Putting Politics Aside: Supporting Pregnant Women Who Have Experienced Sexual Violence

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> Each time a woman stands up for herself, without knowing it possibly, without claiming it, she stands up for all women.
>
> —Maya Angelou

In June 2022, the U.S. Supreme Court issued its ruling in *Dobbs v Jackson Women's Health Organization* (1), which overturned *Roe v Wade* and eliminated the federally protected right to abortion. In the year since the decision, 14 states have made abortion illegal. The issue of abortion rights has become politically polarized, with both pro-life and pro-choice factions holding strong moral convictions about their viewpoints. Every state may now set its own rules regarding the legality of abortion, with consequent requirements for rapid change in reproductive health practices in some states. Texas is one of the most restrictive states, with the inclusion of Senate Bill 8 (2), which bans abortions after detection of embryonic cardiac activity—around 5–6 weeks after the start of the patient's last menstrual cycle—often before the woman realizes she is pregnant. The Texas Health and Safety Code Section 171.208 (3) bill additionally grants the right for any person in Texas to bring a civil action (with statutory damages no less than $10,000) as follows:

> . . . against any person who performs or induces an abortion. . . [or] knowingly engages in conduct that aids or abets the performance or inducement of an abortion. . . regardless of whether the person knew or should have known that the abortion would be performed or induced.

The full ramifications of how these restrictive state laws may affect general medical health and mental health care remain ambiguous. The language of the Texas bill is vague, leading to concern by reproductive and mental health providers of potential legal liability if they discuss reproductive options with their patients. Some organizations in Texas have adjusted their rape crisis counseling services to offer less candid discussion about pregnancy options with women who have been raped and to be more vigilant about the potential for entrapment by anti-abortion activists (4, 5). Medical ethical principles for confidential doctor-patient communication and patient-centered treatment may also be in jeopardy (6). For example, Senate Bill 8 in Texas makes abortion illegal after 5–6 weeks and has no exceptions for rape or incest. Advocates for sexual assault survivors in Texas risk being sued if they offer an abortion referral to a survivor carrying a baby conceived through rape (5).

Women's advocates propose that the Texas law could trap people experiencing domestic abuse in their abusive relationships. A recent study (7) reported that mental distress has increased among women of reproductive age following the Supreme Court decision overturning *Roe v Wade* and new barriers to legal abortion. Rape resulting in pregnancy is a public health problem in which sexual violence and reproductive health connect. According to the U.S. Centers for Disease Control and Prevention's National Intimate Partner and Sexual Violence Survey, 2016/2017 Report on Sexual Violence (8), one in four women (26.8% or 33.5 million) reported experiencing a completed or attempted rape at some time (pg. 3). More than half (56.1%) of these women were raped by an acquaintance, more than one in three (39.3%) by an intimate partner, and about one in six (16.0%) by a family member (pg. 7). Almost half were first victimized as minors (pg. 11). It is estimated that one in seven of these individuals (almost 3 million women and girls) became pregnant. Two-thirds had ongoing concerns for their safety (pg. 14). These safety concerns are realistic, because women who are pregnant or have recently given birth are twice as likely to die by homicide than from any other cause of maternal mortality, most often at the hands of an intimate partner (9, 10).

Multiple medical organizations have decried the Dobbs ruling. The American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, as well as the American Psychiatric Association published a joint statement (11) on June 24, 2022, entitled, "Physicians: SCOTUS Decision Jeopardizes Patient-Physician Relationship, Penalizes Evidence-Based Care." This statement said:

> Our organizations, representing over 400,000 physicians and medical students, condemn the Supreme Court decision in Dobbs v. Jackson Women's Health Organization, striking down the protections afforded to people in need of abortion care for five decades. Our organizations have consistently opposed any legislation or regulation that interferes in the confidential relationship between a patient and their

physician and the provision of evidence-based patient care for any patient—and this decision will allow states to gravely interfere in that relationship by penalizing and even criminalizing the provision of evidence-based medical care. This ruling will curtail access to critical reproductive health care for millions of people across the country, will grow the health inequities that already exist in the medical system, and will set a dangerous precedent for legislative interference across medicine.

Health equity advocates have highlighted abortion access as a racial justice issue (12–15). Although women of all ages and ethnic and socioeconomic backgrounds access abortions, women who access abortion are more likely to be low-income, unmarried, and from racially or ethnically minoritized populations. Black women access abortions at three times the rate of White women (16). Structural factors, including systemic racism, unequal access to quality family planning services, economic disadvantage, suspicion of the medical system, and decreased access to educational opportunities, contribute to observed differences, especially for pregnant teens (12) The most commonly reported reasons for seeking an abortion are inability to financially support a child, unpreparedness to have a child or to have another child, and having an abusive or unsupportive partner (17). In predominantly Black, Indigenous, or Latine underresourced communities, there has been a decline in ready access to contraceptives and the option to terminate unwanted pregnancies, as well as declining access to prenatal services and obstetrical care. Recent estimates suggest that a nationwide abortion ban would increase maternal mortality by 21% overall and by 33% among Black Americans (18). Unwanted pregnancies may result in long-term negative mental health and quality of life outcomes for women and families (19). Adolescent parenthood also has been correlated with poor mental health, including higher rates of depression, elevated risk for suicidal ideation, higher rates of domestic violence, and increased risk for substance use—all of which may perpetuate a cycle of poverty (12).

Clinical Vignette

Amara is an 18-year-old recent high school graduate in Texas who has participated in intermittent therapy with Dr. Williams since experiencing an episode of depression in her junior year. Her depression was exacerbated in January when she broke up with her long-term boyfriend. After a year of regular psychotherapy and treatment with a selective serotonin reuptake inhibitor, Amara requested to wean off the medication to see whether she would need to continue it during college. With Dr. Williams' guidance, by early May, Amara had successfully discontinued the medication. They terminated therapy when Amara graduated from high school, with the caveat that she could return if needed. Amara was planning to go away to college in the fall and had been excited for the next stage in her life.

It was now July and Amara had called Dr. Williams' office requesting an urgent appointment. Dr. Williams was able to fit her in the next day. When Dr. Williams met Amara in the waiting room, she could tell that Amara had been crying. Amara came into the office quickly and sat down as tears welled up in her eyes.

"I can see you are really upset, Amara. Shall we talk about it?" Dr. Williams said. The doctor fetched the tissue box and handed it to Amara.

After a long pause, Amara blurted out, "I'm pregnant."

Dr. Williams took a moment to consider the ramifications of what Amara had just said. She took a deep breath and gazed at Amara empathically.

"Can you say more?" Dr. Williams encouraged.

"It was at a party—you know, at someone's house before graduation. It was a swim party. My mom really didn't want me to go, but I finally talked her into it. She was worried that there would be drugs and drinking and told me to call and come right home if there was. I promised. But, of course, there was drinking and marijuana. I usually don't drink, but I thought, 'What the heck, it's graduation.'" Amara paused, wiping her eyes and blowing her nose before proceeding. "One of the girls had an older brother. He was cute, you know, and he kept bringing me drinks. We talked, and he was flirting. Maybe I had been flirting too. Everyone went inside for food, and we stayed in the pool. He kissed me, and that was fine. But then I said we should go inside too, and I went into a bathroom near the pool to put on my clothes. He followed me and pushed his way in before I could close the door. Then . . . well, he raped me. I felt so scared, and guilty, and afraid—I didn't know what to do. He hurt me. And no, I didn't scream," Amara finished, beginning to cry.

"I'm not judging you," Dr. Williams said softly. "Freezing is an inborn fear reaction. It doesn't mean that you weren't raped."

Amara continued. "So, I had stopped taking birth control pills about a month before—because I had broken up with my boyfriend and didn't need them. So, I thought my period timing was messed up after stopping the pill. I read that that happens. But when it still didn't come, I checked yesterday—and the pregnancy test was positive. I don't know what to do. I haven't told anyone what happened. It was all my fault. I shouldn't have been drinking and flirting! But I have to go to college—my parents have already paid tuition. They were so proud of me. But now it has been six weeks, and it's too late to get an abortion. What do I do, Dr. Williams?" Amara was visibly sobbing now.

Dr. Williams sat close to Amara and touched her hand. "I'm so sorry that happened. How very scary! And to be going through this alone. I'm glad you felt safe enough to come talk to me about it. Here is what I suggest: I know this is all so new, but we need to make sure you are medically and emotionally taken care of. Have you thought about what you want to do?"

"I am too young to have a baby." Amara sobbed. "I have plans—college, graduate school, career. And I was raped—it

makes me sick just to think that I would have to carry a baby from a vicious rapist. I'm already having nightmares and flashbacks. I'm so scared!"

Dr. Williams stopped and thought about the laws in the state. She calculated the time from when Amara had been assaulted—6 weeks. Dr. Williams knew of a Planned Parenthood clinic out of state, and she was friendly with the director. "I can call the Planned Parenthood in New Mexico. Abortion is legal there, and I know the director. Why don't you take some time to think about what you really want. We can talk again tomorrow to decide a treatment plan—medical and emotional. How bad are the nightmares?"

"Pretty bad," Amara admitted. "I'm afraid to go to sleep at night."

"If you like, I can prescribe prazosin. It is a nonaddictive medication that helps with PTSD [posttraumatic stress disorder] sleep issues. I have an open appointment time tomorrow at 12:30. Does that work for you?"

"Sure—I can call and let work know that I might be in a little late. This is the first time I've felt suicidal since last year. I won't do anything, though. It just seems that my life is crumbling," admitted Amara.

Dr. Williams and Amara made a safety plan, agreed to meet the next day, and Amara was given a week's worth of prazosin.

"Can you get arrested for doing this?" Amara asked fearfully, gazing at Dr. Williams.

"I consider it doctor-patient confidentiality, Amara. We need to be able to have confidential discussions." Honestly, though, she was not sure after the Texas law.

After Amara left, Dr. Williams suddenly became concerned. She called Amara. "Hello, Amara. I just thought about the confidentiality of your medical record. You are an adult now, but I think your mother still may have proxy access." She informed Amara how to discontinue the proxy access if she did not want her mother to see any of her record.

Amara thanked her. "See you tomorrow, Dr. Williams."

Dr. Williams hung up with Amara and called the Planned Parenthood clinic in New Mexico.

Psychotherapeutic Engagement, Doctor-Patient Confidentiality, and Women's Reproductive Health

How may the new state reproductive health laws affect doctor-patient confidentiality and the mission of empowering optimal patient decision-making? Elizabeth Sepper, professor of law at the University of Texas at Austin explained that "physicians have independent speech rights, to speak to their patients openly" (5). "Physicians should not be scared of the 'a-word.'" She argues that doctors and hospital systems should consider their ethical and professional obligations to give patients complete information about their diagnoses and options (5).

The American Psychiatric Association's medical ethics principles (6) state:

> In some cases, the law mandates conduct that is ethically unacceptable. When physicians believe a law violates ethical values or is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.

In a Perspective article in the *New England Journal of Medicine*, Matthew Wynia (20) argued that compelling doctors to choose between harming patients and breaking the law threatens the integrity of the medical profession. The American Medical Association (21) denounced the Dobbs decision, calling it "an egregious allowance of government intrusion in the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients' rights to evidence-based medical care." Dr. Wynia (20) opined about actions medical organizations can take in the face of laws that threaten patients' well-being:

> Should they support establishing committees to decide when a pregnant person's life is in sufficient danger to warrant an abortion? Should they advocate for allowing patients to travel elsewhere for care? Or should they encourage their members to provide evidence-based medical care, even if doing so means accepting—en masse—fines, suspensions of licensure, and potential imprisonment?

He argues for civil disobedience by the medical profession:

> . . . professionally sanctioned, open, and large-scale acts of civil disobedience might in the end be less risky for doctors than strategies involving professional groups trying to help members work around unethical laws or individual doctors acting surreptitiously against a law or taking a stand alone.

One of the key tenets of medical practice is the healing power of the doctor-patient relationship. The four key elements of this relationship are trust, knowledge, regard, and loyalty. The nature of the relationship has an impact on patient outcomes, with a trusting relationship with a knowledgeable physician that provides unconditional mutual regard and joint loyalty demonstrating superior outcomes (22). The doctor-patient relationship represents a fiduciary relationship, in which the physician agrees to respect the patient's autonomy, maintain confidentiality, explain treatment options, obtain informed consent, and provide the highest standard of care. Patients often feel vulnerable in revealing their private fears, traumas, worrisome symptoms, and yearnings. Patients who perceive their doctor as supporting their autonomy have described greater patient trust in the doctor-patient relationship, greater satisfaction with their care, and better mental health–related quality of life (22).

As physicians, we need to keep the best interests of our patients at the center of our practice. Despite the emotional political rhetoric and our own personal beliefs, the needs of the patient must guide our care. These needs include providing honest, supportive, trauma-informed, patient-centered care to pregnant patients who have experienced sexual violence.

Tips for Engaging a Pregnant Traumatized Woman

1. Provide culturally humble, positive regard for women presenting with a history of sexual trauma. Ask about the patient's level of comfort and what may enhance her feeling of safety.
2. Clarify the nature of confidentiality (and potential limits). Explaining confidentiality is particularly essential when providing treatment for minors. Remain cognizant of potential breaches of confidentiality through diagnoses and billing codes that insurance companies share, as well as through proxy access to the medical record by parents or spouse. Mark notes as sensitive.
3. Highlight the patient's primary concerns. Provide time to help her clarify her emotions, priorities, and how you can be most helpful. Encourage patient autonomy and self-advocacy.
4. Assess level of distress, symptoms of PTSD, and potential for self-harm or suicide. Ensure that a safety plan is in place—discussed and in writing.
5. Provide a sense of the future while validating current emotions.
6. Assess for any medical needs—such as physical trauma or evaluation and treatment of sexually transmitted diseases.
7. Assess the patient's support structure, such as family, friends, significant other, religion, or pets. Investigate which of those can provide support to her in this situation.
8. Provide honest psychoeducation about pregnancy options in the state—pregnancy termination options and support for maintaining the pregnancy. Reassure the patient that you want to provide the space for her to make the decisions that are best for her health and welfare.
9. Provide clinical feedback and recommendations about follow-up treatment.
10. Clarify clinician availability and methods of communication available—phone, e-mail, or health information portals—and ensure this information is given in writing. Identify plans for urgent or emergent crises.
11. Address barriers to care (financial, transportation, or other) and help problem-solve with the patient and case management or other support through your medical practice organization.
12. Talk to youths and all patients (including men) about the importance of safe sex practices and how to access birth control easily and affordably.
13. Check with your institution or legal advisor about the limits of doctor-patient confidentiality concerning issues of abortion. Work with your professional organizations to ensure doctor-patient confidentiality and patient-centered care.

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