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ARTICLE

Mental Health Matters: A Look At Abortion Law Post-*Dobbs*

Kristin Telford and Lauren B. Solberg

University of Florida College of Medicine, Gainesville, FL, USA
Corresponding author: Lauren B. Solberg; Email: lsolberg@ufl.edu

Abstract

In June 2022, in *Dobbs v. Jackson Women's Health*, the U.S. Supreme Court overturned the precedent set by the 1973 decision in Roe vs. Wade, leaving access to abortion to be regulated by each state, rather than a U.S. constitutional right. Some states are setting gestational age limits, beyond which point only under certain circumstances can an abortion be obtained. Other states are banning abortion outright (regardless of gestational age) unless an "exception" is met. Certain states include an exception for abortion when a woman's physical health is at risk if they continue the pregnancy, but, at the same time, do not provide an exception for women whose mental health is at risk (a "mental health exception").

Mental health conditions that develop, continue, or are exacerbated during pregnancy may be manageable or treatable, and women may want to continue their pregnancy even while experiencing such conditions. However, the absence of a choice to terminate their pregnancy as a result of these mental health conditions means women who are unable to successfully manage or treat their mental health during pregnancy have no choice but to experience the impact on their mental health – and reconcile any resulting impact on the fetus.

This article will discuss the role a mental health exception plays in state abortion statutes by analyzing the impact of pregnancy on mental health and resources available to support those who experience mental health impacts during pregnancy while, simultaneously, advocating for the inclusion of a mental health exception in state abortion laws.

Keywords: abortion; bioethics; legislation; mental health

Introduction

In 2021, Jackson Women's Health Organization challenged Mississippi's Gestational Age Act[1] banning abortion after fifteen weeks.[2] In the months following, the dispute traveled up through the appeals process, and eventually, the U.S. Supreme Court overturned the precedent set in *Roe vs. Wade*[3] in its 2022 *Dobbs vs. Jackson Women's Health* decision.[4] Now, abortion is no longer considered a constitutional right,[5] and the legalization and regulation of abortion is left to each state.

State statutes governing abortion exist on a spectrum, with some states allowing broad(er) access to abortion while others have limited, banned, or seek to ban abortion in its entirety.[6] States that ban abortion entirely may still except circumstances where the physical health or life of the pregnant person is in jeopardy, thus allowing abortion in limited circumstances. They may explicitly or implicitly except – and thus allow

[1] MS Code § 41-41-191 (2022).
[2] 597 U.S. [ ] (2022).
[3] 410 U.S. 113 (1973).
[4] *Supra* note 2.
[5] *Id.*
[6] *See e.g.*, Colorado which allows abortion at any gestational age (C.R.S. 25-6-404); New York which allows abortions up to 24 weeks gestation, after which abortions are legal if the health of the pregnant person or the pregnancy is at risk (NY Pub. Health Law 2599-BB); Mississippi which bans abortion after 15 weeks gestation except in the case of a medical emergency or severe fetal abnormality (MS Code 41-41-191).

abortion in – circumstances where the mental health of the pregnant person is in jeopardy (a "mental health exception"). State statutes may also explicitly prohibit mental health as a consideration for an abortion. This Article will discuss the presence or absence of such mental health exceptions in state statutes governing abortion, the ethical implications of including or excluding a mental health exception in state abortion laws, and abortion as it relates to mental health. While the impact of pregnancy and access to abortion on physical health is of great importance, this Article will be limited to the scope of mental health.

The first section of this Article offers a brief historical review of abortion as a constitutional right. The second section provides an overview of the reasons women seek abortions to provide context for exceptions within state abortion laws. The third section discusses the impact of pregnancy on mental health, specifically regarding mental health conditions during pregnancy, their treatment, and the impacts of both mental illness and treatment of mental illness on people who are pregnant as well as the impact on the fetus. The fourth section examines intimate partner violence, rape, incest, and the stigma of mental illness in relation to their impacts on mental health during pregnancy, as well as the impact of abortion itself on mental health. The fifth section discusses key national and state-based resources available to pregnant people who are balancing pregnancy and mental illness. In conclusion, we advocate for a mental health exception to be implemented in state abortion laws.

Part I. Abortion and The U.S. Constitution

a . Abortion and The U.S. Supreme Court

In the early and mid-twentieth century, many states implemented abortion bans, though there was an overall trend of state statutes enabling—rather than restricting—access to abortion post-1950.[7] Then, in 1973, the *Roe* Court held that under the 14th Amendment, a women's right to abortion during the first trimester is protected, and government interference with that right should be restricted.[8]

In 1992, *Planned Parenthood v. Casey* ultimately affirmed that women had the right to abortion, but the Court discarded the trimester framework established in *Roe*, instead adopting an undue burden standard for states to follow.[9] The *Casey* Court held that a state law posed an undue burden—and thus was unconstitutional—if it posed a "substantial obstacle" for a patient seeking an abortion prior to the viability of the fetus.[10]

In 2016, the Court held in *Whole Woman's Health v. Hellerstedt* that the Texas statutes requiring abortion clinics in the state to meet the standards of an ambulatory surgical center and requiring physicians performing abortions to have admitting privileges to nearby hospitals posed an undue burden on patients seeking an abortion, and therefore were unconstitutional.[11] In a similar case decided a few years later, the Court held that a Louisiana statute requiring physicians performing abortions to have admitting privileges at a hospital within 30 miles was also unconstitutional.[12]

In 2022, in its *Dobbs* decision, the Court reversed the decades of precedent described above in holding that there exists no constitutional right to abortion in the U.S.[13]

b . The New Legal Landscape

Post-*Dobbs*, states have complete authority to regulate abortion. While state statutes regulating abortion must still pass constitutional muster, the test for whether they do so is the rational basis test[14]—a lower bar

[7] *Supra* note 3 at 139-40.
[8] *Id.* at 166.
[9] 505 U.S. 833 (1992).
[10] *Id.* at 877.
[11] 579 U.S. 582 (2016).
[12] *June Medical Services, LLC v. Russo*, 591 U.S. 1101 (2020).
[13] *Supra* note 2.
[14] *Id.* at 3.

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than the undue burden standard established in *Casey*.[15] Because state legislatures are now in a position to unilaterally apply their own regulations and limitations to abortions offered and performed within their states' bounds—including whether to legalize abortion at all and under what circumstances and at what gestational limits—the ways in which abortion is regulated today are consistently evolving. With the reversal of *Roe*[16] and *Casey*,[17] state laws and their varied individual exceptions to abortion determine pregnant peoples' access to the procedure, and these laws differ significantly.[18] For example, in states such as Texas, Oklahoma, and Mississippi, abortion laws clearly define abortion exceptions (i.e. exceptions allowing for an abortion when it would otherwise be banned) only for instances where the *physical* health of the pregnant person is in danger.[19] States such as New York, California, Connecticut and Hawaii, permit abortion when the "health" of the pregnant person is in danger,[20] resulting in ambiguity as to whether the exception applies to both physical and mental health, or to physical health only. As of May 2023, Alabama is the only state that specifically allows for mental health to be a factor in an abortion exception.[21]

Although a general health exception could be understood to include the pregnant person's mental *and* physical health, additional clarity for health care professionals and patients would be helpful – and arguably essential.

Part II. Why People Seek Abortions

Helpful to understanding the context of mental health exceptions in state abortion laws is an exploration as to why women seek abortions, and whether mental health plays a role in a pregnant person's choice to obtain an abortion. A large study conducted in the U.S. in 2004 found that the most common reasons for seeking abortion included the concern about a child's interference with work, education, and ability to care for other dependents (seventy-four percent); lack of financial resources to care for a child (seventy-three percent); and not wanting to be a single mother, or relationship problems (forty-eight percent).[22] Similarly, and more recently, the Turnaway Study—a book published in 2021 about a study following one thousand women, some of whom had abortions and others who did not, over the course of ten years—found the top three reasons women seek abortion were lack of financial preparation, timing, and partner-related reasons, respectively.[23]

Additionally, a 2009 literature review discussing qualitative and quantitative research on why women seek abortions was consistent with the above.[24] The authors grouped the reasons for abortion into three

[15]The "rational basis" standard means "[a] law regulating abortion…is entitled to 'a strong presumption of validity'" and "must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests." *Id.* at 77. The majority in *Dobbs* calls the undue burden test "unworkable" (*Id.* at 62) but the rational basis standard of review is the lowest standard of review for constitutional questions, as compared to an intermediate or strict scrutiny standard.

[16]*Supra* note 3.

[17]*Supra* note 9.

[18]We expect ongoing changes to state laws governing abortion as state legislatures and citizens make decisions about what they want abortion access to look like in their states. We anticipate continued constitutional challenges to new state laws as well (*see, e.g.*, *Planned Parenthood v. SC*, 2023, holding that a state law banning abortion after cardiac activity is detected is unconstitutional.)

[19]MS Code 41-41-191; OK Stat. 63-1-745.5; TX Health and Safety Code 170A.001.

[20]NY Pub. Health Law 2599-BB; CA HSC 123468(b)(2); CT Stat 19a-602(a); HI R.S. 453-16(c).

[21]Mabel Felix et al., *A Review of Exception in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF.org (May 18, 2023); Ala. Code 26-23H-3.

[22]Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Persp. Sex & Repro. Health 110, 112 (2005).

[23]Diana Greene Foster, The Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having – or Being Denied Access to – an Abortion (2021).

[24]Maggie Kirkman et al., *Reasons Women Give for Abortion: A Review of the Literature*, 12 Arch. Women's Mental Health 365 (2009).

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main categories.[25] The first—"woman-focused"—included reasons such as timing (the most commonly identified reason), physical or mental health concerns (their own or that of the fetus), and already having children/not wanting children at all.[26] The second major category—"other-focused"—included choices to seek an abortion based on other people, such as an intimate partner, the potential child, children who were already born, or violence/sexual assault.[27] Lastly, "material reasons" included financial or housing concerns, or being unready to be a parent.[28]

While research findings such as these are often simplified into such categories, people surveyed routinely cite more than one reason for seeking an abortion;[29] the decision to seek and obtain the procedure is often complex and multifaceted. The decision to obtain an abortion is individualistic, and often cannot be reached using a "one-size-fits-all approach," which a legislature that limits abortions to only a narrow set of circumstances (such as threat to the *physical* health of the pregnant person) appears to create. Women who seek abortion for reasons that they and their physicians deem legitimate, but whose circumstances do not fit into their home state laws' sometimes narrow exceptions, or who are unable to travel to states where an abortion in their circumstance is legal, are left with limited options that could adversely impact them and their future child(ren).[30]

Part III. Mental Health and Pregnancy

a. Pregnancy and the Treatment of Depression

Pregnancy has been described as a factor that can protect against the development of mental health conditions, such as depression.[31] However, when comparing relapse rates in pregnant women with major depression, sixty-eight percent of women who discontinued their medication during pregnancy experienced relapse of their depression, while twenty-six percent of women who continued their medication experienced relapse.[32]

With those data in mind, along with the many changes a person experiences during and after pregnancy,[33] it may not come as a surprise that as many as one in seven women suffer from perinatal depression, defined as the occurrence of a depressive disorder during pregnancy or following childbirth.[34] While depression has been managed effectively in non-pregnant women by the use of antidepressants such as Selective Serotonin Reuptake Inhibitors (SSRIs) in combination with psychotherapy,[35] the use of pharmacological therapy such as SSRIs during pregnancy is controversial due to their potential adverse

[25] *Id.* The study authors named these categories. *See id.*

[26] *Id.* at 373.

[27] *Id.* at 374.

[28] *Id.* at 375.

[29] Aida Torres & Jacqueline Darroch Forrest, *Why Do Women Have Abortions?*, 20 Fam. Planning Persp. 169 – 176, 169 (1988).

[30] The inability to travel may be due to practical concerns, for example if travel is too costly, and/or would take too much time and interfere with the ability to work. The inability to travel for an abortion may also be a legal limitation. Justice Kavanaugh's concurrence in *Dobbs* discusses whether a state may limit travel to another state for the purpose of seeking an abortion; he concludes that the constitutional right to travel would bar such a limitation and such travel will be permissible. *Supra* note 2, at 3 (Kavanaugh, concurring). The dissent articulates its concern, however, that states may prohibit women from interstate travel for the purpose of seeking an abortion. *Id.* at 3 (Breyer, Sotomayor, and Kagan, dissenting).

[31] Lee S. Cohen et al., *Relapse of Major Depression During Pregnancy in Women Who Maintain or Discontinue Antidepressant Therapy*, 295 JAMA 499, 499 (2006).

[32] *Id.* at 504.

[33] Jennifer S. Haas et al., *Changes in the Health Status of Women During and After Pregnancy*, 20 J. Gen. Internal Med. 45, 51 (2005). Such changes include functional and physiologic changes, financial changes, and changes in mental health. *Id.* at 48-49.

[34] Susan J. Curry et al., *Interventions to Prevent Perinatal Depression: U.S. Preventive Services Task Force Recommendation Statement*, 321 JAMA 580, 580 (2019).

[35] L. L. Altshuler et al., *The Expert Consensus Guideline Series. Treatment of Depression in Women*, Postgrad. Med., Spec. No. 1-107 (2001).

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effects on the fetus.[36] The FDA Adverse Event Reporting System reflects that from 2012-2021, the most reported adverse events from SSRI and Serotonin and Norepinephrine Reuptake Inhibitor (SNRI) use during pregnancy were congenital malformation, spontaneous abortion, and low birth weight, respectively.[37] These findings are consistent with those from other studies showing decreased birth weight, miscarriage, and premature birth associated with antidepressant use throughout pregnancy.[38]

While the research clearly illustrates the potential for adverse effects when SSRI/SNRIs are used during pregnancy, the actual extent of these risks is less clear.[39] Due to the risks associated with treating depression during pregnancy, it is reasonable—and consistent with the medical standard of care—for physicians to discuss the option with their patients of discontinuing SSRIs or SNRIs during pregnancy. It is also reasonable for those at higher risk of developing a mental illness throughout pregnancy—such as those with previous history/family history of mental illness or history of trauma/abuse—to decide the risks of SSRIs or SNRIs during pregnancy are outweighed by the risks they incur if they discontinue their medication.[40] Furthermore, untreated depression, anxiety, and stress throughout pregnancy have been linked to preterm birth, preeclampsia, eclampsia, postpartum depression, and suicidal ideation.[41] Combined, the prevalence of perinatal depression, which was shown to be 7.4%- 12.8% throughout three trimesters of pregnancy,[42] and the safety questions surrounding the use of pharmacological therapy to treat depression during pregnancy,[43] contribute to the substantial need for discussion of a mental health exception in state abortion laws.

The absence of mental health exceptions from state abortion laws leaves pregnant people with mental illnesses limited options regarding not only their health outcomes but also the health outcomes of the fetuses they carry. This reality owes to risks associated with mental health treatment during pregnancy as well as *discontinuation* of mental health treatment during pregnancy. These data do not—nor do we—suggest that people who are pregnant and have mental health conditions such as depression seek or discuss abortion at rates higher than those unaffected by mental health conditions. However, the absence of exceptions in state abortion laws allowing for abortion due to patients' mental health conditions means pregnant people with mental health conditions in those states necessarily must assume the risks of pregnancy without the option of making informed decisions that effectively weigh their mental health conditions against pregnancy, its effects, and its aftermath.

b. Pregnancy and Other Mental Health Conditions

Depression during pregnancy is well-studied; anxiety (independent of depression) has also been heavily researched in recent years, likely due to its negative effect on fetal health outcomes.[44] Causes of anxiety during pregnancy include possible neonatal development disorders, pregnancy complications, body changes, potential for birth trauma to the infant, and increased doubts about the ability to be a good

[36]Michal Dubovicky et al., *Risks of Using SSRI/SNRI Antidepressants During Pregnancy and Lactation*, 10 Interdiscip. Toxicology 30-34 (2017).

[37]F Alyami & JJ Guo, *EPH8 Pregnancy Outcomes of Serontonin-Norepinephrine Reuptake Inhibitors (SNRI): Analysis of FDA Adverse Event Reporting System (FAERS) Database (2012-2021)*, 25 Value in Health S435 (2022).

[38]Sura Alwan et al., *Safety of Selective Serontonin Reuptake Inhibitors in Pregnancy: A Review of Current Evidence*, 30 CNS Drugs 499-515, 500-501 (2016); Dubovicky, *supra* note 36, at 31.

[39]Alwan, *supra* note 38, at 504.

[40]Christie A. Lancaster *et al.*, *Risk Factors for Depressive Symptoms During Pregnancy: A Systematic Review*, 202 Amer. J. Obstet. & Gyn. 5-14 (2010).

[41]Aleksandra Staneva et al., *The Effects of Maternal Depression, Anxiety, and Perceived Stress During Pregnancy on Preterm Birth: A Systematic Review*, 28 Women & Birth 179-193, 182 (2015); Dubovicky, *supra* note 36, at 31.

[42]Heather A. Bennett *et al.*, *Prevalence of Depression During Pregnancy*, 103 Obstet. & Gyn. 698, 703 (2004).

[43]Dubovicky, *supra* note 36, at 31.

[44]Zohreh Shahhosseini et al., *A Review of the Effects of Anxiety During Pregnancy on Children's Health*, 27 Mater Sociomed. 200, 200 (2015).

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parent.[45] Like depression, antenatal anxiety has been linked to increased risk of premature birth and low term birth weight.[46]

While anxiety can be effectively managed through medication and therapy, the stigma surrounding mental health during pregnancy has been shown to lead to increased anxiety levels for many women and is a potential barrier to seeking care. People may find themselves feeling guilty or ashamed for experiencing antenatal anxiety as these feelings may contradict the expectations they had for parenthood, which only further exacerbates and continues the cycle of potentially needing care and not receiving it.[47]

With respect to a mental health exception allowing for an abortion when state law would otherwise prohibit it due to compromised mental health of the pregnant person, antenatal anxiety is reason to value such an exception, especially with the emergence of evidence for the distinction of pregnancy-related anxiety as separate from generalized anxiety. While more research is needed, current research suggests pregnancy-related anxiety is associated with serious concerns about childbirth and the child's health. Pregnancy-related anxiety was also shown to be able to predict birth weight, gestational age, and postnatal mood disturbance independently of standard anxiety symptom measures.[48]

The Centers for Disease Control (CDC) defines preterm birth as an infant born alive before the end of thirty-seven weeks of pregnancy.[49] The CDC defines low birth weight in the United States as weight at birth of less than 5.5 pounds.[50] The World Health Organization (WHO) comprehensively describes the extent of the potential impact that preterm birth and low birth weight can have on fetal health outcomes; implications of low birth weight include fetal and neonatal death or other health complications, delays in growth and development of cognition, and neurocognitive disorders later in life.[51] Notably, low birth weight infants are twenty times more likely to die than infants born heavier.[52] Similarly, many survivors of preterm birth face learning disabilities and visual/hearing problems.[53] Both preterm and low birth weight babies may require special care in the neonatal intensive care unit (NICU) after birth to help with their breathing, protect against infections, provide nutrition,[54] and monitor more serious concerns such as respiratory distress, immature brain development, and necrotizing enterocolitis.[55] While these represent more short-term consequences of low birth weight and preterm birth, long term consequences include cerebral palsy, blindness, deafness, and hydrocephaly.[56]

[45]Liana Deklava et al., *Causes of Anxiety During Pregnancy*, 205 Procedia – Soc. & Behav. Sci. 623-26, 624-25 (2015).

[46]Xiu-Xiu Ding et al., *Maternal Anxiety During Pregnancy and Adverse Birth Outcomes: A Systematic Review and Meta-Analysis of Prospective Cohort Studies*, 159 J. Affect. Disorder 103-10, 106-08 (2014).

[47]Megan McCarthy et al., *Women's Experiences and Perceptions of Anxiety and Stress During the Perinatal Period: A Systematic Review and Qualitative Evidence Synthesis*, 21 BMC Pregnancy & Childbirth (2021).

[48]Emma Robertson Blackmore et al., *Pregnancy-Related Anxiety: Evidence of Distinct Clinical Significance From a Prospective Longitudinal Study*, 197 J. Affect. Disorder 251-58, 253-55 (2016).

[49]*Preterm Birth*, Ctrs for Disease Control (2023), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm (last visited Jan. 10, 2023) [https://perma.cc/YFZ8-536S].

[50]*Birthweight and Gestation*, Ctrs for Disease Control (2023), https://www.cdc.gov/nchs/fastats/birthweight.htm (last visited Jan. 10, 2023) [https://perma.cc/V22L-DJAG].

[51]*Low Birth Weight*, WHO, https://www.who.int/data/nutrition/nlis/info/low-birth-weight (last visited Jan. 10, 2023) [https://perma.cc/YC57-ML2J]. Neurocognitive disorders include conditions such as Alzheimer's disease or other dementias (e.g., Lewy body or vascular dementia).

[52]*Id.*

[53]*Id.*

[54]Jill Jin, *Babies with Low Birth Weight*, 313 JAMA 432, 432 (2015).

[55]University of Kentucky, *Short and Long-Term Effects of Preterm Birth*, Univ. Ky. Healthcare, https://ukhealthcare.uky.edu/wellness-community/health-information/short-long-term-effects-preterm-birth (last visited Jan. 10, 2023) [https://perma.cc/7M6B-4ET5]; Bhoomika K. Patel & Jigna S. Shah, *Necrotizing Enterocolitis in Very Low Birth Weight Infants: A Systemic Review*, ISRN Gastroenterol. (2012).

[56]Donald R. Mattison et al., The Role of Environmental Hazards in Premature Birth: Workshop Summary, Institute of Medicine (US) Roundtable on Environmental Health Sciences, Research, and Medicine (2003).

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The short-term and long-term consequences of mental illness during pregnancy on the fetus should be considered in the context of those who may seek to terminate their pregnancy due to mental illness. These adverse outcomes may present increased financial burdens and increased stress, both which could impact the ability to care for existing and future children.[57] In states where abortion laws do not provide a mental health exception, women who experience mental illness during pregnancy and would like to seek termination for reasons of their choice but can no longer do so because of the state they live in will, essentially, be forced to come to terms with the potential short-term and long-term impacts of their mental illnesses on their fetuses, themselves, and their families.

Additional research could further support the need for mental health exceptions in state abortion laws —research into the direct effects pregnancy has on mental health is an area particularly ripe for such efforts. Seeking an abortion should involve informed decision-making, and right now, physicians cannot necessarily predict how a mental health condition like anxiety will manifest itself during a time like pregnancy. Having a mental health exception would ensure that those who do experience anxiety are able to make the best decision possible for themselves and their future child(ren).

Part IV. Health Disparities and Other Extenuating Circumstances

a. Intimate Partner Violence and Mental Health

Intimate partner violence (IPV) is another topic of concern in the discussion of mental health and pregnancy. Researchers estimate that between 5.3%-10.9% of pregnant women experience some form of abuse during their pregnancy.[58] IPV during pregnancy has been associated with increased levels of depressive symptoms as compared to nonvictims, increased stress levels, suicide, endorsement of suicidal ideation, [59] and post-traumatic stress disorder[60] – all of which may have adverse impacts on both the pregnant woman and the fetus.[61] Of course, IPV does not necessarily warrant abortion; the concern is that someone who is pregnant and experiencing IPV may want to terminate the pregnancy for any number of reasons, such as an effort to stop the abuse, to avoid raising a child with someone who inflicts violence, or to mitigate the mental health impact the abuse is having on their health during pregnancy, among other reasons. However, the absence of language including—or language definitively excluding —abortion for mental health reasons leaves room for an exacerbation of mental health consequences related to IPV during pregnancy. While state laws with exceptions allowing for abortion when the physical health or life of the pregnant person is at risk effectively address one aspect of IPV—the physical impact—the clearly identified impact of IPV on mental health[62] is arguably just as significant.

[57] Ashwini Lakshmanan et al., *The Financial Burden Experienced by Families of Preterm Infants After NICU Discharge*, 42 J. Perinatology 223-30 (2021); Karli Treyvaud et al., *Family Functioning, Burden, and Parenting Stress 2 Years After Very Preterm Birth*, 81 Early Hum. Dev. 427, 427 (2011).

[58] Linda L. Dunn & Kathryn S. Oths, *Prenatal Predictors of Intimate Partner Abuse*, 33 J. Obstet. Gyn. & Neonat. Nurs., 54 (2004); Linda E. Saltzman et al., *Physical Abuse Around the Time of Pregnancy: An Examination of Prevalence and Risk Factors in 16 States*, 7 Maternal Child Health J. 31-43, 34-35 (2003); Sandra L. Martin et al., *Physical Abuse of Women Before, During, and After Pregnancy*, 285 JAMA 1581-84 (2001) (explaining why different studies identify different percentages); Sandra L. Martin et al., *Intimate Partner Violence and Women's Depression Before and During Pregnancy*, 12 Violence Against Women 221-39, 222 (2001) (noting that the number could even be as high as seventeen percent who experience violence during pregnancy). These numbers may be even higher due to under-reporting of IPV.

[59] Jacquelyn Campbell et al., *Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence*, 30 J. Women's Health (Larchmt) 236-44 (2021).

[60] Linda Rose et al., *Impact of Intimate Partner Violence on Pregnant Women's Mental Health: Mental Distress and Mental Strength*, 31 Issues Mental Health Nurs. 103-111 (2010).

[61] Linda R. Chambliss, *Intimate Partner Violence and Its Implication for Pregnancy*, 51 Clin. Obstet. & Gyn. 385-97 (2008).

[62] *See supra* note 58, citing data regarding the impact of IPV on mental health.

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b. Rape, Incest, and Mental Health

Following *Dobbs*,[63] access to abortion in cases of rape or incest has become more restricted than it was prior to the decision.[64] Although a comprehensive discussion of state laws' inclusions and/or omissions of exceptions allowing for abortion in cases of rape or incest is outside the scope of this Article, the impact of rape and incest on mental health during pregnancy is relevant. According to the National Women's Study, one-third of all rape victims develop post-traumatic stress disorder (PTSD), and are 6.2 times more likely to develop PTSD than women who had never been raped. Rape victims were also three times more likely to have a major depressive episode, and one-third of rape victims reported seriously considering suicide.[65] Thus, beyond questions of whether a pregnant person chooses to continue a pregnancy resulting from rape is the impact of rape itself on the pregnant person's mental health, and the resulting choice they may make to terminate the pregnancy given that impact.[66]

Like rape, incest—sexual contact between family members that may or may not result in pregnancy—can also negatively impact mental health.[67] A four-year retrospective study found that the most frequently seen mental health disorder resulting from incest was PTSD, with 77.5% of study participants who were victims of incest reporting mental health disorders.[68] Pregnancy resulting from incest may pose unique challenges in the absence of a mental health exception for those seeking abortion who experience PTSD, or other mental health disorders not necessarily generated by pregnancy but by the incest itself.[69]

c. Transgender Care

Because transgender men who have not undergone sex reassignment surgery could still become pregnant, their access to abortion in the context of mental health cannot be omitted from this discussion. A transgender man is a person who was assigned a female sex at birth but identifies as a male.[70] While research concerning the impact of pregnancy on transgender men is limited, mental health concerns that persist amongst pregnant transgender men include dysphoria; a state of unease or generalized dissatisfaction with life, visibility, isolation from lack of societal acceptance towards seeing pregnant men; and lack of respectful care from providers.[71] Other studies have found similar results showing that pregnant transgender men are at a higher risk for depression due to lack of care and lack of knowledge amongst health care providers. For example, a 2021 study found that out of 1694 transgender people, thirty-six percent said they would consider trying to end their pregnancy on their own without a provider, with twenty percent of them saying one of the reasons was due to mistreatment by medical providers.[72] Due to

[63] *Supra* note 2.

[64] *See*, *Tracking the States Where Abortion is Banned*, N.Y. Times (2023), https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html (last visited Jan. 12, 2023) [https://perma.cc/5JQD-KL33] (identifying at least thirteen states where abortion is banned; prior to *Dobbs*, abortion was a U.S. constitutional right and states could not ban it entirely. *See supra* note 3.).

[65] Dean G. Kilpatrick, *The Mental Health Impact of Rape*, Nat'l Violence Against Women Prevention Rsch. Ctr. (2000), https://mainweb-v.musc.edu/vawprevention/research/mentalimpact.shtml [https://perma.cc/6EHK-PGWB].

[66] *Id.*

[67] Osman Celbis et al., *Evaluation of Incest Cases: 4-Years Retrospective Study*, 29 J Child Sex. Abuse 79-89 (2019).

[68] *Id.*

[69] *Id.*

[70] Linell Smith, *Glossary of Transgender Terms*, Johns Hopkins Med., https://www.hopkinsmedicine.org/news/articles/glossary-of-terms-1 (last accessed Jan. 10, 2023) [https://perma.cc/5DSH-JLKK].

[71] Mari Greenfield & Zoe Darwin, *Trans and Non-Binary Pregnancy, Traumatic Birth, and Perinatal Mental Health: A Scoping Review*, 22 Int. J. Transgender Health 203-16 (2021).

[72] Heidi Moseson et al., *Abortion Attempts Without Clinical Supervision Among Transgender, Nonbinary, and Gender Expansive People in the United States*, 48 BMJ Sex. & Repro. Health e22-e30 (2022); Patti Verbanas, *Pregnant Transgender Men at Risk for Depression and Lack of Care, Rutgers Study Finds*, Rutgers (Aug. 15, 2019), https://www.rutgers.edu/news/pregnant-transgender-men-risk-depression-and-lack-care-rutgers-study-finds (last visited Jan. 10, 2023) [https://perma.cc/BBV3-V5YA].

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the mental health implications of pregnancy on transgender men, an inclusive mental health exception in state abortion laws may be needed to prevent further exacerbation of the already substantial health disparities existing amongst the LGTBQ+ community.

d. Care for African American and Black Patients

Limiting access to abortion through restrictive state abortion laws, combined with ambiguity surrounding exceptions to state abortion laws, especially regarding mental health, has the potential to impact all women's abilities to choose to terminate their pregnancies. However, the impact on minority pregnant women who may seek to terminate for reasons related to their mental health is significant, in no small part due to the racial/ethnic health disparities already existing in the United States. Although depression is prevalent among pregnant women in general,[73] studies have shown an increased prevalence of depression in pregnant Black women, as compared to that of White women.[74] For example, after adjusting for various participant demographics, pregnant Black women in Eastern North Carolina had an approximately fifty percent greater prevalence of increased depressive symptoms than did White women.[75] Although more research is needed to evaluate why pregnant Black women experience depressive symptoms at a higher rate than their White counterparts, explanations may include increased perceived and actual racial discrimination, decreased life satisfaction, and increased major depressive disorder.[76]

The difference in the prevalence of depression during pregnancy amongst Black women in comparison to Whites further supports the value of a mental health exception in state abortion laws to protect minority communities. Without the option of such exception, we may continue to see an increase in infant mortality and post-neonatal death amongst Black communities not only due to existing healthcare disparities but also due to the increased risk for preterm birth and low birth weight pregnant Black women with depression face when compared to other racial/ethnic groups.[77] Furthermore, African American women with depression during pregnancy are more likely to give birth preterm or deliver a low-birth-weight infant respectively, than African American women without depression.[78]

e. The Stigma of Mental Illness

People with mental health conditions still face stigma—both for having a condition and for seeking treatment for the condition—which in turn leads to underuse of mental health resources among those affected.[79] This is specifically notable in minority communities. For example, Black women with lower socioeconomic status reported experiencing more stigma about mental health conditions, and were less likely to obtain care for mental health conditions, as compared to White women also of lower socioeconomic status.[80] Regarding exceptions to abortion prohibitions, this discrepancy matters.

[73] *See, e.g.*, Suzanne T. Orr et al., *Racial Disparities in Elevated Prenatal Depressive Symptoms Among Black and White Women in Eastern North Carolina*, 16 Annals Epidem. 463 (2006).

[74] *Id.*

[75] *Id.*

[76] Karen A. Ertel et al., *Racial Discrimination, Response to Unfair Treatment, and Depressive Symptoms Among Pregnant Black and African-American Women in the United States*, 22 Annals Epidem. 840 (2012); *id.*

[77] Shannon D. Simonovich et al., *Meta-Analysis of Antenatal Depression and Adverse Birth Outcomes in U.S. Populations 2010-20*, 40 Health Affairs 1560, 1560 (2021); Panagiota Kitsantas & Kathleen F. Gaffney, Racial/Ethnic Disparities in Infant Mortality, 38 J. Perinatal Med. 87, 89 (2010); Kevin Fiscella, *Racial Disparity in Infant and Maternal Mortality: Confluence of Infection, and Microvascular Dysfunction*, 8 Maternal Child Health J. 45, 45 (2004).

[78] Simonovich, *supra* note 78, at 1563.

[79] American Psychiatric Association, *Stigma, Prejudice, and Discrimination Against People with Mental Illness*, Psychiatry.org, https://www.psychiatry.org/patients-families/stigma-and-discrimination (last visited Jan. 11, 2023) [https://perma.cc/T7ZX-WQYA].

[80] Ozlem Eylem et al., *Stigma for Common Mental Disorders in Racial Minorities and Majorities: A Systematic Review and Meta-Analysis*, 20 BMC Pub. Health 1 (2020).

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Because ethnic minorities are less likely to seek mental health care, it is more likely that mental illness will go undiagnosed, especially during pregnancy. Undiagnosed/untreated mental health conditions during pregnancy have been associated with poor nutrition, noncompliance with medical care recommendations, alcohol or other substance use,[81] likely harming both the pregnant person and the fetus. Ultimately, the stigma associated with mental health and the prohibitive effects that stigma has upon efforts to seek treatment underscore the need for increased access to mental health resources during pregnancy, including the potential inclusion of a mental health exception in state abortion laws.

f. The Impact of Abortion on Mental Health

In considering the impact of a mental health exception in state abortion law, the impact of abortion on mental health is relevant. The Turnaway Study found that abortions did not negatively impact the mental health of the people who underwent the procedure, with most women reporting after having an abortion that it was the right choice for them.[82] However, restricting access to abortion, according to the same study, led to higher anxiety rates in the first few months following abortion denial among women who were denied abortion as compared to those who underwent them.[83] Thus, while the impact of the abortion or denial thereof on the patient's mental health six months to one year later was the same, the initial short-term difference is considerable.[84]

Part V. Mental Health Care Resources

While this Article generally advocates for the inclusion of a mental health exception in state abortion laws, it cannot do so without addressing at least one reason one might argue against the need for such an exception: the adequacy of the resources available to a pregnant person who chooses *not* to terminate the pregnancy.[85] Recently, the U.S. government funded and established a maternal mental health hotline.[86] It is a free service available twenty-four hours per day, seven days per week, in both English and Spanish. With call and text options, this hotline provides mental health resources and support (such as counseling) for people who are pregnant, thinking about becoming pregnant, or have already delivered a child and need help with managing symptoms of conditions such as depression and anxiety.[87] This is a particularly useful resource for people in rural areas and/or who may otherwise not have access to mental health care. While hotlines are not the same as comprehensive health care, implementation of this program could lead to reduced anxiety/depression amongst pregnant woman by providing them with the resources they need, leading to better outcomes for both the pregnant person and the fetus.

Woman, Infants, and Children (WIC) is another national program that helps people who are pregnant—and their children—access health care. The program provides funding for states to support families with children (including people who are pregnant) who need assistance with food; WIC includes education programs on nutrition and health as well.[88] Women who have used WIC during pregnancy

[81]Thea Moore & Jennifer Pytlarz, *Untreated Psychiatric Disorder in Pregnancy: Weighing the Risks*, 3 Mental Health Clinician 83, 83 (2013).

[82]Foster, *supra* note 23.

[83]*Id.*

[84]*Id.*

[85]Other arguments may be posited, such as the personhood of a fetus, the need or right of the state to protect the life and health of its citizens.

[86]Health Resources & Services Administration Maternal & Child Health, *Maternal Mental Health Hotline*, MCHB https://mchb.hrsa.gov/national-maternal-mental-health-hotline (last visited Jan. 11, 2023) [https://perma.cc/UP6Y-8996].

[87]*Id.*

[88]*See Special Supplemental Nutrition Program for Women, Infants, and Children)*, U.S. Dept. of Agriculture Food & Nutrition Servs., https://www.fns.usda.gov/wic (last visited Jan. 10, 2023) [https://perma.cc/QJ9W-54DN] [hereinafter WIC].

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delivered infants with improved birth weights in comparison to those who were eligible for WIC but did not use it.[89] Because WIC provides healthy foods, this program could reduce stress and anxiety in pregnant people who cite lack of financial security as a reason for terminating a pregnancy. Knowledge of and access to this program could provide comfort in knowing they would not only have food throughout the pregnancy but up until the infant is five years old.[90]

Options such as local programs established to support pregnant women could provide mental health resources, too. For example, Florida has several local programs that offer access to resources for pregnant women such as Florida Baby Bellies and Beyond,[91] a program that implements maternal depression screening; Healthy Start Program,[92] which provides access to resources such as food and primary care to pregnant women regardless of socioeconomic status; and the Nurse-Family Partnership,[93] which brings a nurse into the home to help with the newborn until they reach a certain age. Programs such as these may relieve some of the anxiety or stress that pregnant woman feel before and after giving birth.

However, access to local programs can differ significantly by both state and county. One county may offer one or more resources, but its neighbor might offer none; to effectively provide mental health care to pregnant people, more uniform access to resources is critical. Also, most of these local programs take income into consideration in choosing who to partner with; thus, only those in certain income brackets are eligible to use the resources,[94] leaving those who fall in the gap between the wealthy and the poor with even fewer resources to aid them throughout their pregnancy.

PART VI. Conclusion

Physicians have referred to the language with which many state abortion laws have been written as frustrating, burdensome, and a source of increased stress because of uncertainty how to comply with them and the fear of consequences due to noncompliance.[95] Terms such as "medical emergency" or "threat to health or life" are ambiguous; physicians struggle with this ambiguity, as reasonable physicians may differ on whether a situation is urgent or emergent. And the reality is that a mental health condition can become a physical one quickly should a patient's mental health deteriorate (e.g., when depression yields to a suicide attempt, or when a patient decompensates physically due to lack of adequate nutrition and exercise resulting from depression).

States like Texas, which only allow abortion where the physical health of the pregnant person is in danger, leave physicians in vulnerable positions when instances outside of an emergency pertaining to physical health potentially necessitate an abortion.[96] However, even in states such as California that provide broader access to abortion—e.g., where the "health" of the patient is at risk—physicians must still contend with the ethical and legal issue of determining when these exceptions apply in an effort to avoid criminal prosecution and civil suits that may arise from even inadvertent noncompliance.[97] In light

[89]Stephanie Ettinger de Cuba et al., *Prenatal WIC is Associated with Increased Birth Weight of Infants Born in the United States with Immigrant Mothers*, 122 J. Acad. Nutrition & Dietetics 1514, 1514 (2022).

[90]*Id.*

[91]*Baby Bellies & Beyond*, Babies bellies & beyond (2023), https://babybelliesandbeyond.com/?v=7516fd43adaa (last visited Jan. 11, 2023) [https://perma.cc/AGX7-DJGZ].

[92]*Healthy Start*, Health Resources & Servs. Admin (2023), https://mchb.hrsa.gov/programs-impact/healthy-start [https://perma.cc/5VPH-EWDS].

[93]*About Us,* Nurse-Family Partnership (2023), https://www.nursefamilypartnership.org/about/ [https://perma.cc/A7KM-FP9R].

[94]*See, e.g.*, WIC, *supra* note 88.

[95]*See* Rebecca J. Mercier, *The Experiences and Adaptations of Abortion Providers Practicing Under A New TRAP Law: A Qualitative Study*, 91 Contraception 507-512 (2015).

[96]TX Health & Safety Code 170A.001.

[97]Martha F. Davis, *The State of Abortion Rights in the U.S.*, 159 Int. J. Gyn. & Obstet. 324-329, 325-26 (2022); CA HSC 123468(b)(2).

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of the risks to mental health that pregnancy can pose, and the often confusing and evolving nature of state of abortion laws in the U.S. post-*Dobbs*, a specific mental health exception is ethically and medically acceptable—perhaps even necessary.

Kristin Telford is a second-year medical student at the University of Florida College of Medicine. She graduated from Florida International University where she was a member of the women's soccer team, and earned both a Bachelor of Science in Biological Sciences and a Bachelor of Arts in Natural and Applied Sciences. In her studies at the UF College of Medicine, she is a student in the Medical Ethics and Law track where she is engaged in in-depth study of issues in law and bioethics. All views expressed are the author's own.

Lauren Solberg is an Associate Professor in the University of Florida College of Medicine, Department of Community Health and Family Medicine, and the Director of the College of Medicine Program in Bioethics, Law and Medical Professionalism. Professor Solberg teaches medical students, graduate and undergraduate students about clinical and research ethics, and has received funding from the NIH and the NSF to develop education programs and conduct research on topics in law and bioethics. Her work has been published in various law and biomedical journals. Professor Solberg earned her JD from Vanderbilt University and her Master of Theological Studies from Harvard University. All views expressed are the author's own.

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