



## Original Research Article

## Assessing psychosocial costs: Ohio patients' experiences seeking abortion care ☆

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## ABSTRACT

**Objectives:** Existing research has not thoroughly characterized the psychosocial costs associated with seeking abortion care in restrictive states. Our study seeks to fill this gap by analyzing the accounts of Ohio abortion patients from 2018 to 2019.

**Study design:** Using inductive and deductive approaches, we analyzed semi-structured in-depth qualitative interviews with 41 Ohio residents who obtained abortion care from one of three clinics in Ohio or Pennsylvania.

**Results:** Ohioans seeking abortion care often experienced fear of judgment, interpersonal strain, and stress as a result of efforts to overcome pre-Dobbs financial, geographic, and timing challenges. Those who needed financial assistance or traveled more than an hour generally reported greater exposure to psychosocial costs.

**Conclusions:** Participants in this study incurred a complex set of psychosocial costs. Psychosocial costs often resulted from, or were exacerbated by, the financial, geographic, and time-sensitive burdens that patients experienced seeking care.

**Implications:** The psychosocial costs incurred by patients seeking abortion care may be exacerbated in restrictive contexts, especially those who do not have access to insurance coverage for care. Psychosocial costs associated with care seeking are likely to increase as states implement more severe restrictions post-Dobbs. To fully understand abortion costs, researchers must examine costs comprehensively, including both financial and psychosocial costs.

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## 1. Introduction

Abortion patients routinely navigate regulatory environments that shape their experiences. Regulations can close nearby clinics, impose waiting periods between appointments, and lead to increased travel distances, appointment delays, and financial burdens for patients [1–7]. In Ohio, abortion restrictions include in-person, state-mandated counseling followed by a 24-hour waiting period (necessitating at least two clinic visits) [8]. At the time of data collection, Ohio banned abortion 22 weeks from the last menstrual

period (LMP) [9]; Ohio has since limited abortion care after detection of cardiac tones (usually about 6 weeks from the LMP) after the United States (US) Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* in June 2022 [10]. As of August 2022, Ohio's state legislature has proposed but not yet passed additional restrictions, including a total ban on abortion care after fertilization [11]. Ohio also prohibits public health insurance coverage for abortion except for cases of life endangerment, rape or incest [8].

Researchers have documented the financial costs and logistical burdens of targeted abortion regulation at the national and state level [1,3,11–14]. Structural and policy-related forces, such as poverty, lack of insurance coverage, and lack of providers, place abortion care out of reach for some seekers, and policy-related

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obstacles are particularly pronounced in restrictive settings [15]. Less is known about the psychosocial costs associated with the process of seeking abortion care in restrictive environments, such as fear, interpersonal strain, and stress. Most recently, Biggs and colleagues (2020) have developed the Psychosocial Burden among People Seeking Abortion Scale (PB-SAS), which seeks to assess “a person’s subjective perception of the burden experienced seeking abortion care, including the perceived difficulty overcoming logistical barriers to care, as well as worry about a range of socio-emotional factors that may have a negative impact on their psychological well-being” (p. 628, italics in original) [16]. Drawing from data collected from clinics in three states that offer public funding for abortion and have few restrictions (California, Illinois, and New Mexico), they identified four dimensions of psychosocial burden: structural challenges, pregnancy decision-making, lack of autonomy, and others’ reactions to the pregnancy. Biggs and colleagues found that experiencing psychosocial burden is associated with mental health symptoms (including anxiety, stress, and depression) overall. Notably, participants were most likely to endorse items related to pregnancy decision-making (ending the pregnancy) and least likely to endorse items related to lack of autonomy; structural challenges such as locating a clinic, travel, and scheduling were also scored comparatively low; these findings likely reflect that this study was conducted in states with greater geographic access to and insurance coverage for abortion. Paying for abortion and other costs were not included in the final scale. Prior research conducted with abortion patients lacking insurance coverage has found that paying for abortion constitutes the largest barrier to accessing care [17–21].

Psychosocial costs such as fear of judgment, interpersonal strain, and stress often have a cyclical relationship to the structural challenges patients may face such as locating a clinic, travel, and costs. Georgsson and colleagues found that patients seeking abortion care in Sweden expressed fears and worries about the abortion process, physical reactions to the procedure, and psychological aspects of the experience [22]. Similarly, family members with antiabortion attitudes can contribute to patients’ fear of social judgment, self-judgment, and a need for secrecy [23], which may lead to interpersonal strain and increased financial burden. Understanding the cyclical relationship between psychosocial costs and structural challenges such as financial obligations, logistical constraints (i.e., travel, scheduling, and waiting periods), and poverty in restrictive abortion contexts in the US can provide a more comprehensive understanding of the costs associated with abortion care.

In this study, we describe Ohio patients’ experiences seeking abortion care. We explore the mechanisms through which abortion restrictions shape the financial, logistical (i.e., travel), and psychosocial costs patients encounter as they seek care, including how financial, geographic, and time-sensitive burdens often yield psychosocial costs. Through this research we hope to broaden our understanding of abortion access beyond legal, financial, and geographic barriers to also explore the psychosocial costs that result as patients navigate their path to abortion care.

## 2. Material and methods

Between June 2018 and November 2019, we conducted semi-structured in-depth interviews (IDIs) with 42 Ohioans seeking abortion care from two clinics in Ohio and one clinic in neighboring Pennsylvania. In Ohio, staff connected patients who expressed interest in participating to an onsite researcher. Patients who sought care in Pennsylvania also contacted researchers via information on the flyer to set up interviews when an interviewer was not onsite. Researchers verified eligibility and obtained consent. Most interviews took place at a clinic while participants

waited for one of their scheduled appointments, but participants could be interviewed up to 2 weeks after their abortion at a location of their choosing. In order to participate in the study participants needed to be 18 years of age or older, live in Ohio, speak English proficiently, and have sought abortion care at a study clinic. We provided each participant a \$50 gift card incentive.

### 2.1. Interview guide

Our IDIs began with an open-ended approach that allowed participants to tell their story in their own words. We then introduced more specific questions about their experience seeking care. Interviews covered participants’ family, work, and living situations; pregnancy circumstances; how the participant found information about abortion and clinics; arranging the abortion; and experiences of social support. Interviews ranged from 60 to 90 minutes and we recorded interviews with permission of participants. Participants completed a short demographic survey at the conclusion of the interview.

### 2.2. Interview team

The interview team consisted of two researchers. Each researcher specializes in qualitative methods and had more than 15 years’ experience conducting in-depth interviews. TCO is a cis-gender, Black woman, and DB is a cis-gender, white woman. Both live and work in Ohio and are between the ages of 40 to 50. Interviewers conducted the first 10 interviews as a team and leveraged their positionalities through self and team reflection throughout these early interviews. Researchers reflected on how their preconceptions and beliefs influenced the interview; this process of reflection was carried out throughout the data collection process. For the remaining interviews, TCO conducted another five interviews in Cleveland and 11 interviews of patients seeking care in Cincinnati alone. DB conducted an additional five interviews in Cleveland and 11 interviews of patients seeking care in Pittsburgh alone. This process yielded a total of 42 completed interviews.<sup>1</sup>

### 2.3. Analytic approach and data management

We uploaded interview recordings to a secure server; graduate students and a professional service transcribed the recordings. Both interviewers and a graduate student verified transcriptions for accuracy. The analysis employed both inductive and deductive approaches [17]. TCO began the coding analysis with knowledge of the existing literature, such as challenges related to travel and financial constraints, identified emergent themes through memoing and discussion among research team members. Coding consisted of a 3-step process. We identified 11 interview domains which covered topics such as finding a clinic and making an appointment, circumstances surrounding the pregnancy and social support shaped our initial organization of codes. Next, we created specific codes based on factors research suggests shapes the experience of seeking abortion care such as travel and financial costs. Once the first two steps were complete, we allowed the data to guide the identification of emergent themes, leading to a more focused coding strategy. The following emergent themes served as a focus for our analysis, (1) fear of judgment, (2) interpersonal strain, and (3) stress. We utilized ATLAS.ti (version 8.4.4) for analysis.

<sup>1</sup> We excluded one Cleveland interview from analysis due to a recording failure, bringing the analytic sample to 41. The team decided that the fieldnotes were insufficient for analysis.

2.4. Ethical considerations

The University of Cincinnati Institutional Review Board approved this study. We removed identifying information from transcripts and assigned pseudonyms to protect participants' identities.

3. Results

The analytic sample contained 19 participants from a clinic in Cleveland, Ohio; 11 from Cincinnati, Ohio; and 11 from Pittsburgh, Pennsylvania [Fig. 1]. All participants identified as cis-gender women, and most were in their 20s [Table 1]. Almost all participants identified as Black (51%) or white (51%). Participants could choose more than one racial category, and 5% did so, making our percentages for racial categories total more than 100%. Thirty four percent reported a previous abortion. A majority had participated in education beyond high school (74%), but fewer had completed college degrees (15%). More than a third (37%) of participants reported income below the federal poverty line. Although 54% had insurance, most participants reported the procedure was not covered by their insurance; only one participant used insurance to cover her care. All participants paid out-of-pocket for their abortion: these payments varied, with a substantial minority (39%) qualifying for financial assistance offered by the clinic. In some cases, this assistance reduced the out-of-pocket expense for the procedure to \$0. Other participants paid over \$800 for their procedure. Half traveled more than 40 minutes to reach the clinic. Participants reported having incurred an average of \$100 in additional costs associated with lost wages, childcare, and travel expenses.

3.1. Psychosocial costs: Fear of judgment

We identified fear of judgment as a psychosocial cost associated with seeking abortion in a restrictive context. Respondents experienced fear of judgment. Some participants anticipated judgment from their friends and family, making it more difficult to utilize their networks for help in navigating the restrictive landscape. For example, Brittany, a 21-year-old Black woman, struggled with the cost of the procedure and travel. Although her father could have provided support, Brittany did not ask him for fear of judgment: “[My father] could’ve been there for me, but he also would have judged me for a long time, if I told him.” Fear of judgment resulted in isolation and fewer options for assistance from family and friends. Others expressed more amorphous fear of judgment connected to their uncertainty about the legal status of abortion: Dana, a 24-year-old white woman, (incorrectly) believed that abortion was no longer legal in Ohio and traveled 85 miles (about a 3-hour drive, roundtrip) to receive care at a clinic in Pennsylvania. She noted that even seeking care in Pennsylvania where she knew abortion was legal “felt like I was doing something illegal



Fig. 1. Locations of study recruitment sites in Ohio and Pennsylvania.

Table 1

Demographic characteristics and travel times of 41 abortion patients from Ohio.

	n (%)
Age	
21–25	17 (41)
26–30	17 (41)
31–35	5 (12)
36–40	2 (5)
Ethnicity	
Spanish, Hispanic, Latina	2 (5)
Not Spanish, Hispanic, Latina	39 (95)
Race <sup>a</sup>	
American Indian or Alaska Native	1 (2)
Asian	1 (2)
Native Hawaiian or Pacific Islander	0 (0)
Black or African American	21 (51)
White	21 (51)
More than one race	2 (5)
Gender	
Cis-gender women	41 (100)
Another gender	0 (0)
Education	
0–11th grade	2 (5)
High school graduate or GED	9 (22)
Some college or Associate's degree	24 (59)
College graduate or more	6 (15)
Household income	
Under \$9999	9 (22)
\$10–\$29,999	10 (24)
\$30,000–\$49,999	9 (22)
\$50,000 or more	13 (32)
Travel time to clinic (one way)	
15 min or less	13 (32)
16–30 min	6 (15)
31–45 min	5 (12)
46–60 min	8 (20)
61–120 min	5 (12)
Over 2 h	4 (10)
Previous abortion	
Previous abortion	14 (34)
No previous abortion (or not reported)	27 (66)
Insurance holders <sup>b</sup>	
Yes	22 (54)
No	19 (46)
Financial assistance (clinic)	
Yes	16 (39)
No	25 (61)

<sup>a</sup> Participants could choose more than one racial category, and 5% did so, making our percentages for racial categories total more than 100%.

<sup>b</sup> This value reflects participants that indicated carrying some form of health insurance. This value does not reflect whether insurance was used to pay for their procedure.

and wrong,” illustrating the way fear of judgment can persist beyond restrictive settings. In Dana’s case, misunderstanding of abortion legality also resulted in higher travel costs as she travelled further than she needed to for care.

3.2. Psychosocial costs: Interpersonal strain

Study participants commonly reported interpersonal strain – conflict, discomfort, or disengagement in relationships – in their efforts to secure abortion care. In some cases, interpersonal strain stemmed from participants’ need to cover abortion-associated financial costs. Jaqueline, a 32-year-old white woman, described how the expenses associated with her abortion created tension in her relationship: “You know it just puts like a lot of strain between my husband and I.” Jacqueline then detailed how the financial setback challenged the couple and exacerbated her husband’s emotional absence:

Like trying to play catch up financially, it’s just a setback and he’s just like, I feel like we can’t catch a break. Once the dust settles, I think he’ll probably be a little more emotional about it, but

right now I think it's just he's very irritated at what it's [financially] costing us.

Financial costs created emotional consequences for the couple. While Jacqueline was optimistic that her husband's irritation and emotional disconnect would subside, she received less support from him than she wanted at the time of the procedure.

Other participants were less optimistic about their relationships surviving the strain. Nicole, a 24-year-old Black woman, was seeking an exit from an abusive relationship. She would have preferred not to tell her boyfriend about her pregnancy or her procedure, but because she needed a ride to the clinic, Nicole had to reveal her abortion to him. While this disclosure enabled her to get to the clinic, the ride took an emotional toll:

This morning his emotions have been through the roof, and it's frustrating and I'm trying to make the best of the circumstance and he's acting like a child, so ... [pause] it doesn't really help the situation at all.

Though Nicole spoke about not wanting to be tied to her partner any longer, disclosing her pregnancy and obtaining his help to get care created unwanted proximity, both physically and emotionally. Nicole's disclosure extended her connection to a violent man. While the significant financial and travel costs can be easily measured, the consequences of Nicole's compromised privacy and her boyfriend's "childishness" (and his ability to disclose her abortion to others) are harder to quantify, yet significant to her well-being.

### 3.3. Psychosocial costs: Stress

The overwhelming majority of our sample described stress associated with securing abortion care.

Many struggled with the cost of their abortion and the financial toll it imposed on their families. Nina, a 28-year-old Black woman who reported an income of less than \$9999, sold her food stamps in order to raise cash for her \$380 procedure. Nina expressed guilt over having to choose between feeding her family or paying for her abortion, but believed that the long-term consequences of carrying a pregnancy to term would pose an even greater threat to her family. Stacy, a 23-year-old Black woman, also with an income below \$9999, reported that paying for her care "would add another stress to herself" beyond her decision to terminate. To cover her procedure, Stacey had to donate plasma multiple times; she recalled the stress of seeking care taking a toll on her body, "There were a couple of times where my blood pressure was too high to donate, and I would have to wait another day to come back because of the stress."

Economic challenges were especially stressful because access to care was time-sensitive, given Ohio's 22 LMP gestational limit at the time of data collection, and because the cost of care increased over time. Keisha, a 29-year-old Black woman, sought abortion care at 8 weeks, but she did not have enough money. She returned with funds at 12 weeks, to learn that not only had the cost of the procedure increased with pregnancy length, but also that she had developed a medical condition that required her to seek care at a different facility in a more distant city, before referring her back to her original care site. Keisha ultimately obtained her abortion at 20 weeks 3 days LMP, and she described the sequence of events leading to her abortion – raising money, attending seven appointments, traveling between two cities about 4 hours apart, drawing closer to the state limit – as "stress."

Like Dana (mentioned earlier), Monica, a 26-year-old white woman, crossed state lines for her abortion. Although the closest Ohio clinic was less than 30 miles from her home, she wanted to avoid Ohio's requirement for multiple clinic visits and other delays in care rooted in regulations. The 24-hour mandatory waiting period for Ohio required two in-person visits, while Pennsylvania al-

lowed abortion providers to provide mandated information by telephone 24 hours to the abortion, necessitating just one visit. Monica drove about an hour to receive care in Pennsylvania.

I feel as though if I could have had it done here [in Ohio], kind of under the same way they do it there [in Pennsylvania], I could have had it done sooner and it just would have been a lot less planning and stress and everything else.

Participants who lived more than an hour away from their care site reported more significant travel expenses. Traveling expenses included gas, motel, and vehicle depreciation. Michaela, a 27-year-old Black woman who reported a total household income of less than \$9999, expected to incur expenses for overnight stays and depreciation:

I don't live here, so then we have to drive 2 hours and 20 minutes home to drive back, wear and tear on the car, and then it's like okay, if they do it tomorrow, then we're gonna try to get a motel somewhere close.

If she found a motel near the clinic, Michaela would drive nearly 5 hours roundtrip; if she returned home between the two appointments, her travel time (and associated costs) would double. Michaela's experience sheds light on the complexity of monetary and time costs associated with mandatory waiting periods; either option was expensive, which frustrated her and contributed to her feelings of stress, while seeking abortion care. When asked about the impact of mandatory waiting periods Michaela responded, "I'd prefer to do it all in one day. It's stressful."

## 4. Discussion

This study documents the psychosocial costs associated with Ohioans' seeking abortion care. Their stories painted a complex picture of the psychosocial costs they incurred in the process of obtaining care. Ohioans seeking abortion care often experienced stress, fear of judgment, and interpersonal strain as a result of efforts to meet financial, geographic and time sensitive requirements for their procedures. These psychosocial costs are interrelated, contributing to burdens that could persist well after the abortion. For example, when low-income patients stretched their finances to cover their care in the absence of insurance coverage, they often experienced stress and sometimes even interpersonal strain when they sought help. These stories highlight how one type of cost begets others.

Psychosocial costs may disproportionately affect patients who live in restrictive locations with less accessible care and have the need to travel for abortion care. Our data illustrate that the challenge of paying for abortion expenses carries significant consequences and hidden psychosocial costs that put strain on interpersonal relationships. The financial challenges are coupled with a complex set of consequences and psychosocial costs that can make abortion access more difficult.

To our knowledge, no other study has evaluated Ohio patients' experiences of psychosocial costs, and the connections between psychosocial, financial, geographic and time-sensitive costs. A growing body of literature shows how changes in regulatory environments shape the hurdles patients experience in obtaining abortion care [24–26]. These studies found that limited clinic options increase travel distances, delays, and costs for patients, and may impede access to care for some patients. Less attention has focused on the psychosocial costs that can occur alongside, and sometimes resulting from, these other challenges. Moreover, by situating our study in a landscape of limited services and inadequate financial coverage, we found that lack of autonomy (especially needing to disclose the pregnancy and/or the abortion) and structural challenges (especially needing to locate, travel to, and pay for

care) were more prominent in Ohioans' accounts of the psychosocial costs associated with care seeking in relation to decisional processes than are identified in Biggs and colleagues' study of less restrictive settings. The prominent association of financial challenges with added stress is particularly notable because our sample was less likely to have an income under the poverty line than a nationally representative sample [27]. Consequently, Biggs and colleagues may consider retesting their PB-SAS scale in more restrictive environments or with patients traveling from restrictive states to more supportive states, especially to reassess the role of structural challenges such as locating a clinic, travel, and scheduling. By documenting and assessing patients' psychosocial costs we can more fully understand patients' experiences seeking abortion care.

#### 4.1. Limitations

We cannot calculate a response rate for this study, nor did we ascertain reasons why potential participants decided not to participate. Although qualitative approaches can provide insight into the experiences and mechanisms associated with social processes, they are not designed for generalizability [28]. We interviewed participants at various stages in their abortion process, for example, most participants seeking care in Ohio were pre-abortion and all Pennsylvania participants were post-abortion, we choose not to discuss comparisons of sites because the differences in interviewing did not yield meaningful differences in psychosocial costs by participants' paths to care. This study captured the experiences of only those participants who overcame the barriers of Ohio's restrictive abortion landscape to reach a clinic. Including voices of those unable to overcome barriers to care could shed light on the intersection of psychosocial, financial, geographic and time sensitive barriers that preventing people from receiving abortion care.

This research describes the relationships among various costs encountered among participants living in Ohio who seek abortion care. We found that participants seeking abortion care experienced financial burdens, delays in care, and increased travel distances; associated with these challenges are psychosocial costs, such as fear of judgment, interpersonal strain, and stress. The psychosocial costs and consequences of increasingly restrictive policy environments are multifaceted. For example, if Ohio's Medicaid covered abortion, it could mitigate many patients' financial burden, speed access to care, and thus the consequent stress and interpersonal strain. This research focuses on the impact abortion regulations have on the psychosocial costs to patients' care-seeking experience in a hostile state that has since become even more restrictive, requiring even more Ohioans to travel to neighboring states for care and to incur greater psychosocial costs. Future research should consider the psychological consequences of reduced access to abortion care in a post-Dobbs context.

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