Evolving Abortion Law and Forensic Psychiatry

Susan Hatters Friedman, MD, Jacqueline Landess, MD, JD, Nina Ross, MD, and Aimee Kaempf, MD

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In 1973, the U.S. Supreme Court ruled in *Roe v. Wade* that prohibiting abortion violated a woman's constitutional right to privacy.[1] Nearly 50 years later, in 2022, the Supreme Court overturned *Roe* in *Dobbs v. Jackson Women's Health Organization.*[2] In this editorial, we discuss how changing abortion law affects psychiatrists who practice at the interface of mental health and the law by reviewing the implications in the pre-*Roe*, *Roe,* and *Dobbs* eras. We aim to demonstrate how abortion law status is highly relevant to both the clinical and evaluator roles of forensic psychiatrists. As access to safe, legal abortion becomes increasingly uncertain, psychiatrists will likely encounter women with unwanted pregnancies who are unable to procure termination. Psychiatrists will need to provide treatment to this population, including understanding the potential effects of medication in pregnancy as well as effects of untreated illness. Pregnant women may enquire about the mental health sequelae of obtaining an abortion versus carrying an unwanted pregnancy to term. Psychiatrists will need to assess suicide risk in the context of unwanted pregnancy and may be asked to provide psychiatric certification for abortion care. Psychiatrists working in correctional or forensic hospital settings will be increasingly faced with the challenges of caring for pregnant and postpartum women within institutional systems that are often ill-equipped to meet perinatal needs. As forensic evaluators, psychiatrists may continue to be consulted for a variety of civil and criminal matters pertaining to abortion care, including medical decision-making capacity assessments, Jane Doe evaluations, and questions relating to cases of alleged fetal harm.

Pre-*Roe* Era

Before the *Roe* decision in 1973, illegal abortion was common in the United States.[3] In 1930, abortion was the official cause of death for 18 percent of deaths related to pregnancy and childbirth, with actual numbers likely much higher due to the secretive nature of abortions.[3] By 1960, the *British Medical Journal* had noted that psychiatric grounds could be used to obtain an abortion in cases of fetal anomaly if the mother was experiencing great anxiety regarding fetal defects.[4] In 1962, Sherri Chessen, star of the children's television show *Romper Room*, unknowingly ingested thalidomide during early pregnancy, bringing the topic of abortion in America to international attention. Concerned about the risk of delivering a severely malformed infant, she traveled from Arizona to Sweden for an abortion.[5]

Dr. Susan Hatters Friedman is the Phillip J. Resnick Professor of Forensic Psychiatry and Professor of Psychiatry, Reproductive Biology, Pediatrics, and Law (Adj) at Case Western Reserve University, Cleveland, OH. Dr. Landess is Clinical Assistant Professor of Psychiatry, Medical College of Wisconsin, Milwaukee, WI. Dr. Ross is Assistant Professor of Psychiatry, Case Western Reserve University. Dr. Kaempf is Clinical Associate Professor, Department of Psychiatry, University of Arizona Medical Center, Tucson, AZ. Address correspondence to: Susan Hatters Friedman, MD. E-mail: sjh8@case.edu.

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Prior to 1967, American states significantly limited legal abortions, though many women sought illegal abortions.[6,7] Most states allowed for legal abortion when the mother's life was threatened, if medical certification was provided.[6] Initially, medical conditions were the primary justification, but with improving medical care in pregnancy, psychiatric certifications became more common. For instance, psychiatrists would certify that a woman was imminently suicidal if she did not have an abortion.[6] In 1967, Colorado, North Carolina, and California liberalized their statutes and expanded psychiatric exceptions. For example, California required that a woman's mental health must be gravely impaired such that she would be a danger to herself or others or in need of supervision if she did not obtain an abortion.[6] In the next three years, the overwhelming majority of California's legal abortions were performed related to substantial risk to the woman's mental health.[8] Though psychiatrists served as gatekeepers for abortion, studies that followed women who were granted and who were denied abortions were lacking at the time.

In 1969, the year that the American Academy of Psychiatry and the Law was founded, both the American Psychiatric Association and the Group for the Advancement of Psychiatry issued statements stating that abortion should be removed from criminal law and considered a medical concern.[7] In 1970, New York legalized abortion[7] and subsequently New York doctors performed abortions on women traveling from other states. By 1973, 13 states had exceptions and four had repealed abortion bans,[9] placing psychiatrists into a fraught position.

In 1972, Cleveland Clinic psychiatrist Richard Schwartz noted in the *Case Western Reserve Law Review*: "although the practice of abortion has been illegal in most states until recently, it has been an 'open secret' that a woman can obtain a safe abortion in a licensed hospital if she can find a psychiatrist who will say she might commit suicide if her pregnancy is not terminated" (Ref. 7, p 840). Schwartz further noted that, even as of 1972, this practice was limited to middle-class women, that follow-up studies had shown abortions to have few harmful psychiatric effects, and that forcing women to bear unwanted children was harmful to the mental health of both women and their families. Schwartz noted, "it is impossible on any medical or scientific grounds to establish agreed-upon indications for psychiatric abortions" (Ref. 7, p 843). Women would convince themselves or psychiatrists that they were depressed and likely to be suicidal. These abortions then, may "favor the histrionic, the emotionally unstable, and the deceitful woman, permitting her to abort while denying abortion to women who are truthful and emotionally stable" and further, that the required pathway to obtaining an abortion "favor[s] the rich" and obtaining an abortion "depends far less on the state of her health than upon the state of her pocketbook" (Ref. 7, p 844).

One can imagine evaluations in which members of a population in crisis exaggerate or malinger symptoms to procure legal terminations.[9,10] A routine psychiatric referral in abortion cases may lead to guilty feelings or the woman's worries about her mental health.[11] Decision-making capacity might even be called into question: "To obtain abortions, women had to present themselves as psychologically disturbed, while this presentation itself necessarily undercut their decision to terminate their pregnancy" (Ref. 4, p 19). For the psychiatrist, another paradox is created in opining about the risk of suicide yet not seeking psychiatric hospitalization.

Despite individual beliefs regarding abortion, psychiatrists felt various levels of unease using psychiatric practice to authorize abortion in women who did not actually meet legal criteria. Psychiatrists ranged in their decisions and rationale. Some refused to participate in abortion evaluations because of the "harmful social impact over the long term because they abate pressures that might lead to liberalization of the abortion laws" (Ref. 7, p 844) or for religious reasons. Others were willing to authorize some abortions on the basis of suicide risk or simply certifying all cases that presented to them.[12] Not surprisingly, abortion determinations depended "upon the philosophical point of view of the psychiatrist whom [the pregnant woman] happens to consult" (Ref. 7, p 845). Once New York liberalized its abortion law, Schwartz noted: "She no longer has to go through the humiliating charade of trying to convince psychiatrists that she is mentally ill or suicidal. And the psychiatrists in New York are no longer faced with the painful dilemma of deciding whether to allow themselves to be 'used' by society to make decisions which properly should remain in the hands of the woman, her husband, and their physician" (Ref. 7, p 847).

Roe Era

In the past five decades, forensic psychiatrists have participated in evaluations regarding abortion in both

the civil and criminal arenas, including informed consent and capacity evaluations, evaluations for judicial bypass of parental consent (known as "Jane Doe evaluations"), and forensic evaluations prompted by the prosecution of pregnant women. In 1992, shortly after *Planned Parenthood v. Casey*,[13] Appelbaum noted that "although most psychiatrists practicing today have never played such a role [as physicians certifying threats to the woman's life or health], it is not a new one for the profession" (Ref. 6, p 967). Most available research about abortion comes from the *Roe* era.

Abortion and Mental Health

Abortion access, or lack thereof, disproportionately affects women with mental illness. Compared with women with no mental health history, women with psychiatric illness have higher rates of contraception nonadherence, unplanned pregnancy, and late pregnancy detection.[14,15] Patients with psychiatric illness may face additional barriers to obtaining an abortion, including finances and difficulty accessing care, particularly if termination becomes illegal in their state.[16] Much of the research exploring the relationship between abortion, psychiatric illness, and psychosocial determinants of health has been criticized for being scientifically unsound for many reasons, including the inappropriate control groups and failure to consider critical confounding factors such as pre-abortion mental health.[17] The landmark Turnaway study avoided many of these methodological flaws.[18] This study followed pregnant women who either received an abortion or were prevented from obtaining a wanted abortion, finding no causal relationship between abortion and mental illness. But women who were denied a wanted abortion and thus made to carry an unwanted pregnancy to term were more likely to experience adverse psychosocial determinants of health, such as poverty, staying with an abusive partner, and difficulty bonding.[18]

Informed Consent and Capacity Evaluations

To meet informed consent standards, a clinician must provide relevant, accurate medical information to the patient and also ensure that the patient has medical decision-making capacity and is making decisions voluntarily without coercion.[19] Compared with other areas of medicine, the informed consent process relating to abortion has been uniquely complicated because of confounding factors such as time constraints, sociopolitical controversies, stigma, religious beliefs, powerful emotions and conflicts among stakeholders, and rapidly changing legislation, which may generate fear and confusion among women and health care providers.

Psychiatrists have been consulted when there is doubt about a woman's ability to make decisions about abortion. All adults are presumed to have medical decision-making capacity, and the presence of a psychiatric illness does not equate to incapacity.[19,20] It has been recommended that evaluations of a woman's ability to consent to abortion follow the same approach as any assessment of capacity to consent to a serious, irreversible medical procedure, with some special considerations. Women have received misleading or inaccurate information regarding various potential physical and psychological sequelae of pregnancy termination as a result of so-called "informed consent" laws in some jurisdictions that require patients to be provided with state-specified information during pre-abortion counseling.[21] Furthermore, as discussed previously, a history of methodologically flawed research has led to misconceptions that having an abortion worsens mental health, despite more scientifically sound studies showing that the risk of mental health problems among women who have an abortion is no greater than the risk among women who carry an unwanted pregnancy to term.[17] Next, women may experience ambivalence about the decision to terminate a pregnancy, even when certain of the choice. Some level of ambivalence is common and does not, in and of itself, signify mental illness or preclude a woman from having medical decision-making capacity.[22] Given that women with mental illness may be susceptible to coercion, psychiatrists conducting capacity evaluations have been advised to verify that a woman's choice is being made independently and free of undue influence.[19,21] Finally, psychiatrists' awareness of biases has been critical to ensure that their personal opinions about abortion not sway their assessments or recommendations. Any attempt to persuade or manipulate a woman's decision is unethical.[21]

Jane Doe Evaluations

In a 1987 book review in The Journal, Benedek described adolescent abortion as "one of the more perplexing and difficult legal and ethical issues facing today's mental health clinician" (Ref. 23, p 310).

When a woman reaches the age of majority (18 in most states), she is considered an adult and able to make medical decisions. For pregnant younger teens, however, most American states have required parental notification or consent to obtain an abortion.[24] These laws have provisions allowing pregnant minors to anonymously petition courts for the judicial bypass of parental consent. To obtain a judicial bypass, barriers may include meeting an attorney, filing a case, providing proof of pregnancy, and completing pre-abortion counseling, in addition to a psychiatric evaluation.

These forensic evaluations are often termed "Jane Doe evaluations." They have been unusual forensic evaluations in that they require rapid completion because of timeframes and do not allow for collection of collateral information or even knowing the name of the evaluee. In addition, "limited literature exists to guide psychiatrists' decision-making, and criteria to qualify for judicial bypass are often poorly defined" (Ref. 24, p 401). For example, in Ohio, the juvenile court utilized a standard of clear and convincing evidence to consider whether the minor was "sufficiently mature and well enough informed to intelligently decide whether to have an abortion" or alternatively find that parental notification is "not in her best interest" (Ref. 24, p 401), for example, because of maltreatment or incest. The central question for forensic psychiatrists in these cases has been capacity to provide informed consent. With no standard definition for maturity, courts have applied their own interpretations.

Criminalization of Pregnancy Outcomes

Even prior to *Dobbs*, pregnant and postpartum women have been criminally prosecuted, civilly committed, and subjected to legal hardships for acts related to pregnancy and alleged fetal harm. From 1973 to 2020, there were roughly 1,700 criminal charges against women in which the pregnant woman's actions or omissions were alleged to have resulted in fetal or neonatal harm.[25,26] Pregnant women and new mothers were charged, prosecuted, incarcerated, and, in some cases, convicted for pregnancy loss, stillbirth, neonatal death, miscarriages, and self-induced abortions under an array of criminal laws including feticide, child abuse, chemical endangerment, child endangerment, delivery of drugs to a minor, and murder.[25,27]

Some believe that chemical endangerment laws have been necessary to legally mandate women with substance use disorders into treatment. But inadequate funding and limited access to services for pregnant women are problematic.[28,29] In addition, Hall and colleagues questioned whether these laws could be interpreted as prosecuting a status (that of an addicted pregnant woman), which would be unconstitutional under *Robinson v. California.*[30] The irony of these laws is that a woman who uses substances and gives birth to a stillborn is subject to less serious charges than a woman who uses substances, and gives birth to a live infant who dies soon thereafter.[31,32]

Some states have also used existing fetal homicide laws to prosecute pregnant women. Minnesota was the first state to pass a feticide law in 1986. After Congress passed the Unborn Victims of Violence Act in 2004, following the death of Laci Peterson and her unborn son,[33] a number of other states passed similar laws. These laws were intended to punish perpetrators who harmed or killed pregnant women and their fetuses. Most of these laws specifically excluded women seeking abortions, medical providers, and the pregnant woman herself. Despite this, women have been prosecuted under these laws for pregnancy loss, including for self-induced abortions and fetal loss following a suicide attempt.[34,35] Forensic psychiatrists have been involved in mitigation or criminal responsibility evaluations in these cases.

Dobbs Era

Dobbs has many implications for forensic psychiatrists. Psychiatric opinions may again be sought regarding the psychiatric necessity of an abortion, and there may be a demand for evaluations of pregnant or recently pregnant women for substance abuse and criminal charges.

Increased prosecution usually means increased incarceration; in this case, of pregnant or postpartum women who will likely need psychiatric care. Correctional psychiatrists will be called upon to care for these women and their many complex needs.[36,37] The collateral consequences of incarceration, even if ultimately not ending in conviction, will affect these women, who may lose their jobs, friendships, partners, and family relationships. Incarcerated women often have other children who are at risk of being placed in foster care and experience the effects of traumatic separation.[36] Women of minority and low-income backgrounds will likely be disproportionately affected, as we have seen in the era of mass incarceration and the war on drugs. In addition, the patients of both correctional psychiatrists and forensic psychiatrists treating

women in forensic hospitals or on community sanctions will have much greater difficulty procuring an abortion than those living freely in the community.

Forensic psychiatrists may be called upon to assist attorneys and courts at various stages of the criminal and civil process, including expert testimony regarding criminal responsibility, mitigation, risk assessments, child custody, and parental rights. A forensic psychiatric evaluation may be necessary in cases where the woman miscarries or self-induces an abortion and is charged with assault, manslaughter, or murder (perhaps facing capital punishment). This evaluation may require assessment of her state of mind at the time of the crime and education of the factfinder about the influence of immaturity, depression, substance use, posttraumatic symptoms, social stressors, and other factors that influenced her decision to terminate or her alleged negligence resulting in fetal injury and, sometimes, demise.

Under *Dobbs*, abortion-related malpractice cases may rise as obstetricians, fearing civil penalties or criminal prosecution, delay treatment for threatened miscarriage or ectopic pregnancy, waiting instead until the mother's life is in clear, imminent danger. Forensic psychiatrists may be asked to evaluate emotional distress among plaintiffs seeking psychological damages as a part of such malpractice claims.

Evaluations for Psychiatric Necessity

More recent international reports, using modern research knowledge, describe what psychiatric practice has entailed in Antipodean countries limiting abortion access, similar to the American *Dobbs* era. Abortion was decriminalized across Australian jurisdictions, beginning in Western Australia in 1998, and finally in South Australia in 2022. It was not until 2020 that New Zealand removed abortion from the Crimes Act 1961, declaring abortion as a medical concern. This was despite a 1970 position statement by the Australia New Zealand College of Psychiatrists that abortion should be left to medical professionals' clinical judgment.[11,38] In 1977, New Zealand psychiatrist John Werry opined to the Royal Commission: "there is little doubt that most abortions are performed 'on compassionate grounds masquerading as psychiatric'" (Ref. 4, p 17).

In New Zealand, 98.9 percent of the abortions in 2006 were completed related to the "mental health exception," specifically to prevent danger or injury to the woman's mental health.[4] Cases were certified by a consultant's (attending psychiatrist's) professional opinion. Recommendations were made for psychiatric evaluation in cases of patients with: major psychiatric illness, a history of postpartum psychosis, ambivalence over their decision, and passive compliance with abortion because of the wishes of a parent or spouse.[11] As of 2012,[38] tasks that psychiatrists in the Antipodes performed related to abortion included assessing and managing the woman's mental health; assessing capacity to consent to abortion; assessing the impact of either abortion or lack of abortion on mental health; determining legality of a proposed abortion, including writing a report; and supporting the obstetric team. Some psychiatrists exercised their right to conscientiously object.[38]

Three decades ago, in 1992, when Appelbaum[6] considered psychiatrists' potential responses to the then-possibility of *Roe* being overturned, scientific knowledge regarding the effects of abortion on women remained limited. He noted that in some cases, such as those women with severe mental disorders who require treatment with potentially teratogenic medications, and women with a history of postpartum psychosis in which we can estimate risk, are "easier for psychiatrists to play a useful role" (Ref. 6, p 168). Appelbaum[6] suggested possible choices of actions for psychiatrists should *Roe* be overturned: serving as honest scientific experts acknowledging the limits of knowledge, serving as advocates for abortion, or having nothing to do with abortion to protect integrity and force reform. Appelbaum presciently noted: "a return to restrictive abortion laws, with psychiatric certification as one of the only ways of gaining access to abortion, will confront psychiatrists with dilemmas from which there is no clear escape. Their choices will be callous honesty, dishonest compassion, or sanctimonious abstention . . . . *Roe* extracted psychiatry as a whole from an ethical morass. Its possible demise will not be pleasant" (Ref. 6, p 968). In fact, depending on the legal changes, psychiatrists may again be called upon to determine the psychiatric necessity of abortion, using up-to-date knowledge and evaluations of mothers. In contrast to the pre-*Roe* situation, however, many new abortion laws (like Ohio's "heartbeat ban") now explicitly exclude mental health-related reasons from medical exceptions.

Prosecution Under Fetal Personhood Laws

Even after the constitutional right to abortion was established in *Roe*, pregnant women were criminally

prosecuted under a host of laws for actions or omissions allegedly leading to fetal harm. Fetal personhood laws, some granting legal rights from the earliest point of gestation, will likely only increase criminal prosecutions against pregnant women. The state of Missouri has long expressed the view that fetuses and embryos are legal persons, and other states are amending their legislation.[27,39] Thus, pregnant women may be increasingly prosecuted not only for illegal abortions but for many other actions made criminal because they are pregnant and negligently, recklessly, or intentionally acted in ways that could harm their fetus. Women who obtain illegal abortions may even be subjected to capital punishment in the post-*Dobbs* world.[40]

The fetal personhood movement has implications far beyond the criminalization of elective abortion, allowing prosecutors to file charges for pregnancy loss in various scenarios. Many convictions of pregnant women for substance use are not upheld on the basis of a lack of legislative intent to prosecute pregnant women, that a fetus was not a child, a lack of established harm to the fetus, and inadequate notice to the defendant.[41] If states extend legal personhood to fetuses, however, many future convictions might stand.

Surveillance and Reporting

Physicians may become increasingly required to participate in surveillance and reporting of pregnant women in a manner similar to how physicians are mandated reporters of child abuse. Already, physicians in 25 states and the District of Columbia must report suspected prenatal drug use, with some requiring drug testing if use is suspected,[42] despite statements from the American College of Obstetricians and Gynecologists recommending drug testing only with consent and discouraging threats of criminal prosecution to compel treatment.[43] Physicians might also be expected to report women who have obtained abortions, legal or not. For example, the Indiana Complications Statute requires physicians to report to the state "any adverse physical or psychological condition arising from the induction or performance of an abortion."[44] Psychological complications, including depression, suicidal ideation, anxiety, and sleeping disorders, are explicitly listed. The federal district court struck down the law, finding it unconstitutionally vague, but the Seventh Circuit Court of Appeals upheld it on appeal because the law was challenged pre-enforcement.[45] The appellate court noted that future as-applied challenges might be successful. Notably, the court commented that the complications statute does not provide doctors with adequate guidance to determine how the symptoms they observe are directly connected to or caused by an abortion. While it is yet to be seen how this statute will be applied, psychiatrists could certainly become involved in these cases and play a crucial role in educating other medical professionals and courts about the lack of scientific evidence linking specific psychiatric symptoms with abortions, much less the ability of a practitioner to identify a specific, external cause for the person's suicidality or other symptoms.

Conclusions

Since *Dobbs*, the United States has entered an era in which the right to abortion is not protected by the Constitution. The roles of psychiatry in the pre-*Roe* United States and abroad may help us anticipate what to expect in the future, but uncertainties remain. As a field, we will be required to navigate many changes and challenges.

In recent decades, our knowledge about both mental health and pregnancy termination has expanded. The field of reproductive psychiatry is likely to become more broadly relevant to clinicians and forensic evaluators alike in the wake of the *Dobbs* decision. Correctional psychiatrists will likely see an influx of pregnant women into the carceral system, and psychiatric experts will likely be consulted for a variety of civil and criminal questions relating to abortion.

Prior to *Roe*, psychiatrists certifying suicide risk in cases where a woman would otherwise be denied an abortion faced an ethics dilemma and sometimes felt compelled to circumvent the law in an effort to ensure abortion access. Such acts of civil disobedience are problematic for our profession. It would erode trust in our field if we were to, for example, not apply the legal criteria for civil commitment or competency to stand trial in situations where we had some objection to the law in question. In 1963, Sim noted "there is a parallel between the role of the psychiatrist in abortion and his role in court in cases of capital murder" (Ref. 46, p 148). Indeed, women may potentially face capital punishment if they obtain a criminal abortion in the post-*Dobbs* era. Forensic psychiatrists will need to consider how to perform evaluations relevant to pregnancy termination in an impartial manner, just as we must for

other contentious topics, such as the death penalty. If a great many psychiatrists refuse to work in this area because of personal beliefs, there could be too few left to meaningfully engage in this important health topic affecting a significant number of our patients and evaluees. Even if psychiatrists were to decline expert witness work relating to abortion cases, abortion legislation will affect all practitioners in clinical roles. Therefore, we must be familiar with rapidly changing abortion law, understand the literature relating to abortion and mental health, and be mindful of our own feelings and biases about abortion to practice our profession competently, ethically, and objectively.

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