Access to Abortion After Dobbs v. Jackson Women's Health Organization: Advocacy and a Call to Action for the Profession of Psychiatry

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On June 24, 2022, the US Supreme Court released a decision in Dobbs v. Jackson Women’s Health Organization that the Constitution of the United States does not “prohibit the citizens of each State from regulating or prohibiting abortion” ([1], page 79). “We now …. turn that authority to the people and their elected representatives” ([1], page 79]). Thus, decades of legal precedent on abortion law were overturned. This decision allows individual states to determine access to abortion services. As of August 25, 2022, nine states have banned abortion, four states have banned abortion at 6 weeks after the last menstrual period, and one state has banned abortion at 20 weeks after the last menstrual period [2]. According to the Guttmacher Institute, it is estimated that 58% of women in the USA of reproductive age live in a state “hostile to abortion rights” [3]. When states prohibit abortion, women’s decision-making as to whether to continue their pregnancy to viability and term is negated.

Numerous medical organizations have denounced the Court’s decision. The American Medical Association, in an alliance with the American College of Obstetrics and Gynecologists and more than 75 health care organizations, opposed all legislative interference in the patient-clinician relationship [4]. The alliance stated that patients needed to be able to access—and clinicians need to be able to provide—the evidence-based care that is right for them, including abortion, without arbitrary limitations, without threats, and without harm [4]. The American Association of Medical Colleges stated that restrictive laws will severely limit a patient’s access to comprehensive reproductive health care, interfere in the patient-physician relationship, and override what is ultimately a clinician’s responsibility to provide the best medical care for every patient [5]. The American Psychiatric Association stated that the Court had jeopardized the physical and mental health of millions of American women and undermined the privacy of the physician–patient relationship, and the Association reiterated its long-standing support for legal abortion services [6]. A large gap is now anticipated in abortion training for residents in obstetrics and gynecology [7].

What then is the role for academic psychiatry after the Supreme Court’s decision? In this editorial, we focus on the primary prevention of unwanted pregnancies, addressing the psychological implications of abortion denial, and opportunities for advocacy. We discuss these topics in the context of particularly vulnerable groups who are living in states with abortion bans, including those restricted in their ability to travel; those who are living in violent circumstances; minors who are mentally, emotionally, cognitively, and fiscally limited or incapable in their ability to care for a child; and women with major mental disorders or cognitive disabilities. Our primary intent is to advocate for adjustments and improvements in psychiatric and social services and in educational processes for meeting the challenges of this new legal landscape.

Preventing Unwanted Pregnancies

Violent partners may both promote or restrict access to abortion services [8]. Human traffickers too can force women or girls to become or remain pregnant or to lose...
their pregnancy [9–11]. Patients with major mental disorders are at elevated risk of various forms of sexual violence, including rape, compared to those without mental disorders [12]. Although the evidence is limited and dated, patients with major mental disorders also report higher rates of abortions than comparison groups [13, 14]. Such findings might reflect decision-making that is coerced or concerns about women’s ability to financially support a future child, their ability to care for a child given the mental disorder, or negative thinking colored by the disorder. Furthermore, as noted, the victim of violence may be a minor who is developmentally, socially, emotionally, and cognitively incapable of raising a child, threatening the well-being of both mother and offspring. An unwanted pregnancy, caused by violence, is one of the adverse childhood experiences that can have long-lasting, negative effects on health, well-being, life opportunities, and physical consequences [15].

Taking a thorough sexual and reproductive history is therefore a key first step in identifying those at risk of unwanted pregnancies [16, 17]. Women’s contraceptive practices should be understood in relation to their desire to get pregnant and to their risk for sexually transmitted infections. These histories should compassionately and validly inquire about the possibility of women being forced into unwanted sexual encounters or being coerced in their decisions about the use of contraception, as well as coercive practices concerning women’s decisions as to whether to continue the pregnancy or to terminate it. Those at risk for unwanted pregnancies, including adolescents and minors, should be counseled about contraceptive practices that reduce risks consistent with the mental health provider’s accurate knowledge of those practices and connected with a colleague in obstetrics and gynecology for education and recommendations.

In selected cases, outreach to patients’ sexual partners will be needed to assist in the educational processes and to elicit their support in women’s decision-making. Some patients, including those who are cognitively impaired, may be limited in their understanding about the issues at stake, including contraceptive options, and exhibit impairments in their decision-making about how to prevent unwanted pregnancies [18]. In these cases, efforts should be made to ensure that patients have been well educated about available gynecological and family planning services and the range of contraceptive options.

**Psychological and Other Consequences of Denial of Abortion**

The authoritative resource for learning about the potential longer-term psychological implications of denial of abortion is the Turnaway study. This cohort study followed women for 5 years who had received an abortion in the USA when just below the gestational limit for approval by the abortion facility and those who were denied an abortion because they were just beyond the abortion facility’s gestational limit [19–26]. An alternative comparison group for understanding the psychological consequences of those receiving an abortion compared to those denied would have been women who chose not to abort [20]. Such a study, however, would be limited by multiple potential confounders related to women’s reproductive choices. The women who presented for abortions in these studies were recruited from 30 facilities in 21 states throughout the USA [19–26], and the findings should be considered in context of the limitations associated with cohort studies.

At 1 week after seeking an abortion, women receiving wanted abortions had similar or better mental health outcomes than those who were denied a wanted abortion, including symptoms related to anxiety, self-esteem, and life satisfaction [21]. Symptoms in the denied abortion group quickly improved to levels similar to the other group [21]. Women with a history of mental health conditions and experiences of traumatic life events were at greater risk of experiencing adverse outcomes if denied an abortion than if receiving a wanted abortion [21]. Although negative and positive emotions were reported about abortion denial 1 week later, emotions became significantly less negative and more positive over the course of the pregnancy and after childbirth [24]. In multivariate models, lower social support, more difficulty deciding to seek abortions, and placing the baby for adoption were associated with more negative emotions [24]. It should also be appreciated that, according to one quantitative synthesis of publications before 2010 on the mental health effects of abortion, abortion was judged to be a statistically validated risk factor for the development of various psychological disorders [27].

During the first 2 years of the Turnaway study, baseline predicted mean depressive symptom scores for women denied abortions (just above the gestational limit for approval) were similar to those for women receiving an abortion (just below the gestational limit) [20]. Depressive symptoms declined over time, and there were no differences in depressive symptoms at 2 years between groups [20]. Similarly, anxiety levels in the two groups declined and converged over time [20]. There were no longer-term (30 month) differences in perceived stress or emotional social support between women who received versus those who were denied abortions [19]. Levels of suicidal ideation were also low and not significantly different over the 5 years between women who had abortions and those who were denied [22].

Two studies by the Turnaway group reported on longer-term socioeconomic outcomes as well as maternal bonding.
and child development among children born after denial of an abortion [23, 25]. After adjusting for baseline differences between groups, women denied abortions who gave birth had higher odds of poverty at 6 months after denial than did those who received abortions, and women denied abortions were less likely to be employed [25]. These differences remained significant for 4 years [25]. The children of women who were denied an abortion were compared with children born to those who received an abortion and had a subsequent child within 5 years [23]. Although perinatal and child health outcomes were not different between groups, analytic models revealed that poor maternal bonding was more common for children of women denied an abortion when compared to those who received an abortion and had a subsequent child [23].

Particularly Vulnerable Populations

Two of us (MG, JC) have identified several vulnerable populations at risk of restricted access to abortion services [28] and who likely will experience significant burdens from laws requiring the physician to determine whether a fetal heartbeat is present and prohibiting an abortion after a heartbeat was detected [29]. These populations include women of color and immigrants, those with decreased freedom to travel, pregnant minors, women with major mental disorders or cognitive disabilities, and those who are victims of violence.

Restrictive abortion policies are associated with lower abortion rates, especially for those who have low incomes, who are also disproportionately Black and American Indian groups [30], and those living further away from abortion clinics [31–33]. Other groups restricted by a decreased freedom of movement include women who are primary care providers for young children, women who are incarcerated or in detention centers, or who are impoverished or homeless [28]. Adolescents or minors may face challenges in accessing abortion services [34], lack knowledge about sources of care, delay care because of a lack of resources particularly when emancipated and living away from family support, or depend on their parents for support. Even minors without cognitive or emotional deficits may lack the developmental maturity and insight to comprehend the challenges of raising a child. They often require the guidance of caregivers, physicians, and psychiatrists to help them make decisions. Women with major mental disorders or cognitive deficiencies may have suffered unwanted pregnancies from sexual assaults and may experience challenges in accessing public, medical, and psychiatric services when not well supported. Moreover, decision-making for those with major mental disorders may be chronically and variably impaired in relation to the severity of their mental disorder or related to associated stressors, medical problems, or substance and alcohol use [18, 35, 36].

Two particularly vulnerable groups to restrictive abortion laws are women and girls who are victims of domestic violence and those who have been sex-trafficked. Domestic violence has reportedly increased during the COVID-19 pandemic [37] and pregnancy-associated homicide has been increasing [38]. Victims of domestic violence and trafficked persons lack freedom of movement given male or female individuals or partners who are coercive or abusive [8, 39]. Rape and impregnation and forced sexual activities for purposes of sexual gain of the perpetrator are also forms of control in domestic violence or trafficking circumstances. Violent perpetrators may force women into unsafe, illicit abortions, and women without ready access to abortion services might resort to unsafe self-managed abortions, increasing their risk for adverse medical consequences, including a loss of fertility. Restrictive abortion policies may also result in more women being unable to terminate unwanted pregnancies, potentially keeping them and any children in contact with violent perpetrators [40].

Advocacy

The psychiatric profession has a long standard and strong commitment to benefitting vulnerable and marginalized populations. A first principle is that psychiatrists must provide information and counsel in accordance with their state laws, which may even include prohibitions on providing certain types of information. In anticipation of Roe being overturned more than three decades ago, it was counseled that disregarding a law is not an action to be taken lightly [41]. For example, psychiatrists may need to know about the permissibility in their state of using medical abortifacients, such as mifepristone and misoprostol, for terminating early pregnancies, whether prohibited abortions include birth control devices or contraceptives that prevent implantation of a fertilized egg, and whether women can be referred to out-of-state services. Clinical notes should validly reflect counsel to patients and clinical actions that are consistent with the law.

Clinicians practicing in states with bans will need to know about the permissibility of referral to abortion services in neighboring states and what organizations provide information and logistical support to people seeking care [42]. To this end, psychiatrists need to collaborate with academic leaders, social services, and obstetric colleagues to compile lists of within-state and neighboring-state resources. These resources might include psychological and psychiatric services to support women who are distressed or negatively impacted by the Dobbs decision. They might also include information on the National Abortion Federation Hotline [43], as well as other resources which support women
seeking information about abortion policies and legal support [42].

The profession should also seek to develop and optimize curricula for teaching sexual and reproductive history-taking to prevent unwanted pregnancies, especially among vulnerable groups. Consensus guidelines for doing so exist [44], although there are few high-quality studies to guide curriculum development and essentially none in psychiatry [45]. Indeed, research suggests that psychiatrists and other mental health workers may not be adept at routinely identifying patients’ family planning needs [46–48]. Such planning is particularly important in child and adolescent psychiatry, since starting young is the best policy for early and ongoing education and is best done in concert with primary care pediatricians, pediatric nurse practitioners, and obstetricians who work with post-pubertal youth.

Family planning services are best offered in the outpatient clinics of mental health centers for those with major mental disorders [49]. Services are also best coordinated and integrated with sexually transmitted infection services, treatment of alcohol and substance use disorders, and parenting classes for mothers [49]. There are few mental health programs that are well integrated with obstetric services nevertheless [50], and there is a need to develop model programs. Psychiatrists can learn from obstetric colleagues about how best to prevent unwanted pregnancies. Psychiatrists also have a role in assisting colleagues in obstetrics and gynecology, given that many program directors perceive that their residents are not equipped to identify patients’ psychiatric needs [51]. In addition, psychiatrists may also need to support health workers in other disciplines who are managing the fallout from the Dobbs decision, given reports that some are stressed and confused about laws that are changing day by day or who are threatened, harassed, and fearful in their roles [52].

Psychiatry residency and fellowship programs may need to incorporate more experiences in integrated mental health care in primary and other specialty settings where there are optimal opportunities for prevention and early identification and intervention. Additionally, in the context of the risks faced by women and their families as described above, child and adolescent specializing programs may need to increase trainees’ preparation to care for youth who are adopted, who are in foster care, and who are at risk for abuse, neglect, exploitation, and various other adverse childhood events. In view of potentially higher demands for mental health services, efforts to expand the psychiatric workforce should continue. An acceptable and well-prepared mental health workforce may be a vital component of compassionately addressing transgenerational cycles or psychosocial adversity and unintended or unwanted pregnancies.

Psychiatry’s response to the Supreme Court’s Dobbs decision should be based in part on evidence concerning the psychological consequences of denial of abortion. The Turnaway studies are influential in this regard but should be considered in relation to other studies and any new information which becomes published. The Turnaway studies illustrate some of the harms associated with denial of abortion [19–21] and do not support the notion that an abortion is a cause of mental health problems [20, 26]. The data suggest that the profession should seek to support women who are experiencing the shorter-term adverse psychological consequences of abortion denials. The Turnaway studies suggest that, in general, women did not suffer lasting psychological consequences, and thus, they were essentially able to cope emotionally with an abortion denial [24]. However, there were notable differences between groups on their financial resources and on maternal bonding [23, 25]. Restrictive abortion laws are reflections, in part, of cultural norms and reinforce stigmatizing norms that shame those who seek abortions [53]. The profession should also therefore advocate to mitigate the stigma associated with seeking abortion services. Psychiatrists are obligated to warn society and governmental agencies about social forces that may seriously undermine psychological and mental health [54].

Women who are homeless or impoverished or restricted in their movements because of dependent or violent relationships may not have the means to cross state lines to obtain an abortion. Psychiatrists should advocate for the development of services for vulnerable and marginalized and impoverished populations, victims of domestic violence, trafficked persons, and all those who are restricted in their movements or who are most vulnerable to the burdens associated with denied abortions. These services should include informational and educational services, financial supports when indicated to address poverty and reduced access to abortion services, financial supports for impoverished mothers of young children, provision of employment opportunities, parenting classes, affordable day care, and housing and other forms of sanctuaries to protect women’s safety when they are subject to violent relationships or circumstances. Psychiatrists also need to learn more through research about the acute and longer-term psychological, economic, and social consequences of denial of abortions and of obtained abortions. And psychiatrists should confront the cultural factors that stigmatize and discriminate against patients who belong to vulnerable groups and who are most likely to be harmed by the Dobbs decision.

Recognition of the potential consequences of the Dobbs decision should inspire psychiatrists to action to support women who are harmed, to mitigate those harms, and to support our professional organizations to do the same. These potential harms justify efforts at local, state, and federal levels to improve access to abortion services and to overturn restrictive laws [28] and to promote the professional principles that apply when assisting pregnant women’s
decision-making [55]. The psychiatric profession, especially because of its long-standing and strong commitments to benefiting vulnerable and marginalized populations, should lead these efforts in collaboration with obstetricians and gynecologists and others in the medical and health care professions.

Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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