Ethical Documentation in a Politicized Reproductive Health Climate

A Trauma-Informed Teaching Strategy for Counselor Education

Restrictions on reproductive health care have created ethically complex conditions for counselors documenting crisis and trauma cases involving pregnancy. This brief outlines an instructional strategy that prepares counseling students to navigate documentation in states where pregnant clients face limited medical options and where clinicians fear legal or licensure consequences. Using a reproductive mental health vignette, state policy analysis, and SOAP note practice, the activity teaches students to balance client autonomy, confidentiality, and nonmaleficence during documentation. Ethical considerations, instructor reflexivity, and assessment approaches are described. The strategy promotes competent, trauma-informed practice amid today's challenging sociopolitical climate.

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Politicized Reproductive Health Climate

The reproductive health landscape in the United States has become increasingly complex, as many states have implemented restrictive pregnancy-related laws. These restrictions have created delays in medically necessary care and have placed clinicians in positions of uncertainty regarding legal boundaries (Brandi & Gill, 2023). Researchers have documented significant fear among medical providers regarding criminal penalties, threats to licensure, and the possibility of civil action if they provide or refer for pregnancy-related care that state law now considers unlawful (Arora et al., 2024; Brandi & Gill, 2023).

Pregnant individuals who receive diagnoses involving fetal nonviability or severe pregnancy complications face heightened emotional distress, especially when care options available within their state are limited (Ramer et al., 2024). Studies have identified increased rates of depression, anxiety, posttraumatic stress symptoms, and feelings of immobilization among individuals who are denied necessary medical interventions or who must travel long distances to seek care (Gerdts et al., 2016; Miller et al., 2022; Serchen et al., 2023). These experiences compound the emotional and physical stress already associated with medically complex pregnancies.

Mental health counselors frequently work with clients who seek support during moments of crisis related to pregnancy loss, fetal diagnoses, or complicated decision-making. Documentation in these situations requires accuracy, clinical reasoning, and ethical restraint. Record keeping in crisis services becomes even more delicate when clients fear that their personal health decisions could be used against them in legal or political contexts. Counselors must consider how documentation might be interpreted by courts, employers, insurance companies, or other entities that may legally request access to clinical notes (O'Neil et al., 2021; Syed et al., 2024). As recommended by the American Counseling Association (ACA) Code of Ethics (Standard B.2.d), counselors must prepare for such requests by taking steps to prohibit the disclosure or limit it as narrowly as possible to avoid harm (ACA, 2014).

RELEVANT LITERATURE

Research demonstrates that restrictive reproductive health policies negatively impact perinatal mental health outcomes, increasing rates of anxiety, depression, and trauma-related symptoms among pregnant individuals (Gerdts et al., 2016; Miller et al., 2022). These policies create barriers to care that disproportionately affect marginalized communities, including low-income individuals, people of color, and those in rural areas (Jones & Jerman, 2017). The criminalization of pregnancy outcomes in some jurisdictions has created a "chilling effect" on healthcare provision, with providers fearful of legal repercussions for standard medical care (Arora et al., 2024; Goodwin, 2020). Documentation practices have emerged as a particular concern, as medical records can be subpoenaed and used in criminal investigations or civil

proceedings (Ghaith et al., 2022). Therefore, counselors must understand the ethical principles of beneficence, nonmaleficence, autonomy, and justice as they relate to documentation practices with pregnant clients (ACA, 2014, Standards A.1.a., A.1.b., B.6.a.; Cottone & Tarvydas, 2021). The *ACA Code of Ethics* emphasizes the protection of client welfare and the maintenance of confidentiality, while also requiring adequate documentation to ensure ethical practice (ACA, 2014, Standard B.6.g). These obligations necessitate careful ethical reasoning and a thorough understanding of state-specific regulations.

RATIONALE AND KNOWLEDGE GAP

Although documentation is a central component of counselor training, most programs do not address how shifting political environments influence documentation practices. Students often report uncertainty about how to document pregnancy-related distress, how to protect client autonomy when laws limit available medical options, and how to reduce potential risks if records are later disclosed (Syed et al., 2024). These challenges are compounded by the need to uphold ethical standards, such as nonmaleficence, confidentiality, fidelity, and sound professional judgment, within legal climates that may threaten client safety.

Despite the relevance of these concerns, counselor education programs rarely offer structured instruction on the intersection of reproductive health, mental health treatment, and documentation ethics (Bridges, 2020). As a result, students often feel unprepared for real-world practice, particularly when determining what information is necessary to document, how to limit sensitive details, and how to safeguard clients from potential legal or political consequences while still producing clinically useful records.

The andragogical approach described here addresses this gap by providing structured, case-based learning that integrates crisis intervention theory, ethical decision-making frameworks, and practical documentation skills. By examining state-level policy variations and their implications for clinical practice, students develop critical thinking skills necessary for ethically responsive counseling in restrictive contexts. This instructional strategy responds to current sociopolitical realities by preparing counselors to be particularly cautious about how they communicate a client's decision-making process, emotional reactions, and risk factors in written records.

Description of Teaching Innovation and Instructional Strategy

APPLICATION TO COUNSELOR EDUCATION

This teaching strategy is implemented in a crisis intervention and prevention course. The activity is conducted in a single class session, with the first hour focused on perinatal mental health crisis, including discussion of perinatal mood and anxiety disorders (PMADs), statistics and prevalence of PMADs, and maternal mortality rates. The second hour focuses on case analysis and documentation practice.

First Hour: Perinatal Mental Health Crisis

Students examine the landscape of reproductive health policy across states, learning about trigger laws, gestational limits, health exception clauses, and provider protection statutes. This contextual foundation helps students understand how policy environments shape clinical practice. The class reviews perinatal mood and anxiety disorders (PMADs), their prevalence, and maternal mortality rates, with attention to how restrictive policies impact perinatal mental health outcomes and create disparities in care access.

Second Hour: Case Analysis and Documentation

Students receive a detailed clinical vignette featuring a pregnant client facing health complications that threaten pregnancy viability. The case captures the complexity of supporting a client through pregnancy decision-making while attending to her mental health needs and safety.

Clinical Vignette. "Maria, a 32-year-old Latina woman, presents for counseling after learning that her pregnancy has a low likelihood of viability. Her medical team explained that continuing the pregnancy may cause severe complications, but due to her state's restrictions, she cannot obtain all treatment options locally. Maria reports overwhelming anxiety, difficulty sleeping, and episodes of hopelessness. She expresses fear that her medical and counseling records may someday be accessed or misinterpreted. She denies current suicidal intent but acknowledges feeling emotionally exhausted and unsure how to proceed. She states, 'I'm scared about my health, but I'm also scared that anything I say here could somehow be used against me later. Can you promise me this stays private?' She asks directly about what will be documented from the session and whether anyone else could access her records.

Students work in small groups to identify the clinical, ethical, and documentation challenges presented in this case. They consider: What are Maria's immediate mental health needs? What are the counselor's ethical obligations? How might state law impact treatment planning? What documentation considerations arise? How should the counselor respond to Maria's direct questions about confidentiality and record keeping?

SOAP Note Exercise and Critical Discussion. Students individually complete a SOAP (Subjective, Objective, Assessment, Plan) note for an initial session with Maria (See Appendix for SOAP Note Exemplar and Rubric). They are specifically instructed to:

- Document only what was verbally stated or directly observed without unnecessary information. In doing so, students practice the principle of minimal disclosure, revealing only essential information for clinical purpose (ACA, 2014, Standard B.2.e.).
- Avoid assumptions, judgmental or speculative language.
- Record emotional distress in a way that is clinically relevant.
- Acknowledge risk factors clearly and objectively.
- Avoid including personal beliefs, moral judgments, or unnecessary reproductive details.

After completing the note, students compare their documentation choices in pairs, noting what information they included, what they omitted or modified, and their rationale for these decisions.

The class reconvenes for structured discussion using the following prompts:

- What specific information did you include or exclude? Why?
- How did you document Maria's presenting concerns without creating potential legal exposure?
- What language choices did you make regarding pregnancy decision-making and medical complications?
- How did you address Maria's explicit fears about documentation and confidentiality?
- What differences did you notice between your approach and your partner's?

ETHICAL CONSIDERATIONS FOR INCLUSIVE AND RESPONSIVE LEARNING

This teaching approach requires careful attention to the diversity of students' personal experiences, beliefs, and values regarding reproductive health. Because reproductive health intersects with culture, religion, gender, and personal values, this instructional strategy requires an inclusive classroom environment that is trauma-informed, culturally responsive, and attentive to students with lived experiences involving reproductive loss or pregnancy complications. The following practices foster such an environment:

Establishing Psychological Safety

On the first day of class, before introducing any course content, students collectively develop community agreements that explicitly address respectful dialogue on sensitive topics. I share my commitment to creating space for diverse perspectives while maintaining focus

on professional ethical obligations and client-centered care. Students are invited to reflect on their own beliefs related to pregnancy and medical decision-making, but they are also reminded of the counselor's ethical obligation to support client autonomy regardless of personal opinion and values.

Acknowledging Positionality and Addressing Disparities

I openly share my social location as a woman, my professional training in reproductive health counseling, and my commitment to social justice while acknowledging that students may hold different personal beliefs. The discussion includes attention to the disproportionate impact of reproductive restrictions on individuals from marginalized communities. Research has documented that racial and socioeconomic disparities shape access to reproductive care and mental health outcomes (Bridges, 2020; Jones & Jerman, 2017). Counselors and counselor educators have a responsibility to recognize historical and social prejudices in the treatment of marginalized groups and strive to address these biases (ACA, 2014, Standard E.5.c.). The activity encourages students to recognize how systemic inequities influence clients' emotional and practical decision-making processes. I emphasize that the learning objective is not to prescribe personal values but to develop skills for client-centered, ethically grounded practice, regardless of the counselor's personal position on reproductive decision-making.

Providing Content Warnings

Students receive advance notice that the module addresses pregnancy loss, reproductive decision-making, and healthcare restrictions. I encourage students to take breaks and step out if needed and communicate with me privately if they need additional support due to personal experiences with reproductive trauma.

Centering Client Autonomy

Throughout the module, I emphasize that the counselor's role is to support the client's autonomous decision-making process, not to influence the outcome. This framing helps students distinguish between personal values and professional responsibilities.

DEMONSTRATED REFLEXIVITY AND INTRAPERSONAL AWARENESS

Before introducing the activity, I acknowledge my professional background in reproductive mental health and explain why I believe it is important for counselors to learn about documentation in this context. I share my awareness of the cultural and political sensitivities surrounding pregnancy decisions and reflect on how my own identities and clinical experiences shape the way I teach these topics. As an educator teaching this material, I continuously examine my own positions and their potential influence on student learning. My background includes clinical work with diverse populations around reproductive health, experience living in both restrictive and protective policy contexts, and scholarly work on intersectionality in mental health care. Reflecting on this background, I recognize that counselor educators' awareness

of personal bias regarding reproductive health is paramount to effective instruction that centers client autonomy and avoids imposing personal values on student learning.

I also acknowledge the privilege inherent in my current position, teaching in a state with relatively protective reproductive health policies, while preparing students who may practice in more restrictive contexts. This geographic privilege shapes my perspective, and I actively seek consultation from colleagues practicing and teaching in diverse policy environments to ensure I accurately represent the challenges students may face.

SUGGESTED RESOURCES FOR IMPLEMENTATION

Educators implementing this teaching strategy should develop familiarity with current reproductive health policy landscapes. The following resources provide regularly updated information:

Policy Resources:

- Guttmacher Institute State Policy Updates (guttmacher.org/state-policy)
- Kaiser Family Foundation State Health Facts (kff.org)
- American Civil Liberties Union Reproductive Freedom Project (aclu.org/issues/reproductive-freedom)

Clinical and Ethical Resources:

- ACA Code of Ethics (2014), particularly sections on client welfare (Standard A.1.), confidentiality (Standard B), and diversity (Standard B.1.a.)
- American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on Role of Obstetrician-Gynecologists in Abortion Care and guidance on pregnancy complications and emergency care
- American Psychological Association documentation and record-keeping guidelines

EVALUATION OF EFFECTIVENESS

The effectiveness of this teaching strategy is evaluated through students' SOAP note documentation and critical reflections, which indicate improved critical thinking and clinical confidence. The paired SOAP note comparison consistently generates rich discussion because students make diverse documentation choices. This diversity demonstrates that multiple ethically defensible approaches exist, helping students develop tolerance for ambiguity and appreciation for context-dependent decision-making.

ASSESSMENT TOOLS AND METHODS

Student learning is assessed through one two-part assignment and in-class dialogue:

- **Part 1: SOAP Note** - Students complete a SOAP note documenting Maria's initial session, demonstrating their ability to balance clinical thoroughness with protective documentation practices.
- **Part 2: Written Reflection** - Students write a reflection exploring their process of documentation, including what choices they made, why they included or excluded specific information, and what they learned about ethical documentation in politically sensitive contexts.
- **In-Class Dialogue** - Structured class discussions allow students to compare documentation approaches, consider diverse perspectives, and engage in critical analysis of how documentation can support or compromise client welfare.

IMPLICATIONS

This teaching approach prepares counselors-in-training to navigate the increasingly complex intersection of mental health care and reproductive health policy. Students develop critical competencies including: understanding policy contexts and their clinical implications, applying ethical decision-making frameworks to ambiguous situations, creating documentation that serves clinical purposes while minimizing potential harm, and maintaining client-centered practice despite personal values or external pressures.

The andragogical model described here can be adapted across counselor education curricula beyond crisis intervention courses. Documentation ethics could be integrated into practicum/internship seminars, clinical diagnosis courses, or professional ethics classes. The case-based approach transfers well to other sociopolitical topics where counselors must navigate restrictive or discriminatory policies, including conversion therapy bans, gender-affirming care restrictions, or immigration-related issues.

Limitations and Future Directions

Several limitations warrant acknowledgment. First, state laws change frequently, which requires the instructor to update class materials every semester to reflect current legal landscapes. This ongoing investment of time and attention to policy developments represents a significant challenge for busy faculty. Second, some students may find this topic emotionally challenging due to personal experiences with pregnancy loss or reproductive trauma. While content warnings and additional support help address this concern, the risk of retraumatization requires careful attention to creating a trauma-informed classroom environment. Third, this module does not address all dimensions of reproductive health counseling. Topics like fertility challenges, pregnancy loss, perinatal mood disorders, postpartum care, foster care, and adoption each merit dedicated attention that time constraints limit.

Future Directions

Future scholarship should examine how counselors in restrictive policy states navigate documentation dilemmas in practice and what protective documentation practices are most effective while maintaining clinical utility. Future teaching strategies may include electronic health record simulations, interdisciplinary coursework with medical or public health students, and more advanced case studies involving diverse pregnancy complications and client presentations. Research is also needed on how documentation-focused training influences counselors' long-term competence and on supporting practitioner wellness in restrictive contexts.

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Appendix

SOAP NOTE EXEMPLAR AND RUBRIC

SOAP Note Components for the Maria Case Study

SOAP component	Exemplar content (Maria case study)	Evaluation rubric
Subjective	Client reports "overwhelming anxiety," "hopelessness," and "emotional exhaustion." States distress is related to an "ongoing medical crisis" and express concern regarding "confidentiality"	Focuses on reported mood symptoms and stated fears without specific reproductive details.
Objective	Observed tearfulness, rapid speech, and psychomotor agitation. Client appeared fatigued but remained alert and oriented. Denies suicidal or homicidal ideation.	Uses neutral, nonjudgmental language. Records only direct clinical observations.
Assessment	Adjustment Disorder with Anxiety (F43.22). Symptoms developed in response to an identifiable stressor, with onset within the past three months. Client is experiencing a high level of distress that impairs daily functioning (e.g., sleep disturbance and hopelessness). Symptoms are exacerbated by external stressors related to medical care access.	Establishes medical necessity for mental health treatment without mentioning pregnancy outcomes.
Plan	Continue weekly individual counseling sessions focused on anxiety management, distress tolerance, and grounding techniques. Collaborated on a safety plan and provided crisis resources.	Focuses on mental health intervention and safety without outlining specific medical decisions.