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Protecting marginalized women's mental health in the post-Dobbs era

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As the nation comes to grips with the ramifications of the Supreme Court's abortion ruling, the need for mental health support, especially among women who are already underserved, has come into sharp focus. Image credit: Shutterstock/Johnny Silvercloud.

In the wake of the *Dobbs v. Jackson Women's Health Organization* decision and its overturning of the constitutional right to an abortion in the United States, much attention has been focused on the immediate consequences of reduced bodily autonomy. There has been less attention on the mental health toll that is bound to follow. Indeed, American Psychological Association President Frank Worrell warned that this Supreme Court decision—and the ensuing restrictions on safe abortion—would exacerbate America's mental health crisis (1), already brought into sharp focus by the coronavirus disease 2019 (COVID-19) pandemic. As the ramifications of this Supreme Court decision ripple outward, the damage to the mental health of women, particularly women who are already underserved, must be addressed by expanding access to mental health services and integrating such support directly into reproductive care.

Most women who have abortions in the United States are racial and ethnic minorities or of low socioeconomic status, so these restrictions will most severely impact already marginalized populations. Black women, in particular, may be at the highest risk because they are less likely to seek out and receive mental health care (2) and five times more likely to obtain an abortion than their White counterparts (3). Our history is rife with attempts to control minority women's bodies, from raping enslaved women to 20th-century eugenics programs targeting more than 100,000 Black, Hispanic, and Indigenous women (4). The intergenerational legacies

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of these atrocities compound the psychological assault of restricting abortions today.

Twenty-six states have passed abortion laws that are classified as either "hostile" or "illegal" by the Center for Reproductive Rights (5), with at least 15 states having no exceptions for rape or incest, forcing survivors to take their pregnancies to term (6). Critically, the most marginalized women are the most likely to have survived sexual violence: Women with annual household incomes less than $7,500 are 12 times more likely to report sexual assault or rape than women with household incomes over $75,000 (7). Furthermore, 21.2 percent of Black women, 27.5 percent of Indigenous women, and 32.3 percent of multiracial women are raped during their lifetimes, relative to 20.5 percent of White women, according to the 2011 National Intimate Partner and Sexual Violence Survey (8). Although there is no scientific evidence that legal abortion of an unwanted pregnancy imposes a psychological hazard, denying access to abortion can lead to lower life satisfaction, lower self-esteem, and increased anxiety (9). Indeed, having to endure forced childbirth can take a significant psychosocial toll on the traumatized mind of a rape or incest survivor or, for that matter, any sexually active woman who is not prepared for parenthood.

Although there is no scientific evidence that legal abortion of an unwanted pregnancy imposes a psychological hazard, denying access to abortion can lead to lower life satisfaction, lower self-esteem, and increased anxiety.

Banning abortion also does not decrease the rate of abortions, instead opening the door to unsafe and costly alternatives. Indeed, Ralph and colleagues found that women living below 100% of the federal poverty level have a threefold higher prevalence of self-managed abortions than women living at or above 200% of the federal poverty level (10). Disparities in accessing abortion within the formal healthcare system may partially explain these findings. In 2017, women living in rural areas of seven Republican states had to travel more than 180 miles to reach the nearest abortion clinic (11). Black, Indigenous, and Hispanic women, who earn 64, 60, and 57 cents for every 79 cents paid to White women and every dollar paid to White men (12), are less financially able to make such trips, forcing them to either take their pregnancies to term or drain their savings to get an abortion. Neither choice is viable because, healthcare costs aside, raising a child imputes long-term costs for food, shelter, and other necessities. The significant financial stress of abortion-related travel and mandatory parenthood can also cause anxiety and reduce recovery rates for common mental health conditions. Of patients with depression, those with financial difficulties were 4.2 times more likely to still have depression at 18 months follow-up when compared to those without financial problems (13). Wealth will largely determine who can get an abortion, with low-income and uninsured patients precluded and marginalized women disproportionately impacted by economic distress.

Finally, the criminalization of abortion will further stigmatize women who terminate their pregnancies and place them under constant fear of legal repercussions. Concealing and revealing one's abortion history have long been associated with adverse psychological consequences. In fact, in 2020, Biggs and colleagues found that around 60 percent of women expected to be stigmatized in the event that people close to them, or members of their community, knew they had sought an abortion (14). Stigma operates on three primary levels: individually with internalized shame, interpersonally with other's discriminatory attitudes, and structurally with cultural norms, institutional policies, and laws. With legal protections behind a woman's right to choose stripped away, stigma at all these levels—and the double bind of not being able to safely conceal or reveal one's abortion history—will be exacerbated. Given potential liability among those who "aid and abet" abortions, there will likely also be limited support from healthcare providers and social networks, forcing patients to consult online resources and go it alone.

But consulting these resources could add to the danger, with data in period trackers, search histories, private text messages, and more being subpoenaed in lawsuits against women who get abortions. In 2015, for instance, Purvi Patel, an Indian woman living with her disabled grandparents, was sentenced to 20 years for feticide and child neglect after self-inducing an abortion. The primary evidence used by the state of Indiana was text messages Patel sent to a friend about ordering abortion pills (15). In a similar 2017 case, Latice Fisher, a Black mother of three from Mississippi, was charged with second-degree murder based on her online search history on how to "buy Misoprostol Abortion Pill Online" (16). And, over the past decade, "fetal assault" legislation has been weaponized to disproportionately prosecute women of color and almost exclusively poor women (17). *Roe v. Wade* had enshrined a right to privacy, but with this landmark decision overturned, women seeking abortions will be left increasingly targeted, living under constant fear of surveillance and prosecution.

The *Dobbs* decision will exact enduring damage to the health and well-being of all women, especially marginalized women. Unprepared mothers will be forced to carry their pregnancies to term, face immense financial stress via abortion access and mandatory motherhood, and be left increasingly isolated and scrutinized under the veil of criminalization. We recognize that mental health has long been underappreciated and underfunded in the United States, but this is no excuse. The status quo must not be accepted as inevitable.

With the Hyde Amendment restricting Medicare and Medicaid abortion coverage and state restrictions on coverage in health insurance exchanges and private plans (18), abortion funds have become critical tools to remove financial and logistical barriers for marginalized women accessing reproductive care. Primarily sustained by individual donations, these funds help cover the costs of the procedure itself and often also out-of-pocket expenses like transportation, lodging, and childcare (19). Emotional support is occasionally covered, with the New Orleans Abortion Fund being one example (20), but mental health

services, more broadly, are often considered a "luxury" and neglected given these funds' limited financial resources. We must recognize, however, that mental health is as salient as any other aspect of physical health and, in the post-*Dobbs* era, is all the more critical to quality abortion care. As facilitators of such care, abortion funds are uniquely positioned to integrate mental health care into their services. Whether through renewed fundraising, partnerships with existing mental health nonprofits, or other measures, they should be offering this support.

Federal leadership can also help ensure sufficient mental health support for women facing abortion restrictions. Given the national shortage of mental health providers in the United States, especially in Republican-led states (21, 22), one promising avenue to address access concerns might be facilitating telemedical mental health services through reciprocity agreements. Indeed, during the COVID-19 pandemic, many states issued cross-state telehealth waivers, allowing providers in one state to care for patients in another (23). Although many of these policies are now being rolled back, the federal government can encourage continued implementation with federal funding and, in the case of Medicare, mandate licensure reciprocity such that a Medicare provider can provide telemedical services to beneficiaries in any state (23). This policy is already in place for the Veterans Affairs health system and, if framed broadly as a way of supporting access to mental health care, can help women seeking an abortion without being seen as a partisan proposal.

President Biden's recent executive orders to protect access to safe abortion and sensitive health information, ensure emergency medical care, and offer financial assistance to low-income women who must travel for abortions are all critical steps toward supporting a woman's right to choose (24, 25). But as the battle to restore reproductive rights continues in earnest, we desperately need policies that reduce harm, especially when it comes to mental health.

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