

APA Resource Document

Resource Document on the Role of Psychiatrists in the Post-Roe Era

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Introduction

On June 24, 2022, the Supreme Court of the United States released its decision in *Dobbs v. Jackson Women's Health Organization*, which reversed *Roe v. Wade*, the landmark 1973 decision recognizing a constitutional right to abortion (Malina et al., 2022). With the overturning of *Roe*, the legality of abortion procedures fell under the jurisdiction of state governments, which created a patchwork of legislative mandates across the nation. In some states, the effect of *Dobbs* was to activate so-called trigger laws, which banned or restricted abortion and were designed to take effect if *Roe* was overturned. In other states, pre-*Roe* laws limiting abortion that had never been revoked took effect, with various restrictions. Still other states passed new laws intended to limit abortion, while some states passed new legislation protecting abortion rights. Over 75 medical societies, including the American Psychiatric Association, joined the American Medical Association and the American College of Obstetricians and Gynecologists in denouncing *Dobbs* as constituting unwarranted governmental interference in the patient-physician relationship (Coverdale et al., 2023). It is the long-standing position

of the APA that abortion should be available to pregnant persons as part of standard health care and that decisions about abortion should be made by a pregnant person and their physician.

Although the decision to have an abortion is a personal one, access to abortion is a critical component of evidence-based medicine for patients and physicians. Restricting access to abortion has many implications for psychiatry. This document is designed to provide an overview of the data regarding the impact of restricting access to abortion and guidance for psychiatrists regarding how to respond to the challenges that occur when individuals do not have access to abortion.

During the *Roe* era, when women had access to safe medical abortion, about 50% of pregnancies in the U.S. were unintended and approximately 20% resulted in elective termination (Ross, 2022). Abortion, while not risk free, has a low risk of complications, considerably lower than the risks of carrying a pregnancy to term; however, risks do increase with later-term abortion (Ralph et al., 2019). The lack of access to elective abortion, as is now the case in many states, can have widespread implications for the health of pregnant persons. Labor and delivery can involve physical complications, such as hemorrhage, infection, seizures, cardiomyopathy, coagulopathies, and death (Joseph et al., 2021). According to the National Institutes of Health, the 40-week gestational period can also result in diabetes, hypertension, severe and persistent nausea, iron deficiency, miscarriage, and stillbirth. Pregnancy is also associated with psychiatric risks, predominantly of an affective and psychotic nature. Ten percent to 15% of pregnant individuals and 12%-15% of postpartum individuals may develop depressive symptoms. These numbers are higher, and the symptoms may be more severe, for those who have experienced depressive episodes prior to pregnancy. Those with bipolar disorder have a significantly increased risk of postpartum symptoms and are up to seven times more likely to require psychiatric admission than are those without this diagnosis. Approximately 1 in 500-1,000 individuals develops postpartum psychosis, which can be life-threatening for both parent and child (Robinson et al., 2022). Individuals who experience postpartum psychosis have a greater than 50% risk of recurrence in

subsequent pregnancies. Further, there is an increased risk of teratogenicity and birth complications with the use of some psychotropic medications during pregnancy.

Additionally, there are important clinical considerations involved in managing patients with psychiatric conditions, including serious mental illnesses, who have an unplanned pregnancy, particularly if they are taking potentially teratogenic psychotropic medications (Wisner & Appelbaum, 2023). Some data, albeit limited, suggest that restricted access to abortion may be associated with an increased rate of suicide (Zandberg et al., 2023). There is also evidence that those who receive an abortion are more likely to have preexisting psychiatric conditions, including anxiety, mood, substance use, attention deficit, psychotic, eating, and trauma- and stress-related disorders (di Giacomo et al., 2021; van Ditzhuijzen et al., 2015). These data indicate that those with psychiatric conditions may be electing to terminate a pregnancy to maintain their mental health or due to concern that the added stressors of pregnancy and parenting may worsen their mental health or quality of life.

Pregnancies involving rape and incest present additional complexities. One in 20 women in the U.S., or over 5.9 million women, experiences a pregnancy from either rape, sexual coercion, or both during their lifetimes (D'Angelo et al., 2023). Several states have already denied access to abortion for those who become pregnant from these situations, which can lead to further traumatization, depression, guilt, and shame. Intimate partner violence may increase in severity during pregnancy, while also contributing to long-lasting physical and psychiatric conditions. Interpersonal violence (IPV) is a risk factor for suicide, homicide, and overdose-related maternal mortality (Campbell, et al., 2021; Joseph & Modest, 2024). Reproductive coercion and victimization disproportionately impact teens, particularly those of lower socioeconomic status. For individuals of reproductive age who experience IPV, reproductive coercion, forced pregnancy, or the leveraging of punitive abortion laws by abusive partners can further contribute to perinatal mental health and substance use conditions (ACOG, 2013; Miller et al., 2010; Grace & Anderson, 2018). Among women experiencing IPV, those who are unable to obtain an

abortion are less likely to experience reductions in violence (Roberts et al., 2014). Forced pregnancy also increases women's entrapment in abusive relationships, which in turn increases the risk for a range of mental health conditions (Nelson et al., 2022). Individuals with intellectual difficulties or limited reproductive knowledge are also at risk of exploitation. Violating autonomy and requiring traumatized individuals to carry and deliver a pregnancy without consent can objectify patients and create both clinical and moral quandaries (Madigan et al., 2014; Leeners et al., 2010). This can lead to punishment of the victim and violation of the rights of pregnant persons.

Children born to individuals who were denied an abortion have disrupted bonding with the parent, experience greater poverty, and suffer negative health outcomes. In comparison, enabling individuals to postpone childbearing is associated with better outcomes for children. An unwanted pregnancy can also have negative effects on the existing children in a family, reducing their likelihood of positive life outcomes (Foster, 2022; Foster et al., 2018). Families with an unwanted pregnancy can have difficulty covering basic living expenses and experience greater household poverty (Foster et al., 2018).

Abortion restriction negatively impacts the most marginalized persons in our society. Structural and systemic bias and stigma already result in negative maternal health outcomes for minority populations. Denying access to abortion is likely to magnify these inequities, as the majority of individuals who seek an abortion have lower incomes (Jerman et al., 2016). Those without resources will be compelled to 1) carry an unwanted pregnancy and have a forced birth, while also bearing the burden of social, obstetric, and mental health sequelae previously outlined; 2) undergo a self-managed abortion, placing them at risk for arrest and prosecution when presenting for subsequent emergency care; or 3) access an unsafe third-party abortion, with increased risk of morbidity and mortality.

The burden of raising more children can exacerbate the cycle of poverty (Ogbu-Nwobodo et al., 2022; Crear-Perry et al., 2021). Among those who undergo an abortion, 75% fall below the federal poverty line by 200% or more, making those who are low income the most overrepresented group

among people receiving an abortion. Black and Latinx individuals are also overrepresented among those who undergo an abortion, in comparison to their percentages in the general population (Jerman et al., 2016). People who are publicly insured via Medicaid have for many years had barriers to accessing abortion created by the Hyde Amendment, which prohibited the use of federal funds for abortion. This has significantly limited access to abortion for, among others, those who identify as Native American, which is a group that is known to experience disproportionately high rates of sexual assault and unintended pregnancy (Arnold, 2014).

Further, the criminalization of abortion may result in increased contact with the criminal justice system, which already disproportionately affects people who live in poverty and those with psychiatric and substance use disorders (Malina et al., 2022). The maternal mortality and mental health crises were already disproportionately affecting minoritized individuals who have less access to comprehensive reproductive and overall health care (Bryant et al., 2010) and are further amplified for minoritized people who experience IPV. Criminalization stands to worsen health inequities, compounding the inequities already inherent in the U.S. criminal justice system.

Efforts to enforce abortion bans will significantly restrict privacy in the health care setting, breeding mistrust of clinicians, especially among members of disenfranchised groups. Many laws restricting abortion limit what physicians can say to their patients about the availability of abortion services—at risk of criminal or civil liability—impinging on clinicians’ freedom of speech to the detriment of their patients’ health. There may also be unintended consequences impacting other aspects of reproductive health care, such as in vitro fertilization and other fertility treatments, changing legalities surrounding the availability of oral abortion medications and contraceptives, and regulation of other emerging genetic and stem cell technologies.

In contrast, people who undergo an abortion, despite misconceptions to the contrary, are not more likely to have negative mental health outcomes (National Academies of Sciences, 2018; Major et

al., 2008). The milestone Turnaway Study found no differences in rates of depression, anxiety, or suicidal ideation among women who had an abortion compared to women turned away from an abortion clinic because their pregnancy had advanced beyond the point where abortion was permitted under state law. In contrast, women denied an abortion may experience more serious health outcomes related to labor and delivery, become trapped in abusive relationships, suffer increased anxiety and a lower sense of self-worth, or have poorer physical health for many years after the pregnancy. This study directly contradicts many elements of the misinformation and stigma surrounding abortion procedures (Biggs et al., 2020).

The remainder of this APA resource document will outline clinical considerations for psychiatrists in a post-*Dobbs* world and provide guidance in navigating a new and complex landscape related to abortion.

Considerations for Psychiatric Care

Access to Psychiatric Care

Psychiatrists will undoubtedly encounter treatment-related challenges in jurisdictions in which access to abortion has been restricted or banned. Given the effects of abortion denial on obstetric and mental health outcomes, *Dobbs* will likely lead to increased demand for psychiatric care both during and after pregnancy. Unwanted pregnancy is a risk factor for antenatal depression and anxiety as well as postpartum depression (Biaggi et al., 2016; Mercier et al., 2013). The mental health system in the U.S. is already in crisis and unable to meet the current demand for psychiatric care. Prior to *Dobbs*, psychiatrists and allied mental health professionals had, and now continue to have, limited training in the management of psychiatric disorders during and after pregnancy (Osborne et al., 2018). The number of specialized training programs is growing but still limited. Given the mental health workforce shortage, lack of training in reproductive mental health, and potential increase in demand for mental health

professionals after *Dobbs*, there will be even higher demand for mental health care. Filling the maternal mental health care gap will increasingly fall on obstetric, family medicine, and pediatric clinicians.

Limited short-term options exist for addressing the mental health workforce issues. Perinatal Psychiatry Access Programs (Access Programs) are an evidence-based model that increases the capacity of clinicians serving perinatal individuals to address their mental health needs (Byatt et al., 2018; Masters et al., 2023). Investments in adaptations to Access Programs and other models of care will be necessary to address the treatment needs of pregnant persons with psychiatric illness due to abortion restrictions. Additionally, psychiatric and other mental health professional organizations will need to advocate for increased resources to support the mental health needs of pregnant persons denied an abortion and training for psychiatrists in reproductive and perinatal mental health. Recognizing reproductive psychiatry as an essential component of all psychiatric training and as a subspecialty recognized by the Accreditation Council on Graduate Medical Education will be crucial to building a workforce that is knowledgeable in addressing the treatment needs of people being denied an abortion. Training on responding to contextual factors that impact both maternal mental health and access to treatment and services, such as IPV, sexual violence, other forms of trauma, and adverse social determinants of health (e.g., poverty, housing instability), is also critical.

Pregnant psychiatric patients who lack resources to seek a legal abortion in other jurisdictions will require empathic support; referral to organizations that can provide community and family resources such as child care, parenting classes, health care, financial planning, and monitoring of their mental health if they are compelled to complete an unwanted pregnancy; and partnerships with programs that specifically address IPV. Support will be even more important for patients who are carrying a pregnancy as a result of a nonconsensual act, incest, or reproductive coercion in jurisdictions

without relevant exceptions to abortion bans. Some may attempt to induce an abortion on their own, which increases the risk of both medical and psychiatric sequelae.

Clinical Care

Extra vigilance will be required to monitor worsening mental health symptoms in the postpartum period for patients with an unwanted pregnancy. Psychiatrists treating such patients will need to be aware of their risk factors for postpartum mood or anxiety disorders, including previous psychiatric illness, such as perinatal mood or anxiety disorders. Unwanted pregnancy is more prevalent among those with preexisting psychiatric conditions in comparison to those with preexisting neurologic conditions and healthy controls, which should inform psychiatric care of those of reproductive age (Tozoglu, et al., 2020).

Mixed feelings about a pregnancy and lack of external support increase the risk of postpartum mood and anxiety disorders, as do current and past experiences of IPV and sexual violence. In addition to being aware of the traumatic effects of IPV and forced pregnancy, psychiatrists need to be aware of and work to mitigate abuse aimed at interfering with a pregnant partner's use of mental health- and substance use-related services (e.g., treatment interference, recovery sabotage, and custody-related threats) (Warshaw et al., 2014; Warshaw & Tinnon, 2018). Some pregnant individuals may need support in deciding whether they want an abortion. Some may be under pressure from family members, friends, or partners as to whether or not to have an abortion. Given that abortion is no longer legal in many states, pregnant individuals may now experience more pressure to not have an abortion. Some may have difficulty navigating the ever-changing legal landscape due to ongoing litigation and court decisions. Psychiatrists can support pregnant individuals making these challenging decisions. Such decisions need to be individualized and noncoercive, limiting the psychiatrist's own potential biases. This support process can include psychoeducation and discussion of the risks and benefits of undergoing an abortion or carrying the pregnancy to term. It is imperative that such discussions are trauma-informed,

center the pregnant individual's values, and consider their psychosocial and socioeconomic situation and support network (Cameron, 2010; Catalao et al., 2020).

Trauma-informed care is a critical aspect of all reproductive health care, including abortion care. This is especially important if the pregnancy occurs as a result of a nonconsensual act or coercion. Patients who have experienced traumatic events are vulnerable to re-traumatization during health care encounters (Nagle et al., 2022). Trauma survivors may experience distress during what some consider routine medical procedures or due to the power imbalance inherent in the patient-clinician relationship. Recognizing and responding to trauma is a critical component of psychiatric care, as trauma can impact one's health, social functioning, and ability to engage in healthy behaviors (Sperlich et al., 2017). According to the Substance Abuse and Mental Health Services Administration, trauma-informed care includes 1) recognition of the impact of trauma and paths for recovery; 2) recognition of the signs and symptoms of trauma; 3) responses that integrate knowledge about trauma into policies, procedures, and practices; and 4) prevention of re-traumatization (Abuse, 2014). Trauma-informed care shifts the patient-clinician interaction away from a problem-focused approach to a strengths-based approach. A trauma-informed approach does not assume universal trauma; it anticipates the possibility of trauma and purposefully cultivates an organizational structure and treatment framework aimed to identify trauma symptoms and enhance physical and emotional safety for both patients and the clinicians serving them.

It is also important to consider the potential impact on medical professionals in other specialties, especially obstetrics, who will need to adequately detect and address possible mental health issues related to distress over lack of abortion access and the psychiatrist's role in assisting with these challenges. For example, psychiatrists may be consulted on dilemmas involved in caring for pregnant persons who do not have access to abortion or have given birth to an unwanted child. It is critical for other professionals to detect and address trauma-related disorders. Individuals carrying an unwanted

pregnancy to term may need additional support such as individual or group peer support, psychotherapy, and closer monitoring for the development of mental health symptoms.

It is generally recommended that pregnant patients continue psychiatric medications that are known to be personally effective, because the risks of untreated illness often outweigh the risks of medication exposure to the fetus. However, complex challenges may arise when a patient is on a potentially teratogenic medication. For example, while valproic acid is generally not recommended for use among women of reproductive age, a patient could be taking it when they become pregnant. Though the patient might otherwise have preferred to obtain an abortion or to decide about abortion based on ultrasound findings of fetal malformations, in certain jurisdictions they must now carry the fetus to term. Along with the duty to warn of potential teratogenic risks of a medication, psychiatrists will need to support patients who have to complete a pregnancy that they otherwise would have terminated.

Similar challenges may arise with patients of reproductive age who are sexually active but not planning to become pregnant. Although a medication that is associated with teratogenic effects such as valproic acid should usually be avoided in such cases, if it is being used, psychiatrists should discuss the possible consequences should a pregnancy occur. These discussions will take on added salience in the absence of an abortion option, which makes an effective means of birth control even more important. They will be still more critical for patients who are likely to have particular difficulty with a pregnancy or caring for a child.

It is also important to consider the challenges for individuals with substance use disorders. In many states, substance use during pregnancy is criminalized, and an individual may choose to have an abortion if struggling with a severe substance use disorder. With an opioid use disorder, some pregnant persons might stop opioid use precipitously upon learning that they are pregnant but do not have access to an abortion, which places them at risk for severe withdrawal symptoms and relapse or overdose. It is

important to consider that individuals of childbearing age may feel that they have limited options if substance use during pregnancy and undergoing an abortion are both criminalized. Similarly, this will raise clinical challenges for psychiatrists caring for these individuals.

Family Planning and Contraception

Discussing and providing postpartum contraception is essential for reproductive planning and promoting better mental health outcomes (Zapata et al., 2015). Nonuse of contraception and use of less-effective methods are associated with depressive symptoms in nonpregnant, reproductive-age individuals (Berenson et al., 2003; Farr et al., 2011; Garbers et al., 2008; Hall et al., 2015).

A recent study examined the association between perinatal depression symptoms and postpartum contraception intent, choice, and reported use. In a cohort of perinatal participants with depressive symptoms at baseline, those with sustained depressive symptoms at 5-7 months postpartum were less likely to report use of any contraception and more likely to report using less-effective methods than were perinatal participants without sustained depressive symptoms (Masters et al., in press). Participants with persistent depressive symptoms at 5-7 months postpartum also reported using less-effective contraceptive methods significantly more often than they had initially planned to at 1-3 months postpartum. Based on these findings, individuals with sustained depression are less likely to use contraception, thereby increasing the risk of an unplanned pregnancy.

Psychiatric professionals caring for individuals of childbearing age can play a crucial role in addressing and facilitating family planning goals. Psychiatric care provides critical opportunities to 1) discuss and support reproductive planning and contraception access, with the goal of optimizing mental health outcomes, and 2) decrease unintended pregnancies (Bahk et al., 2015; Herd et al., 2015; Zapata et al., 2015).

For example, psychiatrists often treat patients of childbearing age with chronic depression. To avoid such patients being forced post-*Dobbs* to carry an unplanned or unwanted pregnancy,

psychiatrists can and should play a critical role in ensuring access to contraception. An unintended pregnancy and other stressful life events are risk factors for delayed prenatal care, low birthweight neonates, preterm delivery, and maternal mental health conditions. By expanding their practices to include the provision of appropriate and acceptable contraceptive care, taking into account important cultural and faith considerations with regard to contraceptive choice, psychiatrists can promote better outcomes for perinatal individuals and their children. There are many forms of contraception, ranging from fertility tracking to requiring a medical procedure, such as the insertion of an intrauterine device (IUD). While it is beyond the scope of psychiatric practice to insert an IUD or any other contraceptive device, psychiatrists could expand their practice to proactively discuss contraception, prescribe oral contraceptives when they are indicated, and provide referrals to other clinicians when certain forms of contraception, such as an IUD, are indicated. It is important to provide counseling regarding drug-drug interactions between psychotropics and oral contraceptives. For example, topiramate, amitriptyline, imipramine, diazepam, and selegiline can decrease oral contraceptive efficacy. In addition, oral contraceptives may decrease lamotrigine efficacy. Psychiatrists can also support smoking cessation given that smoking is a contraindication to oral contraceptive use. Psychiatrists can consult with or refer patients to their obstetric and gynecologic colleagues for comorbid medical illnesses, such as hematological disorders that increase the risk of clotting, that may complicate the use of contraception. Psychiatrists can refer to the Centers for Disease Control and Prevention's Medical Eligibility Criteria or the Reproductive Health Access Project for further information and guidelines on contraception.

Due to the need for more medical providers addressing reproductive care issues and the urgent need for treatment, psychiatrists may be needed at times to prescribe contraceptive medication. Psychiatrists can also prescribe or recommend medication for preventing pregnancy after unplanned, unprotected intercourse, often referred to as the morning-after pill. In addition, if not restricted by state law, psychiatrists can prescribe medications for early pregnancy termination (e.g., mifepristone and

misoprostol), often referred to as a medication abortion, which are recommended by ACOG as a safe and effective method of providing an abortion through up to 70 days (10 weeks) of gestation (ACOG, 2020). The expansion of psychiatric care to include contraception and medication abortion would require additional education for most psychiatrists. As a field, psychiatry should consider whether contraception, morning-after pill, and medication abortion prescribing should be included in residency training and continuing medical education for psychiatrists.

In addition, psychiatrists play a critical role in supporting people who are experiencing IPV (APA, 2019), including in the context of family planning. Talking with patients about reproductive coercion and discussing safer contraceptive options can also reduce violence and entrapment and support mental health and well-being (Miller et al., 2017). ACOG also provides guidance on addressing reproductive coercion in the context of IPV (ACOG, 2013).

Issues for Psychiatrists Related to Abortion Ban Exceptions

As noted above, *Dobbs* has allowed states to enact laws restricting or banning access to an abortion. In general, states that have adopted restrictive laws have allowed a small number of exceptions, most commonly to protect the life or health of the pregnant person. In many respects, this recapitulates the situation that existed prior to the decision in *Roe*—although in some important ways that relate directly to the mental health of pregnant persons and the role of psychiatrists, the current situation is notably different. It is worth recounting the history of psychiatrists' involvement with abortion before *Roe* to better understand the situation today.

Prior to 1967, all states markedly limited legal abortions. In some states, the bans were absolute, but most permitted exceptions when the life of the pregnant woman was endangered, including for reasons related to her mental health. Establishing psychiatric grounds for an exception to

the abortion ban usually required a psychiatrist's statement that the pregnant woman would take her own life unless an abortion could be performed (Robitscher, 1980).

This situation began to evolve in 1967, when three states—California, Colorado, and North Carolina—liberalized their abortion statutes. In particular, psychiatric exceptions were expanded as part of this process of broadening access to abortion. California permitted abortions if it could be shown that there was “a substantial risk that continuation of the pregnancy would gravely impair the mental health of the mother to a degree that she would be dangerous to herself or the person or property of others, or would be in need of supervision or restraint.” Psychiatric evaluations asserting that this standard had been met were reviewed by a medical board, which had the authority to approve or reject the procedure (Marder, 1970).

After California implemented the new law, 86% of applications for a legal abortion were made on mental health grounds, and 89% of those applications were approved (Marder, 1970). For the first nine months following a similar change in the Colorado statute, two-thirds of abortions in that state were performed for psychiatric indications (Heller & Whittington, 1970). Psychiatrists became the major avenue by which an abortion could be obtained.

Despite high approval rates for their applications, psychiatrists were concerned that predictions of harm to the pregnant person were being made without an evidentiary basis. As one psychiatrist noted, “The reality is...that we do not have the capacity to predict, with any degree of certainty, which women will experience major psychiatric illness as a result of unwanted pregnancy” (Whittington, 1970). Moreover, the evaluations themselves were challenging. In the words of another psychiatrist, “[T]he normal motivation that promotes cooperation is not present. The patient may consciously exaggerate all of her symptoms and frequently can be considered manipulative and malingering. Her greatest need is to convince the psychiatrist of her inability to continue with the pregnancy” (Marder, 1970).

Indeed, it was widely acknowledged that many psychiatrists were approving applications for abortions that did not meet the existing criteria. An article in the *New England Journal of Medicine* described the situation this way: “There are no clear-cut psychiatric indications for therapeutic abortion. The risk of precipitation or exacerbation of an existing psychosis is small and unpredictable, and suicide is rare. ‘Humanitarian’ reasons frequently determine the decision although they may masquerade under psychiatric labels” (Sloane, 1969). Clearly, many psychiatrists believed that pregnant women had the right to choose to end their pregnancy for a much broader range of reasons than the law permitted. To act on that belief, however, meant generating untruthful evaluation reports, e.g., predicting that someone would die by suicide if the request for an abortion was refused, when that did not reflect their clinical judgment. This placed psychiatrists in an uncomfortable ethical position.

The Supreme Court’s opinion in *Roe* removed the ethical burden from psychiatrists by finding a constitutional basis for access to an abortion before the third trimester. However, in the wake of *Dobbs*, a growing number of states have adopted restrictive abortion laws. The new laws, though, allow exceptions in the case of a threat to the life—and in some cases health—of the mother, and some add exceptions in cases of rape or incest (although often with restrictive provisions, such as the requirement that the nonconsensual act was reported to the police within a short time frame after it occurred) (Felix et al., 2023).

But for psychiatrists, the situation is not as simple as a return to the pre-*Roe* era, because many of the new statutes exclude psychiatric indications as an exception. Tennessee’s law, for example, after recognizing an exception when “the abortion was necessary to prevent the death of the pregnant woman or to prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman,” goes on to exclude mental health indications specifically: “No abortion shall be deemed authorized under this subdivision...if performed on the basis of a claim or a diagnosis that the

woman will engage in conduct that would result in her death or substantial and irreversible impairment of a major bodily function or for any reason relating to her mental health” (Tenn. Code Ann. 39-15-213).

To the same end, other states have chosen to recognize only physical threats to a woman’s health, such as Oklahoma’s law: “‘Medical emergency’ [allowing an exception to the abortion ban] means a condition in which an abortion is necessary to preserve the life of a pregnant woman whose life is endangered by a **physical** disorder, **physical** illness, or **physical** injury, including a life-endangering **physical** condition caused by or arising from the pregnancy itself” [emphasis added] (Oklahoma House Bill No. 4327, May 25, 2002).

In states such as Tennessee and Oklahoma, psychiatrists will never be called on to perform evaluations or produce reports relating to psychiatric indications for abortion. These restrictive statutes appear intended to prevent a recurrence of the situation that existed prior to 1973, where in some states psychiatric indications were the primary vehicle for women seeking exemptions from their state’s ban. This failure to provide exceptions for severe psychiatric conditions—while offering them for other medical conditions in which pregnancy may endanger the life or health of the pregnant person—is not only discriminatory but will threaten the lives and well-being of countless pregnant persons with psychiatric disorders.

However, there are states that have not completely foreclosed possible psychiatric indications for abortion, even in the face of general abortion bans. Alabama’s law, on its face, appears to exclude psychiatric indications from its definition of conditions that would permit an abortion to be performed: “Serious Health Risk To The Unborn Child’s Mother...[allowing abortion] **does not include a condition based on a claim that the woman is suffering from an emotional condition or a mental illness** which will cause her to engage in conduct that intends to result in her death or the death of her unborn child” [emphasis added] (Code of Ala. § 26-23H-1 et seq.). But the statute then recognizes an important exception to that exclusion:

However, [a serious health risk to the unborn child's mother] may exist if a second physician who is licensed in Alabama as a psychiatrist, with a minimum of 3 years of clinical experience, examines the woman and documents that the woman has a diagnosed serious mental illness and because of it[] there is reasonable medical judgment that she will engage in conduct that could result in her death or the death of her unborn child.... [In that case,] the termination may be performed and shall be only performed by a physician licensed in Alabama in a hospital.

Barring successful challenges to the physical/mental health distinction in the courts, abortion access will be available to pregnant persons for psychiatric indications only in a limited number of states with broad restrictions on abortion. Psychiatrists in those states (and perhaps in neighboring states) will again assume the gatekeeper role that the profession served prior to *Roe* and face the potential choice between honesty and acting to protect abortion access (Appelbaum, 1992). Among the challenges psychiatrists will confront when asked for an evaluation that would permit an abortion is deciding how to balance fidelity to patients' interests with the virtue of honesty in performing evaluations. This may be even more difficult when the psychiatrist has not had a preexisting relationship with the person seeking an evaluation. Although no absolute answer can be offered, it is worth keeping in mind that the perceived dishonesty of psychiatrists in the years prior to *Roe* may be a major reason why states today are systemically excluding psychiatric indications for exceptions to abortion bans. Moreover, perceptions of overly lenient or untruthful evaluations could lead even states that currently permit psychiatric indications to close what they may come to view as a loophole in their laws.

Of course, another major challenge in performing such evaluations is the lack of research to ground conclusions about situations and conditions that are likely to constitute threats to the life and/or health of the pregnant person were they denied an abortion. It seems clear that suicidal ideation related to the pregnancy is a serious threat to the life of the pregnant person, as is psychosis with delusions that focus on destroying the fetus, e.g., a belief that the fetus is a demon. It is likely that other conditions

constituting legitimate bases for psychiatric exceptions exist as well, including a history of severe postpartum depression or postpartum psychosis in earlier pregnancies. Those with active or past eating disorders may also face unique health risks during pregnancy that require increased monitoring. But more than anything else, the dearth of evidence on what should or should not constitute mental health exceptions to abortion indicates the importance of renewed research in this area. In addition, professional organizations may have an important role to play in the development of consensual standards for when a substantial risk to the life or health of the pregnant person or the fetus exists, as well as how psychiatrists can best support patients who choose to continue a pregnancy in the face of such risks. Specific standards might help persuade legislatures in states without psychiatric exceptions that provisions recognizing psychiatric disorders as legitimate threats to the life or health of the pregnant person would not create loopholes in state-level abortion bans.

Other Challenges for Psychiatrists Post-*Dobbs*

States that have criminalized providing or aiding a pregnant person to obtain an abortion may seek to obtain a psychiatrist's records to confirm that an abortion occurred and to identify anyone who helped the person obtain it—including the psychiatrist. In such states, psychiatrists will need to be extremely circumspect about recording notes of discussions regarding pregnancy and abortion in the medical record. Protecting the patient's best interests in these cases may require the omission of, or at most an indirect reference to, such information; for example, a discussion about pregnancy and abortion might be characterized as a discussion about personal issues or future plans. This is especially important given the reality that electronic medical records are often shared across health care systems, including with systems in other states, and not every keeper of the information may seek grounds to resist turning it over to law enforcement.

In addition to criminalizing assisting or abetting an abortion, some states (e.g., Texas) allow civil damages to be sought from people who played such a role. At present, pending clarification by the

courts, it is unclear which behaviors are considered sufficient to constitute aiding or abetting an abortion. Would responding to a patient's question about how an abortion could be obtained cross the line? Could a psychiatrist safely suggest that the patient explore out-of-state care options? Would mention that mifepristone could be obtained by mail constitute abetting an abortion? What about discussing the nature of the available procedures for an abortion and their side effects, expressing an opinion that undergoing an abortion would be in the patient's best interests, or offering support to a patient who has already decided to seek an abortion? Psychiatrists practicing in states that allow prosecution or civil litigation for aiding a person in obtaining an abortion should seek competent legal guidance and stay up to date on developments in state law as the scope of these provisions is defined. Moreover, the potential susceptibility of out-of-state clinicians to lawsuits under these laws is unclear; several states have passed "shield laws," statutes seeking to shield their clinicians from prosecution or liability in other jurisdictions, but these too remain untested in the courts (Cohen et al., 2023).

Meeting the Challenges of Practicing in a Post-Dobbs World

The removal of constitutional protections for abortion access will raise clinical, ethical, and legal challenges for psychiatrists. It is incumbent on them to remain educated about developments in the laws regulating abortion access in their states, including court decisions and interpretations of existing statutes, to be prepared to advise their patients accordingly. Familiarity with the doctrines of privacy, consent, and best interests can also bolster advocacy for patients in an evolving social climate. Psychiatrists will need to pay particular attention to the implications of limited abortion access for their patients by helping them anticipate and avoid an unplanned pregnancy and find ways of coping should one occur. In addition, limitations on access to abortion should continue to be contested at the policy level while psychiatrists attend to the needs of their patients created by the current situation.

In general, interdisciplinary collaboration with other health care professionals such as obstetricians and gynecologists will be critical when providing clinical care for individuals of reproductive

age post-*Dobbs*. Psychiatrists may also call on the advice of legal experts to better understand the laws related to abortion in their own jurisdiction and to manage potential civil and criminal liability. In addition, psychiatrists can and should play a role in the public debate over abortion restrictions.

References

- American College of Obstetrics and Gynecology. Committee Opinion No. 554: Reproductive and Sexual Coercion. 2013, Reaffirmed 2022. Available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/02/reproductive-and-sexual-coercion>
- American College of Obstetrics and Gynecology. Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation. 2020, reaffirmed 2023. Available at: <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation#:~:text=Patients%20can%20safely%20and%20effectively,who%20undergo%20a%20medication%20abortion.>
- American Psychiatric Association. Treating Women Who Have Experienced Intimate Partner Violence. 2019. Available at: <https://www.psychiatry.org/getmedia/d8bb1a4a-0830-4f5b-90fd-5049f33e134e/APA-Guide-to-IPV-Among-Women.pdf>
- Appelbaum PS. Psychiatrists and access to abortion. *Hosp Community Psychiatry* 1992;43:967-968. doi: 10.1176/ps.43.10.967.
- Arnold SB. Reproductive rights denied: The Hyde Amendment and access to abortion for Native American women using Indian health service facilities. *Am J Pub Health* 2014;104(10):1892-1893.
- Artiga S, Hill L, Ranji U, Gomez I. What are the implications of the overturning of *Roe v. Wade* for racial disparities? Kaiser Family Foundation, 2022. Available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/#>
- Bahk J, Yun S-C, Kim Y-m, Khang Y-H. Impact of unintended pregnancy on maternal mental health: a causal analysis using follow up data of the Panel Study on Korean Children (PSKC). *BMC Pregnancy Childbirth* 2015;15(1):85. Available at: <https://doi.org/10.1186/s12884-015-0505-4>
- Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet* 2017;389(10077):1453-1463. doi: 10.1016/S0140-6736(17)30569-X.
- Berenson AB, Breitkopf CR, Wu ZH. Reproductive correlates of depressive symptoms among low-income minority women. *Obstet Gynecol* 2003;102(6):1310-1317. doi: 10.1016/j.obstetgynecol.2003.08.012.
- Biaggi A, Conroy S, Pawlby S, Pariante CM. Identifying the women at risk of antenatal anxiety and depression: A systematic review. *J Affect Disord* 2016;191:62–77. doi: 10.1016/j.jad.2015.11.014

- Biggs MA, Brown, K, Foster DG. Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. *PLoS ONE* 2020;15(1):1–20. Available at: <https://doi.org/10.1371/journal.pone.0226417>
- Bryant AS, Worjolah A, Caughey AB, Washington AE. Racial/ethnic disparities in obstetric outcomes and care: prevalence and determinants. *Am J Obstet Gynecol* 2010;202:335–343. doi: 10.1016/j.ajog.2009.10.864
- Byatt N, Straus J, Stopa A, Biebel K, Mittal L, Moore Simas TA. Massachusetts Child Psychiatry Access Program (MCPAP) for Moms: utilization and quality assessment. *Obstet Gynecol*. 2018;132(2):345–353. doi: 10.1097/AOG.0000000000002688.
- Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence. *J Women's Health (Larchmt)* 2021;30(2):236–244. doi:10.1089/jwh.2020.8875.
- Cameron S. Induced abortion and psychological sequelae. *Best Pract Res Clin Obstet Gynaecol* 2010;24(5):657–665.
- Catalao R, Mann S, Wilson C, Howard LM. Preconception care in mental health services: planning for a better future. *Brit J Psychiatry* 2020;216(4):180–181.
- Centers for Disease Control and Prevention. Pregnancy Complications | Maternal and Infant Health (n.d.). Available at: <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-complications.html>
- Cohen DS, Donley G, Rebouche R. Abortion shield laws. *NEJM Evid* 2023;2(4). doi: 10.1056/EVIDra22002.
- Coverdale J, Gordon MR, Beresin EV, Guerrero APS, Louie AK, Balon R, Morreale MK, Aggarwal R, Brenner AM. (2023). Access to abortion after *Dobbs v. Jackson Women's Health Organization*: advocacy and a call to action for the profession of psychiatry. *Acad Psychiatry*. 2023;47(1):1–6. doi: 10.1007/s40596-022-01729-7
- di Giacomo, E., Pessina, R., Santorelli, M., Rucco, D., Placenti, V., Aliberti, F., ... & Clerici, M. Therapeutic termination of pregnancy and women's mental health: determinants and consequences. *World Journal of Psychiatry* 2021;11(11):937.
- D'Angelo DV, Liu Y, Basile KC, Chen J, Smith SG, Friar NW, Stevens M. Rape and sexual coercion related pregnancy in the United States. *American Journal of Preventive Medicine* 2023;66(3):389–398. doi: 10.1016/j.amepre.2023.11.001
- Dobbs v. Jackson Women's Health Organization*. US Sup Ct, No. 19-1392 (2022).
- Farr SL, Curtis KM, Robbins CL, Zapata LB, Dietz PM. Use of contraception among US women with frequent mental distress. *Contraception* 2011;83(2):127–133. doi: 10.1016/j.contraception.2010.07.005.
- Felix M, Sobel L, Salganicoff A. A review of exceptions in state abortion bans: implications for the provision of abortion services. KFF, May 18, 2023. Available at: <https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortion-bans-implications-for-the-provision-of-abortion-services/>

- Foster DG. New abortion bans will increase existing health and economic disparities. *Am J Pub Health* 2022;112(9):1276–1277. doi: 10.2105/AJPH.2022.306993.
- Foster DG, Biggs MA, Raifman S, Gipson J, Kimport K, Rocca CH. Comparison of health, development, maternal bonding, and poverty among children born after denial of abortion vs after pregnancies subsequent to an abortion. *JAMA Pediatr* 2018;172(11):1053–1060. doi: 10.1001/jamapediatrics.2018.1785.
- Garbers S, Correa N, Tobier N, Blust S, Chiasson MA. Association between symptoms of depression and contraceptive method choices among low-income women at urban reproductive health centers. *Matern Child Health J* 2008;14(1):102–106. doi: 10.1007/s10995-008-0437-y.
- Goyal V, Brooks IHML, Powers DA. Differences in abortion rates by race–ethnicity after implementation of a restrictive Texas law. *Contraception* 2020;102:109–114. doi: 10.1016/j.contraception.2020.04.008
- Grace KT, Anderson JC. Reproductive coercion: a systematic review. *Trauma Violence Abuse* 2018; 19: 371–90. Di: 10.1177/152483801666393
- Hall KS, Steinberg JR, Cwiak CA, Allen RH, Marcus SM. Contraception and mental health: a commentary on the evidence and principles for practice. *Am J Obstet Gynecol*. 2015;212(6):740–746. doi: 10.1016/j.ajog.2014.12.010.
- Heller A, Whittington HG: The Colorado story: Denver General Hospital’s experience with the change in the law on therapeutic abortion. *Am J Psychiatry* 1968;125:809–816. doi: 10.1176/ajp.125.6.809.
- Herd P, Higgins J, Sicinski K, Merkurieva I. The implications of unintended pregnancies for mental health in later life. *Am J Pub Health* 2015;106(3):421–429. doi: 10.2105/AJPH.2015.302973.
- Jerman, J., Jones, R. K., & Onda, T. Characteristics of US abortion patients in 2014 and changes since 2008. Guttmacher Institute, 2016. Available at: <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>
- Joseph KS, Boutin A, Lisonkova S, Muraca GM, Razaz N, John S...Schisterman E. Maternal mortality in the United States: recent trends, current status, and future considerations. *Obstet Gynecol* 2021;137(5):763–771.
- Joseph NT, Prater LC, Modest AM. Pregnancy-associated firearm mortality in the U.S., 2008–2019. *Am J Prev Med* 2024. doi:10.1016/j.amepre.2024.02.022
- Leeners B, Stiller R, Block E, Görres G, Rath W. Pregnancy complications in women with childhood sexual abuse experiences. *J Psychosom Res* 2010;69(5):503–510. doi: 10.1016/J.JPSYCHORES.2010.04.017
- Madigan S, Wade M, Tarabulsy G, Jenkins JM, Shouldice M. Association between abuse history and adolescent pregnancy: a meta-analysis. *J Adoles Health* 2014;55(2):151–159. doi: 10.1016/j.jadohealth.2014.05.002
- Major B. Report of the APA task force on mental health and abortion. American Psychological Association, 2008. Available at: <https://www.apa.org/pi/women/programs/abortion/mental-health.pdf>

- Malina D, Ogbu-Nwobodo L, Shim RS, Vinson SY, Fitelson EM, Biggs MA, Mclemore MR, Thomas M, Godzich M, Mangurian C. Mental health implications of abortion restrictions for historically marginalized populations. *N Engl J Med* 2022;387:1613-1617. doi: 10.1056/NEJMms2211124.
- Marder L. Psychiatric experience with a liberalized therapeutic abortion law. *Am J Psychiatry* 126:1230-1236, 1970. doi: 10.1176/ajp.126.9.1230.
- Masters G, Carroll S, Julce C, Person S, Allison J, Byatt N, Moore Simas TA. Assessing the impact of perinatal depression on postpartum contraception intent, choice, and reported use. *Contraception* (In press).
- Masters GA, Yuan Y, Li N, Straus J, Moore Simas TA, Byatt N. Improving front-line clinician capacity to address bipolar disorder among perinatal individuals: a longitudinal analysis of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms. *Arch Women's Ment Health* 2023;26(3):401-410. doi: 10.1007/s00737-023-01324-1.
- Mercier RJ, Garrett J, Thorp J, Siega-Riz AM. Pregnancy intention and postpartum depression: Secondary data analysis from a prospective cohort. *BJOG* 2013;120:1116–1122. doi: 10.1111/1471-0528.12255
- Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception* 2010;81:316–22
- Miller E, McCauley HL, Decker MR, et al. Implementation of a family planning clinic-based partner violence and reproductive coercion intervention: Provider and patient perspectives. *Perspect Sex Reprod Health*. 2017;49(2):85-93. doi:10.1363/psrh.12021
- Nagle S, Sachdeva J, Zhao LX, Shenai N, Shirvani N, Worley L, Gopalan P, Albertini E, Spada M, Mittal L, Moore Simas TA, Byatt N. Trauma-informed care for obstetric and gynecologic settings. *Matern Child Health J* 2022;12:2362-2369.
- National Academies of Sciences, Medicine Division, Board on Health Care Services, Board on Population Health, Public Health Practice, Committee on Reproductive Health Services, ... & Quality of Abortion Care in the US. (2018). *The safety and quality of abortion care in the United States*.
- National Institutes of Health. (2013). What are some common complications of pregnancy. US Department of Health and Human Services. <https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/pages/complications>.
- Nelson HD, Darney BG, Ahrens K, et al. Associations of unintended pregnancy with maternal and infant health outcomes: A systematic review and meta-analysis. *JAMA*. 2022;328(17):1714–1729. doi:10.1001/jama.2022.19097

- Ogbu-Nwobodo L, Shim RS, Vinson SY, Fitelson EM, Biggs MA, McLemore MR... Mangurian C. Mental health implications of abortion restrictions for historically marginalized populations. *N Engl J Med* 2022;387(17):1613-1617.
- Osborne LM, MacLean J v., Barzilay EM, Meltzer-Brody S, Miller L, Yang SN. Reproductive psychiatry residency training: a survey of psychiatric residency program directors. *Acad Psychiatry* 2018;42:197–201. doi: 10.1007/s40596-017-0672-x
- Ralph LJ, Schwarz EB, Grossman D, Foster DG. Self-reported physical health of women who did and did not terminate pregnancy after seeking abortion services: A cohort study. *Ann Intern Med* 2019;171(4):238-247.
- Roberts SC, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med* 2014; 12: 144. doi: 10.1186/s12916-014-0144-z
- Robinson GE, Brown KM, Grigoriadis S, Nadelson CC, Feldman NS, Dhami N, Benders-Hadi N, Mittal LP, Wald M. The mental and physical health impacts of overturning Roe v Wade. *J Nerv Ment Dis* 2022;210(12):891–893. doi: 10.1097/NMD.0000000000001596
- Robitscher J. *The Powers of Psychiatry*. Boston, Houghton Mifflin, 1980.
- Ross N, Landess J, Kaempf A, Hatters Friedman S. Pregnancy termination: What psychiatrists need to know. *Curr Psychiatry* 2022;21(8):8-9. doi: 10.12788/CP.0274.
- Sloane RB. The unwanted pregnancy. *N Engl J Med* 1969;280:1206-1213. doi: 10.1056/NEJM196905292802205.
- Tozoglu E, Aydin N, Yalcin S, Kasali K. Unintended and unwanted pregnancies in women with major psychiatric disorders: a cross-sectional comparative study. *Psychiatry Clin Psychopharmacol* 2020;30(3):230-240.
- van Ditzhuijzen J, Ten Have M, de Graaf R, van Nijnatten CH, Vollebergh WA. The impact of psychiatric history on women's pre-and postabortion experiences. *Contraception* 2015;92(3):246-253.
- Warshaw C, Lyon E, Phillips H, Bland P, Hooper M. Mental Health and Substance Use Coercion Survey: Report on Findings from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline. 2014. Available at: <https://ncdvtmh.org/resource/mental-health-and-substance-use-coercion-surveys-report/>
- Warshaw C, Tinnon E. Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. 2018. Available at: <https://ncdvtmh.org/toolkit/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence/>
- Whittington HG. Evaluation of therapeutic abortion as an element of preventive psychiatry. *Am J Psychiatry* 1970;126:1224-1229. doi: 10.1176/ajp.126.9.1224.
- Wisner KL, Appelbaum PS. Abortion restriction and mental health. *JAMA Psychiatry* 2023;80:285-286. doi: 10.1001/JAMAPSYCHIATRY.2022.4962.

- Wynia MK. Professional civil disobedience — Medical-society responsibilities after Dobbs. *N Engl J Med* 2022;387(11):959–961. doi: 10.1056/NEJMp2210192.
- Zandberg J, Waller R, Visoki E, Barzilay R. Association between state-level access to reproductive care and suicide rates among women of reproductive age in the United States. *JAMA Psychiatry* 2023;80(2):127–134. doi: 10.1001/JAMAPSYCHIATRY.2022.4394.
- Zapata LB, Murtaza S, Whiteman MK, Jamieson DJ, Robbins CL, Marchbanks PA, et al. Contraceptive counseling and postpartum contraceptive use. *Am J Obstet Gynecol*. 2015;212(2):171.e1-e8. doi: 10.1016/j.ajog.2014.07.059.