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Original Research Article

Exploring the emotional costs of abortion travel in the United States due to legal restriction ☆,☆☆

Katrina Kimport*, Maryani Palupy Rasidjan

Advancing New Standards in Reproductive Health, University of California, San Francisco, Oakland, CA, United States

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ABSTRACT

Objectives: Pregnant people have traveled across state and national borders for the purpose of abortion since at least the 1960s. Scholarship has robustly documented the financial and logistical costs associated with travel, but less work has examined the emotional costs of abortion travel. We investigate whether abortion travel has emotional costs and, if so, how they come about.

Study design: We conducted in-depth interviews with 30 women who had to travel across state borders in the United States for abortion care because of their gestation. We analyzed findings thematically.

Results: Interviewees described having to travel to obtain abortion care as emotionally burdensome, causing distress, stress, anxiety, and shame. Because they had to travel, they were compelled to disclose their abortion to others and obtain care in an unfamiliar place and away from usual networks of support, which engendered emotional costs. Additionally, travel induced feelings of shame and exclusion because it stemmed from a law-based denial of in-state abortion care, which some experienced as marking them as deviant or abnormal.

Conclusions: People who have to travel for abortion care experience emotional costs alongside financial and logistical costs. The circumstances of that travel—specifically, being forced to travel because of legal restriction and service unavailability—are foundational to the ensuing emotional burdens. Findings add to the emerging literature on how laws and other structures produce the stigmatization of abortion at interpersonal and individual levels.

Implications

With abortion bans following the overturning of the right to abortion and existing gestational limits in the US, more people will have to travel for abortion care. Attention to the emotional costs of abortion travel can help providers understand what their patients may be experiencing when they present for care.

1. Introduction

Women and other people who can become pregnant have traveled across state and national borders for the purposes of abortion since at least the 1960s, and they continue to do so in contemporary times [1–4]. Broadly, abortion seekers travel for care because of legal restriction and service unavailability—as opposed to, say, seeking lower cost or higher quality care, which may motivate other forms of medical travel [1–16].

Having to travel for abortion care is burdensome. A robust body of evidence shows that both international and domestic travel compel financial and logistical burdens, including costs related to gas and/or airline tickets, lodging, childcare, pet care, and lost wages [2]. Less scholarship has explored the emotional costs of abortion travel. Recent research that has articulated emotional costs of international abortion travel compelled by legal restriction or service unavailability finds that travel—or even the idea of having to travel—can be emotionally upsetting and inspire additional feelings of shame and stigma related to the abortion [9, 11]. Research on the emotional costs of travel for abortion seekers in the

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* Corresponding author.
E-mail address: katrina.kimport@ucsf.edu (K. Kimport).

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United States (US) finds similar effects [17]. Other work focused on the US has documented how having to travel can exacerbate existing psychosocial costs associated with obtaining an abortion [18]. To date, however, the research on abortion travel has not deeply investigated these emotional costs and how they come about.

Following the US Supreme Court's June 2022 overturning of the constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*, the number of women and other people who can become pregnant in the US who must travel for abortion care and the distances they must travel will increase [19]. Even in US states where abortion remains legal, gestational limits force some abortion seekers to travel to obtain care. This makes further investigation into how abortion travel produces emotional costs of pressing research interest. Drawing on interviews with 30 cisgender women in the US who had to travel out of their home state because of gestational limits to obtain abortion care (before *Dobbs*), we examine the emotional costs abortion travel exacts and the mechanisms underlying them.

2. Methods

We report study methods in detail elsewhere [12]. Briefly, between September 2016 and June 2018, this study recruited people who had obtained an abortion after the 24th week of pregnancy via a flyer shared with (1) pregnant people turned away because of gestational duration from 3 clinics in the Southeast, (2) patients obtaining abortions after 24 weeks of pregnancy at a clinic that provides abortion throughout pregnancy, and (3) members of an online support group for people who aborted a pregnancy following an observed serious fetal health issue. The flyer described the study as investigating the experience of seeking and obtaining an abortion after the 24th week of pregnancy and included a toll-free phone number. To encourage potential participants to call and learn about the study, we offered all callers a $10 gift card regardless of eligibility or agreement to participate.

KK screened callers for eligibility, confirming that they were 18 or older, comfortable completing the interview in English, and had obtained an abortion after 24 weeks gestation. She completed an oral consenting process with all interested and eligible callers and scheduled them for an in-depth phone interview at a time convenient to them. All eligible callers chose to participate in an interview.

KK conducted the interviews, utilizing a modified version of the timeline interview methodology in a semi-structured format that allowed both the interviewer and participant to introduce topics [20]. By the end of the interview, participants had shared their experience of pregnancy, pregnancy decision making, seeking an abortion, and obtaining an abortion, including the experience of travel for abortion care.

We audio recorded the interviews, which averaged about 100 minutes in length, and offered participants a $50 gift card to thank them for their time. The Institutional Review Board of the University of California, San Francisco approved all study protocols.

2.1. Analysis

A professional transcription company transcribed the interviews verbatim. KK coded all transcripts using a flexible coding approach in ATLAS.ti 7 [21]. We exported all excerpts coded as related to travel. The initial travel code was expansive, including any discussion of travel to any healthcare provider. Given our focus on travel for abortion care, KK then reviewed these transcripts and excluded excerpts not about physically getting to or from an abortion care provider who offered abortion care after the 24th week of pregnancy. Both authors then subcoded the remaining excerpts using grounded theory techniques, with emotional effects as a sensitizing concept [22]. We did much of this subcoding collaboratively, in active discussion, which allowed us to identify and resolve disagreements and capture emergent themes as we reviewed the data in real time. We considered coding complete when no new codes emerged.

Below, all names are pseudonyms and reported age is age at the time of the interview, which may differ from age at time of abortion.

3. Results

3.1. Sample characteristics

Thirty cisgender women, ranging in age from 18 to 43, completed an interview. Twenty identified as white, 5 as Hispanic or Latina, 3 as Black or African American, 1 as Asian, and 1 as biracial (Asian and white). In terms of educational attainment, most (n=21) had at least some college education. Most described themselves as able to meet their basic financial needs, though 9 were unemployed at the time of their abortion. Participants traveled to 5 different facilities from 14 different US states. They spent at least two and as many as 8 nights away from home. Most (n=19) flew to their facility, driving up to 3 hours to get to the airport and then flying between 2 and 6 hours 1 way. The remaining 11 drove, with 1-way travel durations ranging from 9 hours to 2 days.

3.2. Emotional stress of navigating disclosure

Participants reported that having to travel complicated their ability to keep personal information private, which, for many, resulted in emotional costs. Caroline, a 23-year-old white woman in the South, for example, did not want her parents—particularly her mother—to know about her pregnancy or her abortion. However, her mother used a tracking app to follow Caroline. Caroline explained, "She has a tracker on my phone, so that she knows where I am all the time. (…) I couldn't go out of state or even out of my apartment without her knowing about it." Caroline described feeling "desperation" about having to travel for abortion care, given her mother's surveillance. Ultimately, Caroline disclosed her abortion plan to her father, who agreed to turn off the tracker and lie to her mother about the tracker being broken. Telling her dad carried an emotional penalty. He told her, "'I'm disappointed in you.'" That hurt Caroline, but she reasoned that she had no choice since having her mother know would have been worse.

For some participants, travel meant they had to disclose information to their workplace that they otherwise would have kept private. Travel for abortion care entailed taking time off from work, in addition to the time off required for the abortion itself. Carrie, a 33-year-old white woman in the South, had to explain to her supervisors why she needed the time. Although she noted that her medical information is ostensibly private, she said, "(I) feel like (my work) makes you divulge your personal information (…) They say, 'Well, don't reveal any personal information,' but in a way, you have no choice but to." Because Carrie had to travel, other people in her life had to learn of her abortion, even as she preferred that they did not. For example, her husband disclosed Carrie's abortion to his ex-wife: "he had to text her and tell her that he wouldn't be able to pick his son up that night and he tells her why." Broadly, Carrie said that the overall experience of having to disclose her abortion to so many people "just makes me feel violated."

Others described how having to travel out of state changed the timing of their disclosure to close family and friends. Julie, a 43-year-old white woman in the South, said that she likely would have shared her abortion experience with several of her close friends, but would have done so "a little more after the fact than

right at the beginning of it." However, because she needed a dog sitter and a car that could reliably make the 12-hour drive to the clinic, she had to share her abortion plan with several friends and family members earlier than she preferred in order to get the help she needed. This was uncomfortable for Julie**.** She explained, "I'm not one of these people that wants a whole bunch of people (saying) 'oh, you poor thing.' (Because) I'm handling my business." Telling even close friends before she wanted made her feel dependent and not in control.

3.3. Emotional burden of going to an unfamiliar place

Few participants had previously traveled to the city where their abortion provider was located, and several emphasized how different their destinations were from anything they had known before. Cristina, an 18-year-old Hispanic woman in the South, was from a small town and had never left her home state before. She described feeling overwhelmed because the clinic was in "a big, large city. I've never been there, so I don't know how anything was going." Britany, a 27-year-old Black woman in the South, who similarly had never left her home state, said, "I was honestly terrified, just because I've never been there before." She elaborated that travel is "a big thing for me" and that it is very important to her to "be (…) aware of my surroundings. (…) I didn't know where anything was. I didn't know the people. It was just weird. It just was like, I'm not near home at all whatsoever."

Participants with more travel experience also found their abortion travel stressful. Amy, a 40-year-old white woman in the Midwest, said, "(I)t was very stressful having to plan that trip and get there and be away from everyone and everything I knew." Similarly, Deborah, a 42-year-old white woman in the West, was both overwhelmed by the newness of the city and the work of having to navigate that newness, figuring out food, transportation, and accommodations. She stated, **"**I do know that the component of having to get on an airplane, travel to another city (…) and then get on a plane and come back home—I would not wish that on my worst enemy."

Other participants talked about what having to travel made them leave behind, including family, friends, and support networks. Monique, a 30-year-old Black woman in the South, for example, had to travel alone because she could not afford the cost of having a support person fly with her. She described feeling "nervous" prior to travel and said that she initially wished she had someone with her during travel and at the clinic. Rosa, a 25-year-old Hispanic woman in the West, too, had to travel alone because the cost of travel was so high. She explained, "It was scary because I was alone (…) and I wanted to go home." Cost was not the only impediment to participants' support persons being able to join them. In one participant's case, her boyfriend did not have enough vacation days at his job to be able to travel with her: Olivia, a 25-year-old white woman in the South, explained, **"**He didn't have as many vacation days as I did. He had to go back to work." Had she been able to get care locally, he would have been able to be with her during his non-work hours.

In addition to being separated from their existing support networks, some participants had to rely on strangers to meet their basic needs. Sometimes, this did not work out as intended and led to emotional distress. Camryn, a 30-year-old Black woman in the South, for example, traveled to a state where she knew, as she said, "nobody." Through a local abortion fund, she was connected to volunteers who would house her, feed her, and accompany her to and from the clinic. She was appreciative. Still, it was emotionally overwhelming. As she said, "(I)t was a little disturbing because I've never even been to (city) – and then to stay with people that I didn't know was really scary." After her abortion, for reasons that were never explained to Camryn, the volunteer who was supposed to pick her up was more than 4 hours late. By that point, the clinic had closed, and Camryn had to wait in a nearby coffee shop. She felt panic. She said, "I didn't know she was coming. And I was, like, maybe she's against, you know, women having abortions. And she's doing this on purpose. Like, a lot of things just are running through my head."

3.4. Emotional burden of denial by law

For some respondents, the simple fact that they were denied abortion care in their home state had emotional consequences. For Tonya, a 37-year-old white woman in the South, for example, the necessity of going outside of her existing healthcare system to obtain an abortion inspired feelings of uncertainty about the morality of her abortion. She said,

> [T]o have had it done in [my] hospital, for me, I wouldn't have had such a journey to get the medical validation. Because if you're in a hospital, you're kind of automatically assuming that this is a normal situation, because you're in a facility, and they're doing a procedure that they're all trained in and knowledgeable of. And so, that uncertainty would have been off my plate. […] I would have automatically had the validation.

As she summed up later, "(I)f it had been an (in-state) hospital situation, I don't think it would have felt so abnormal." Other respondents similarly underscored how being forced to travel for care constructed their abortion as "not normal." Rachel, a 46-year-old white woman in the Northeast, argued that being forced to travel was "inhumane because I couldn't be treated at a normal hospital with normal, you know, care and attention," implying that having to travel out-of-state for care, in contrast, marked it as abnormal or deviant and brought with it ensuing feelings of stigma.

Some participants initially interpreted their in-state provider's refusal to perform an abortion to mean that the procedure itself was dangerous, causing them worry. Chara, a 29-year-old Asian woman in the south, described such a fear: why, she and her husband wondered, wasn't it offered by doctors in their home state? Even after talking at length by phone with counselors at the clinic, Chara was "worried how it's going to turn out, and all those worries were with me" on top of having to come to terms with just having learned that her wanted pregnancy carried a fetus with a heart defect that meant it could die in-utero at any moment.

Several participants further described how the legal origins of them being denied abortion care were central to the emotional costs of travel. Ashley, a 35-year-old white woman in the Northeast, used the language of being "cast out" of her hospital and her state when she needed abortion care. Similarly, Amy (introduced above) explained that learning her care providers could not offer her an abortion due to state law made her "feel very let down by my state and by the government." As Eliza, a 35-year-old white woman in the Northeast, reflected, of her state's gestational limit law, "It's forcing shame and stigma on you during what is already the worst moment of your life (of learning your fetus is unhealthy)." Eliza was pointedly clear that the source of the negative emotions she and her husband experienced was state law, not their social networks and not their prenatal team: "At no point did anyone that we knew personally try to put shame on to us—it was the state, but no one that we knew and loved did."

The legal origins of these denials also contributed to presumptions in some participants' social circles that such denials must be for a good reason. In turn, members of these social circles would question participants' abortion decisions, not only withholding the emotional support participants sought but also undermining participants' emotional confidence in their decision. Veronica, a 21-year-old Hispanic woman in the West, recalled her friend discouraging her from traveling to obtain an abortion: "And she was the

one telling me, there's a reason why you can't do abortion after 24 weeks, or why you shouldn't. And she didn't know anything about it." Her friend's trust in law and institutions caused her to presume a legitimate reason for the denial and therefore to question Veronica's judgment and withhold the emotional support Veronica sought.

4. Discussion

Our findings build on existing research to document how being forced to travel for abortion care causes emotional burdens [9,11,17]. This study both documents these emotional costs and unpacks some of the mechanisms behind them, identifying how the circumstances of that travel—that is, being forced by legal restriction and service unavailability—are foundational to ensuing emotional burdens. Because participants had to travel, they were compelled to disclose their abortion to others and obtain care in an unfamiliar place and away from usual networks of support, which engendered emotional costs. Additionally, travel induced feelings of shame and exclusion because it stemmed from a law-based denial of in-state abortion care, which some experienced as marking them as deviant or abnormal. These findings add to the robust literature documenting the burdens of forced abortion travel both within the US and internationally as well as the emerging literature on how laws and other structures produce the stigmatization of abortion at interpersonal and individual levels [2,4,6,8–12,14–17,23,24].

Attention to the specific emotional costs of forced travel can help providers understand what some of their patients may be experiencing when they present for care. With the overturning of the constitutional right to abortion in the US, more abortion seekers will have to travel longer distances for abortion care, meaning many of the facilities that remain open will see a shift in their patient population [19]. In states where abortion remains legal, some abortion seekers will nonetheless have to travel because of gestational limits or service unavailability. Our findings may also inform efforts to reduce the burdens of travel for abortion seekers. Absent the elimination of policies forcing travel, non-policy-based actions such as offering non-judgmental, compassionate emotional support may reduce the emotional burdens of forced abortion travel for some people [13]. Future research should examine interventions to reduce the emotional costs of travel for abortion care.

There are several limitations of our findings. Because our study investigated the experience of people seeking abortions later in pregnancy, we could expect different experiences for abortion seekers traveling for abortion earlier in pregnancy. Additionally, while most interviewees completed their abortion within 1 year of the interview, more time had passed for some between their abortion and the interview. Aspects of travel and/or their recollection of the emotional experience of travel may have changed, limiting the transferability to the contemporary moment. We also note that this study focused on interstate travel in the US and the findings may not be transferrable to abortion seekers who travel across national borders. Finally, most of the participants in this study were white, highly educated, and financially stable. To the extent that people of color and people living on low incomes are disproportionately likely to be pregnant when they do not want to be and, in a post-*Dobbs* US, more likely to be forced to travel for abortion care, future research should investigate whether and how race and class matter for the emotional costs of abortion travel [25].

This analysis demonstrates that having to travel to obtain abortion care entails emotional costs. Our findings illustrate how the fact that this travel is forced by legal restriction is part of what produces those emotional costs. Abortion seekers may choose to travel for abortion care for many reasons and emotional harm is not inherent to traveling. However, as our analysis shows, travel does have emotional costs for some patients, especially when they have no choice but to travel in order to obtain the care they need.

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