Obstetricians and Gynecologists meeting illustrates this fraught relationship. The draft of a program from a regional American College of Obstetricians and Gynecologists meeting in Salt Lake City, Utah showed evidence of a failed collaboration between the Boston Women’s Health Collective and American College of Obstetricians and Gynecologists. The Boston Women’s Health Book Collective was on the program along with two physicians on a panel called “contemporary medical marriage” and on another panel entitled “communicating with the contemporary ob-gyn patient.” The panels were presumably intended to educate physicians about how to communicate with their patients and how to understand the interaction of the women’s health movement with the field of obstetrics/gynecology. However, when the Boston Women’s Health Book Collective agreed to attend the conference, they had been led to believe that they would have the platform to themselves. In handwriting, a member of the group wrote on the program “we cancelled out, because we didn’t want to share platform.” Indeed, a revised version of the program appeared with the same panel title “Seminar: Communicating With the Contemporary Ob-Gyn Patient,” but the Boston Women’s Health Book Collective was missing. Instead, the title was followed by the description “(With Wives.)” As a result of the Boston Women’s Health Book Collective pulling out, women were no longer present on the platform.

\footnote{This was not the only brush between academics and activists. See Carol Downer “Covert Sex Discrimination Against Women As Medical Patients” by Carol Downer, Address to the American Psychological Association, meeting in Hawaii, September 5, 1972, BWHBC Records, Carton 102, Folder 3, Schlesinger Library.}
panel through their affiliation with the Collective, but through their affiliation as “wives,” presumably the wives of the physicians.

Though none of the physicians on the program were women, women were included in the more recreational aspects of the conference. There was a “Ladies Hospitality Room,” where women could come for help, information and tickets for conference activities including a “Nature Hike and Gourmet Picnic” and a “Mormon Historical Highlights” walking tour. Thus, the social activities at the conference included women as companions and valued women’s experience as patients through their status as “wives,” but did not include any women panelists.

Letters to the BWHBC reveal additional awkward exchanges as men struggled with how to conceptualize women as producers of knowledge. A number of letters addressed to the Collective began with the salutation “Gentlemen:” or “Dear Sirs.”¹⁸¹ One of the few requests for help that came from a man was regarding this particular issue.

When I started this letter I got stuck after the Dear! I’m so used to writing “Dear Sir,” “Dear Sirs,” “Gentlemen,”… but what do you say if it is not to a male?
These days, it might be dangerous to say “Ladies” or “Dear Ladies,” but “Dear Women” just doesn’t sound right.
Won’t you please help me out?
Thanks. ¹⁸²

Our Bodies, Ourselves Assesses the Pill

Promoting an understanding of women that privileged bodily experience, the Collective encouraged women to get in touch with their bodies through direct, unmediated experience in ways that transcended medical models. Additionally, being skeptical of medical treatments and the profit motive in a capitalist, male-dominated society, all signs pointed to the likelihood that

¹⁸² Dear BWHBC, June 8, 1972, BWHBC Records, Carton 52, Folder 16, Schlesinger Library.
The *Our Bodies, Ourselves* would have a complicated and critical attitude toward of the contraceptive pill.

The collective was aware that contraceptive pills were big sellers and drug companies had a financial interest in promoting them. *Our Bodies, Ourselves* contained a great deal of factual information about contraceptive pills, detailing the mechanisms of action, procedures for obtaining them, and the risks, side effects, and differences between types of pills. The treatment of the Pill was also framed in critical analysis. *Our Bodies, Ourselves* cited an estimate that in 1968, “drug companies spent $4500 per physician per year on advertising and promotion of all drugs” and that women took $100 million worth of birth control pills.\(^{183}\) The Collective recognized the profit motive as the reason for the “cover-up” of unfortunate results and pamphlets that “distorted or denied known risks.”\(^{184}\)

*Our Bodies, Ourselves* considered Seaman’s work, concluding that many of the cases of injury or death she cited could have been prevented by physicians’ proper examination and screening. To prevent complications, they encouraged women to seek help rather than ignoring warning signs that something was amiss. This proactive approach represents the BWHBC’s belief that women could understand and manage the risks of the Pill themselves as long as they were fully informed, and received competent medical care. The problem, of course, was that many physicians who claimed the Pill was safe had financial interests in its success and the most ardent advocates, such as Robert Kistner, were only “interested in maintaining a kind of MD-priesthood mystique.”\(^{185}\) Meanwhile, population experts such as Alan Guttmacher down-played

\(^{183}\) The Boston Women’s Health Book Collective, *Our Bodies, Our Selves: a Course by and for Women*, 40.  
\(^{184}\) Ibid.  
\(^{185}\) Ibid., 41.
side effects, and other doctors were too busy or irresponsible to learn as much as they should.

Our Bodies, Ourselves placed part of the responsibility to manage risk in women’s hands.

Be sure the doctor examines you carefully, including an internal pelvic exam, breast exam, eye exam, Pap smear, and blood-pressure, blood and urine tests. The interview should include questions about you and your family's medical history of breast cancer, blood clots, diabetes, migraines and so on. Too many doctors prescribe birth control pills hurriedly; it's up to you to make sure you are carefully checked for each one of the contraindications.\footnote{186}

The BWHBC believed that ensuring thorough examination would reduce the risks of the Pill, but these doctor’s visits constituted yet another burden on women. The birth control issue highlighted a “central aspect” of women’s “vulnerability,” because women were responsible for making appointments, seeing doctors, getting examined, going to the drugstore, paying for supplies, and taking “whatever risks are involved.”\footnote{187} Women reported that the burden of birth control caused resentment, but giving up the Pill was not an easy answer.\footnote{188} BWHBC reasoned that the Pill was less dangerous than pregnancy or abortion:

According to United States mortality statistics, 100,000 pregnancies would result in about 25 maternal deaths—eight times the death rate associated with the pill from blood clotting. Of those women who terminate their pregnancies through illegal abortions, about 1 in 100 will die. So if we choose to stop using the pill because we are concerned for our health and safety, we'd better be sure that we are protecting ourselves from the higher risks of pregnancy and abortion.\footnote{189}

Even where abortion was legal, it was safer, but still burdensome.\footnote{190}

\footnote{186}{The Boston Women’s Health Book Collective, Our Bodies, Ourselves: a Book by and for Women, 116.}
\footnote{187}{Ibid., 108.}
\footnote{188}{Homosexuality, celibacy and being single were also described as valid lifestyles.}
\footnote{189}{The Boston Women’s Health Book Collective, Our Bodies, Our Selves: A Course by and for Women, 1971, 41.}
\footnote{190}{The Boston Women’s Health Book Collective, Our Bodies, Ourselves: A Book by and for Women. The 1973 version has a chapter on abortion, claiming abortion as a right, and covering legal abortion in New York, and illegal abortion elsewhere.}
The Collective was also aware of the psychological importance of contraception and its place in a sexual relationship. *Our Bodies, Ourselves* provided an emotionally complex and sympathetic assessment of what it was like to weigh the health risks of the Pill. Unlike Seaman, the Collective did not purport to know the right answer, but they presented a range of perspectives that they sensitively considered.\(^{191}\) They wrote, “If we go off the pill, how do we deal with our feelings of legitimate resentment against the burden of total responsibility for birth control? This is painful because it brings home very sharply our vulnerability; we are the ones who get pregnant.”\(^{192}\) Of course the health risks caused by the Pill put women in a vulnerable position, but so did unwanted pregnancy. The Collective was attuned to the fact that it was not the mere fact of unwanted pregnancy that made women vulnerable, but knowing that it was possible was a painful reality for many women. The Pill did provide some defense to the vulnerable position of not always being in control of pregnancy, but it was not a permanent or foolproof fix. “The fact that is no effective, safe, and esthetically pleasing birth control method serves to maintain the dependent-submissive relationship women have vis-à-vis men.”\(^{193}\) The Collective reasoned that a woman “almost has to feel dependent” on a man because she is “the one who risks impregnation” and bears the humiliation, “social indignation and psychological turmoil” if “a man doesn’t stand by her and support her.”\(^{194}\) Even in the best-case scenario, when a relationship “is supposed to be based on mutual respect and/or love,” it “is in actuality based on this kind of fear and dependence,” which caused “much female anxiety in sexuality.”\(^{195}\) In subsequent versions of *Our Bodies, Ourselves*, birth control was presented in a more positive

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\(^{191}\) In contrast, their view on childbirth was far less flexible, arguing that birth was a natural process and women should avoid painkilling drugs if possible. See: Childbearing Chapter in Ibid.

\(^{192}\) The Boston Women’s Health Book Collective, *Our Bodies, Our Selves: A Course by and for Women*, 1971, 41.

\(^{193}\) Ibid.

\(^{194}\) Ibid.

\(^{195}\) Ibid.
light. Preventing unwanted pregnancy was still a burden, but the book focused on how men could be “reasonable and supportive” partners in sharing the responsibility.\textsuperscript{196}

Though the Collective generally promoted a positive view of sexuality and mutually respectful relationships between sexual partners, the risk of unintended pregnancy presented a challenge to women’s autonomy. The Pill was critically important for its function as an effective birth control method, and also for its psychological protection against fears of unwanted pregnancy. If women did not have to bear the risk of impregnation, they could transcend the “dependent-submissive relationship.”\textsuperscript{197} Our Bodies, Ourselves took a vastly different approach to sexuality compared to The Doctors’ Case Against the Pill, which criticized the Pill for increasing men’s power in sexual relationships. Seaman’s logic suggested that women did not have much to gain from sex, and thus the Pill removed fear of pregnancy as a good excuse to avoid it. Meanwhile, the Collective assumed that women did in fact want to have sexual relationships based on respect or love, but that fear of pregnancy stood in the way. This psychology of reproduction was vastly different from many of the psychoanalytic studies that theorized women’s inability to separate sex from reproduction without experiencing negative consequences. Our Bodies, Ourselves portrayed women’s ability to reproduce as empowering, but it was also a potential liability. In contrast to the representations of women used in marketing and packaging the Pill, the women represented in Our Bodies, Ourselves were able to make concrete decisions, educate themselves, and responsibly account for their actions. Ultimately, BWHBC believed that both the “pro-pill and anti-pill” people had important things to say, and it was up to women to decide for themselves if they thought the Pill was right for them. The Collective listed contraindications and side effects, and encouraged women to make

\textsuperscript{196} The Boston Women’s Health Book Collective, Our Bodies, Ourselves: A Book by and for Women, 1973, 108.  
\textsuperscript{197} The Boston Women’s Health Book Collective, Our Bodies, Our Selves: a Course by and for Women, 41.
sure that their doctors adequately checked them for anything that could go wrong. This left the responsibility for safety shared between mutually informed doctors and patients.

Conclusion

The motivating force behind the women’s health movement was the idea that knowledge was power, and focusing specifically on women’s bodies and experiences would lead to new ways of knowing. Thus, the women’s health movement did not reject medicalized surveillance, but instead encouraged women to become even more aware of their bodies. Women’s health movement activists were concerned with self-examination of the cervix, charting the menstrual cycle, researching contraceptive methods, and they challenged and joined their doctors in the tasks of knowing and observing their bodies. Over the course of the 1960s, women became adept at some of the sorts of monitoring that had traditionally been the work of physicians.

Physicians understood that some women were taking on this role. Mary Lane, the Clinical Director of the Contraception Service of the Margaret Sanger Research Bureau, remarked that:

In the area of fertility control, some women are demanding to know all indications and contraindications to all medically approved contraceptive methods so that they can take their own health histories, do their own screening, their own prescribing—even their own pelvic examinations. Why, in fact, do they need doctors at all? 198

Meanwhile, as the risks of the Pill became more apparent, and they were also understood in a new way. In the 1960s, the risks of the Pill were frequently listed in comparison to other contraceptive methods such as condoms and diaphragms. In contrast, by the 1970s, physicians statistically compared the risks of the Pill to the health risks of pregnancy and abortion. The new

reasoning was that condoms and diaphragms might not cause harm on their own, but because these methods were not perfectly effective, the health risks from unintended pregnancies and childbirths that resulted from these methods’ failures must also be counted. The work of biostatisticians such as Christopher Tietze at the Population Council helped to reframe risk in such a way that pregnancy was denaturalized, and by preventing the dangers of pregnancy, the relative risks of the Pill appeared smaller.\(^{199}\) In a *New York Times* article about the safety risks of the Pill, health journalist Jane Brody wrote, in 1975, “Even for women receiving the best of medical care, the nine months of pregnancy, childbirth and the postpartum period are far more dangerous to life and health than any existing contraceptive method, statistics show.”\(^{200}\) When considering the health risks that resulted from unintended pregnancies, condoms and diaphragms turned out to be even more dangerous that the Pill and the IUD.\(^{201}\) But to further complicate matters, the availability of safe and legal abortion flipped the equation yet again, making the condom and diaphragm the safest choice as long as abortion was used as a backup method.\(^{202}\)

In addition to this reframing of contraceptive risks in the context of risks from pregnancy, childbirth, and legal abortion, health journalists became more aware that the Pill was not the only contraceptive method posing danger. American women increasingly relied on the IUD as their contraceptive of choice in the early 1970s. But in 1974, the Dalkon Shield IUD was removed from the market as A.H. Robbins was flooded with lawsuits claiming that the device caused pelvic inflammatory disease, infertility and severe injuries. Ironically, Hugh Davis, the


\(^{201}\) Petchesky, *Abortion and Woman’s Choice*.

gynecologist who wrote the introduction to *The Doctors’ Case Against the Pill*, and called the Pill “a public scandal,” was the inventor of the Dalkon Shield. The Dalkon Shield, of course, ended up being a public health disaster and a much larger scandal than the Pill.

The Pill also helped remove menstruation from the realm of natural inevitability into something that could be predicted or even controlled. Periods on the Pill became known as “withdrawal bleeding.” Not only was the Pill prescribed to lessen menstrual cramps, excessive bleeding and unpredictable cycles, but it was also used to control the timing of menstruation. No longer simply a natural bodily function, menstruation could be delayed to maximize performance on important exams, or to assure the best chances for sexual adjustment on one’s honeymoon. The possibility of using the Pill to modify the menstrual cycle meant that “the natural period” became denaturalized. By 1970, it was possible to refer to “the natural period” as a thing with “symptoms” to be avoided. In the end, whether a woman chose to embrace or to reject the Pill, it was nearly impossible to escape the particular form of psychologizing and medicalizing of the female body that the Pill assisted in enabling.

204 In April, 1970, the pharmaceutical division of the British company Schering Chemicals sent a brochure to doctors suggesting that they prescribe Primolut N, a progestogen, to delay menstruation for “optimum examination conditions” if a period was expected over exam week. The brochure claimed there was “good evidence that girls are less alert and efficient when menstruating or in the premenstrual week.” Primolut N Brochure, Syntex Collection of Pharmaceutical Advertising, Archives Center, National Museum of American History. Before home pregnancy tests were available, a late period could even be hastened to relieve or confirm fears of an unwanted pregnancy. See: A letter to doctors and brochure for Norone, another British product, from Roussel Laboratories, May 23, 1966, Syntex Collection of Pharmaceutical Advertising, National Museum of American History, Smithsonian Institution.
205 Westoff, *From Now to Zero; Fertility, Contraception and Abortion in America*, 91.
The Pill figured prominently in changing conceptions of women’s psyches during the 1960s. Though women’s use of contraception was nothing new, the possibility of simply and reliably separating women’s physiological makeup from the risk of pregnancy held an unprecedented power. Altering one of the most prominent, and previously unquestioned, characteristics of womanhood rendered women’s psyches and social roles newly mutable. This dissertation explored four different types of expert communities as they grappled with a complex set of debates concerning the social, moral, and medical impacts of the Pill on women’s psyches.

Psychiatrists immediately saw the potential of the Pill to unleash inner conflicts, and to destabilize sexual relationships, which were remarkably sensitive to struggles over managing the fears and possibilities of pregnancy. Psychoanalytic psychiatrists in particular perceived incommensurability between the foolproof certainty of the Pill and women’s ambivalent emotions about pregnancy. As manufacturers and marketers considered packaging and branding, they promoted a vision of women as forgetful, immature, and in need of physician oversight. Pill packaging aimed to counteract women’s noncompliant behavior, while advertisements addressed physicians’ anxieties about patients’ unsupervised pill-taking. Obstetrician/gynecologists and other physicians worried over the moral impact of prescribing the Pill, and they considered how to manage doctor-patient relationships as they watched structures of authority shift. The women’s health movement saw the failures of medical paternalism and
reacted strongly against the characterizations of these expert communities. In the 1970s, the new
conception of women’s psyches put forth by women’s liberation called for women to control
their own bodies, and remain informed about healthcare to guard against exploitation and risk.
Each community of experts gravitated toward a different conception of pill-taking women, but
these articulations of women’s psyches were all fragile and shifting. Taken together, they
ultimately contributed to a broader cultural reimagination of women’s inner lives through their
respective analyses of the Pill.

As the Pill became better known and more thoroughly studied by a range of experts,
demographic and population-based accounts formed a dominant body of research.¹
Psychiatrists’ speculative hypotheses about the differential origins of emotional changes became
less persuasive when weighted against growing evidence that these reactions were fairly
uncommon. Psychiatrists’ research on emotional reactions to the Pill quickly faded in the early
1970s alongside the waning popularity of psychoanalytic thinking in medicine.²

As Americans increasingly adopted daily medication regimens to prevent disease, the
contraceptive pill’s long-term daily dosing pattern ceased to be exceptional. The Pill was just
one of many prescriptions a generally healthy American might take on a given day. The Pill
came with definitive health risks, described in a patient package insert that physicians were
supposed to supply along with the prescription, but a host of other pharmaceuticals used to
maximize one’s health also carried risks. Compliance to medication regimens would continue to
remain a concern, but as the scope of antibiotic resistance continued to expand over the 1960s

¹ For example, large bodies of knowledge were produced from the National Fertility Study based at Princeton’s
Office of Population Research, and the Guttmacher Institute, originally part of the Planned Parenthood Federation of
America.
University Press, USA, 1995).
and 1970s, resistant bacteria were a far greater cause of worry than a missed contraceptive pill.³

The moral concerns that framed access to the Pill in the 1960s did not disappear, but since they remained rooted in political and religious spheres, it became harder for physicians to make moral claims without sacrificing their patient-centered legitimacy. Physicians’ claims of guarding “social responsibility” implied patients’ irresponsibility, and thus the weakening of medical paternalism challenged physicians’ ability to claim to know their patients’ best interests. The prospect of “planning other people’s families,” whether through population control or through refusing Pill prescriptions for unmarried college students, was essentially discredited, though these impulses did not disappear among physicians and policy makers.⁴

While controversy over the safety of the Pill initially helped galvanize the women’s health movement, focus on the Pill was quickly subsumed by other projects. Feminist health activists saw the Pill as just one of a host of potentially dangerous reproductive drugs, procedures and conventions that were part of women’s lives. In addition to Thalidomide, DES and the Dalkon Shield IUD, Hormone Replacement Therapy joined the ranks of dangerous products in 1975, when it was found to cause cancer.⁵ In 1978, bowing to patient pressure, the FDA required a longer information leaflet to replace the Pill’s patient package insert, allowing patients to get a step closer to the detailed information provided to physicians.⁶

Over time, across all constituencies, conceptions of women’s psyches changed. As the Pill was normalized, heightened concerns over women’s mental states and the moral and social

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responsibilities of pill producers and prescribers began to fade, leaving the Pill as simply one more everyday risk of modern life. Women’s roles changed radically over the course of the 1960s, and the sexual revolution helped to loosen conceptions of women’s psyches from the inevitability of marriage and childbearing. Increasing numbers of women joined Betty Freidan in questioning the application of Freudian theories of femininity as they had “filtered into the lives of American women through the popular magazines and the opinions and interpretations of so-called experts.” Recalibrations and feminist challenges from within and outside of the medical profession resulted in Freudian theories becoming less openly acceptable.

At the same time, Americans’ engagement with pharmaceuticals deepened along with a “pharmacopoeia of risk reduction” designed not to treat symptoms, but to reduce the “statistical likelihood” of developing chronic disease in the future. In addition to the classes of drugs designed to minimize risk, many of the most significant pharmaceuticals to emerge after the 1960s were designed to modify mental states or to enhance one’s quality of life. The expanding pharmacopeia further encouraged the co-production of users and patients, blurring the lines between health and illness, and transforming patients into lifelong customers and often, consumer activists.

By the mid 1970s, these particular, historically situated theorizations of women on the Pill yielded to a broader and more encompassing pharmaceuticalization of modern America. As the landscape of risk factors and disease identities widened, psychological conceptions of

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8 Jeremy A. Greene, Prescribing by Numbers: Drugs and the Definition of Disease (The Johns Hopkins University Press, 2008), vii.
9 For examples see: Tone and Watkins, Medicating Modern America; Adele Clarke, Laura Mamo, and Jennifer Ruth Fosket, Biomedicalization: Technoscience, Health, and Illness in the U.S. (Duke University Press, 2010).
11 Tone and Watkins, Medicating Modern America.
women on the Pill ceased to be unique. The Pill was now one of many pills being prescribed for daily use for a diversity of patients, and experts were no longer able to frame women’s interior lives and social roles so narrowly in relation to reproduction. As the terrain of medical risks and pharmaceutical solutions expanded, characterizations of particular types of patients would extend far beyond any singular imagined psychology of women on the Pill.

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