Evaluating the Relationship between Socioeconomic Status and Mental Health after Abortion

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ABSTRACT

Despite the legalization of abortion in the United States over 40 years ago, the debate regarding the morality of abortion continues to this day. In more recent years, there has been a shift in focus in the anti-abortion movement that brings potentially detrimental mental health impacts to the forefront. Overwhelming evidence supports that abortion does not necessarily lead to poorer mental health and that if poorer mental health is observed, this is likely the result of prior sociocultural factors. Despite this overarching finding, the link between socioeconomic status and mental health after abortion has not been adequately studied. This review integrates the findings from critical research reviews and studies regarding abortion, mental health, healthcare inequities, and sexual education.

I suggest that due to societal burdens on women with lower socioeconomic status (SES), from lack of access to proper medical care to heavy stigmatization of abortion, it is likely that lower SES correlates with decreased mental health after an abortion. Blanket studies regarding the effects of abortion on mental health cannot account for the diverse patient population and the complex sociocultural factors, and more research must be conducted to better understand the relationship between the social context of abortion, mental health, and abortion.

INTRODUCTION

Over 40 years after the 1973 landmark case of *Roe v. Wade*, moral and legal controversy continues to exist surrounding abortion. The abortion debate is often fueled by the misuse of research by citing only select pieces that forward the desired agenda. More recently, as potential detrimental mental health impacts of abortion are being brought to the forefront of the controversy, abortion opponents maintain that abortion induces greater emotional harm than childbirth; however, a critical literature review concluded that poor mental health observed after abortion is usually due to the surrounding sociocultural environment or preexisting conditions.[1]

The arguments against abortion center on moral and religious reasoning, often asserting that abortion is not only wrong, but also harms women physically and psychologically, a postulate that has been repudiated by major mental health associations for decades.[2] For example, the widespread "post-abortion traumatic stress syndrome," often cited by anti-abortion activists, is not recognized by the American Psychological Association or the American Psychiatric Association.

[1] Brenda Major et al., "Abortion and Mental Health: Evaluating the Evidence," *American Psychologist* 64, no. 9 (2009).
[2] Susan A Cohen, "Abortion and Mental Health: Myths and Realities," (2006).

In 1987, President Reagan directed U.S. Surgeon General Everett Koop, known for his anti-abortion views, to review the scientific literature on the health effects of abortion. With little experience in public health, many were opposed to his appointment and believed the results of the report to be preordained. However, Dr. Koop was very thorough in his analysis and concluded that the reports were inconclusive and that the public health effects of abortion were "minuscule."[3]

Despite the lack of evidence supporting detrimental effects on the mental health of women after abortion, there may still be significant differences in the mental health of women of differing socioeconomic status (SES) who have sought an abortion. This topic has not been specifically studied in the past; however, integrating the results from several peer-reviewed articles suggests that the mental health of women after an abortion is dependent on access to resources and the sociocultural environment in which abortion is sought.

ABORTION AND MENTAL HEALTH

Access to resources

Public policy decisions often play an essential role in determining access to abortion resources as well as *which women* have access. Greater access to abortion providers, financially, socially, and geographically, has a significant positive correlation with state abortion rates, while abortion costs and abortion rates have a significant negative correlation.[4] Access to family planning clinics also exhibits a significant positive association with abortion rates. These trends suggest that women would be more likely to seek an abortion if they had the resources to do so. Deterrents created using state policy, or funding cuts can result in a decrease in the reported rate of abortion for a state; however, this does *not* indicate that the need for abortion necessarily decreases.

In the United States, the right to an abortion has been disconnected from government funding of legal abortion for low-income women.[5] Pro-choice advocates often assert abortion as a fundamental right for women in the sphere of reproductive health care. Even before *Roe v. Wade*, the Association for the Study of Abortion (ASA) was formed by a group of prominent

[3] Major et al., "Abortion and Mental Health: Evaluating the Evidence," 864.
[4] Stephen Matthews, David Ribar, and Mark Wilhelm, "The Effects of Economic Conditions and Access to Reproductive Health Services on State Abortion Rates and Birthrates," *Family Planning Perspectives* (1997).
[5] Martha F Davis, "Abortion Access in the Global Marketplace," (2010).

doctors and lawyers who believed that the abortion laws as of 1965 were ineffective and harmful.[6] Therefore, the ASA chose to focus on the right of medical professionals to perform abortions safely. Despite legal binds, women continued to undergo illegal abortions and regularly died from those procedures. Members of the ASA advocated for "liberalized abortion laws" in the landmark contraceptive case *Griswold v. Connecticut* in 1965.[7] The right to an abortion represents reproductive freedom and social justice.[8] In contrast, while anti-abortion advocates may claim to support the Right to Life, many people and reproductive rights advocates believe that denying access to abortion and birth control is actually "anti-woman," attempting to "control women, instead of letting women control their bodies themselves."[9]

Historically, women of color were targeted by policies designed to "discourage childbirth;" one example is the practice of restricting access to welfare.[10] However, the effects of welfare on reproductive behavior have been exaggerated in policy debates: A 10% cut in Aid to Families with Dependent Children (AFDC) only "prevents" 1 birth for every 212 women receiving AFDC.[11] Before the *Roe v. Wade* decision, large numbers of black women and low-income women died from illegal abortion procedures, and even after the 1973 landmark case, they continue to have difficulty affording safe, legal abortions.[12] As noted by Betsy Hartmann, "[W]omen are presented as an undifferentiated mass which needs to be empowered, with little recognition of…poor or rich, rural or urban, black or white," which causes misrepresentation of reproductive health "solutions."[13] The history surrounding the relationship between women of color and reproductive control is complicated: from a history of forced sterilization and fear of genocide to a goal of liberation through access to fertility control, without poverty as a constraint.[14]

Policies that directly or indirectly decrease women's access to abortion services *do* decrease the incidence of the procedure, but according to the Supreme Court, certain regulations

[6] Jennifer Nelson, *Women of Color and the Reproductive Rights Movement*(NYU Press, 2003).
[7] Ibid., 11.
[8] Betsy Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control*(South End Press, 1995).
[9] Ibid., xviii.
[10] Davis, "Abortion Access in the Global Marketplace," 1659.
[11] Matthews, Ribar, and Wilhelm, "The Effects of Economic Conditions and Access to Reproductive Health Services on State Abortion Rates and Birthrates."
[12] Nelson, *Women of Color and the Reproductive Rights Movement*.
[13] Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control*, xii.
[14] Nelson, *Women of Color and the Reproductive Rights Movement*.

would be considered invalid if "substantial obstacles" of "undue burden" are placed to prevent women from seeking abortion prior to fetal viability.[15] Government regulation of abortion services certainly complicates the matter of access; however, there are many more dimensions in play when paving the road to positive mental health. Therefore, it is imperative that a more comprehensive review of factors affecting the access to abortion and their effect on mental health need to be undertaken.

Distance, Cost, and Legislation

With more restrictions being placed on women's access to abortion, the distance women must travel to reach a provider, and the cost of the procedure are becoming a major component of this conversation.[16] With the obstacle of distance, the availability of the abortion providers is the root of the problem.

As of 2015, in America's Southeastern states, 93% of counties do not have an abortion provider; 94% of Midwestern counties do not have an abortion provider, and 65% of Northeastern counties do not have an abortion provider.[17] A study conducted in 1995 found that 8% of women seeking abortions in nonhospital facilities traveled more than 100 miles for abortion services in 1992.[18] This figure is likely greater in present day due to new abortion legislation and the decrease in the number of providers. The greatest travel distances were concentrated in Alabama, Kentucky, Mississippi, and Tennessee, which are states where their relatively few abortion providers are concentrated in the largest cities, and the largest facilities usually saw more people who traveled long distances for their services. This all contributes to *who* will have the most access to these resources, with women from lower socioeconomic classes more likely to not have access to abortion services.

The lack of abortion clinics in so many areas of the United States reflects a hostile sociopolitical environment in terms of reproductive rights for women. The decision to consider or

[15] Matthews, Ribar, and Wilhelm, "The Effects of Economic Conditions and Access to Reproductive Health Services on State Abortion Rates and Birthrates," 59.
[16] Thomas J Kane and Douglas Staiger, "Teen Motherhood and Abortion Access," *The Quarterly Journal of Economics* 111, no. 2 (1996).
[17] Melanie Zurek et al., "Referral-Making in the Current Landscape of Abortion Access," *Contraception* 91, no. 1 (2015).
[18] Stanley K Henshaw, "Factors Hindering Access to Abortion Services," *Family planning perspectives* (1995).

to have an abortion then subsequently seeking out the relevant services results in varying experiences among women, from a smooth path to one with numerous obstacles along the way. Delays in accessing abortion disproportionately affect "women of color, young women, and women with lower educational attainment."[19] Another dimension to the concept of long-distance travel is that it may not be solely based on lack of access: It can also relate to the "desire [for] anonymity" or the avoidance of parental involvement.[20] This additional consideration reflects the negative stigma associated with abortion.

In addition to travel time, cost remains an important component of abortion access. The Hyde Amendment, enacted in 1976, made abortion one of the only medical procedures not covered by Medicaid.[21] This amendment disproportionately affects women of lower SES, and with the Supreme Court allowing states the full right to "restrict Medicaid funding for abortion,"[22] it has become more difficult for women on Medicaid to gain access to abortion services.

A large majority of abortion services are paid for by the patients rather than insurance.[23] Even for women with insurance coverage, confidentiality might be a concern that leads women to opt out of insurance benefits. Furthermore, abortion procedures do not come cheap: In 1993, the abortion clinics that performed the fewest number of abortions yearly charged an average of $463 for the procedure, whereas clinics that performed more than 400 procedures each year charged an average $292. Most of the less expensive resources are found in large cities, forcing women in rural areas, who are also more likely to have lower SES, to travel long distances for abortion services. A more recent price estimate of the average cost of abortion in the United States is $504.[24]

TRAP laws, or "targeted regulation of abortion providers," have recently been gaining political traction despite the victory for abortion-rights advocates in *Whole Woman's Health vs. Hellerstadt* in 2016.[25] Although enacted under the guise of promoting health and safety, the

[19] Zurek et al., "Referral-Making in the Current Landscape of Abortion Access," 1.
[20] Henshaw, "Factors Hindering Access to Abortion Services," 56.
[21] Bisakha Sen, "A Preliminary Investigation of the Effects of Restrictions on Medicaid Funding for Abortions on Female Std Rates," *Health economics* 12, no. 6 (2003).
[22] Ibid., 2.
[23] Henshaw, "Factors Hindering Access to Abortion Services."
[24] "U.S. Abortion Statistics," Abort73.com, http://abort73.com/abortion_facts/us_abortion_statistics.
[25] Joanne D Rosen, "Finding Strength in Numbers: The Critical Role of Data in Whole Woman's Health V. Hellerstedt," *Obstetrics & Gynecology* 129, no. 1 (2017).

implicit target of these TRAP laws is the practice of abortion.[26] TRAP laws effectively make abortion less accessible to women, more likely impacting the ease with which lower-income women obtain reproductive services than any other economic group. Although the national rate of abortion is declining, no evidence supports the conjecture that this decline is due to the decrease in providers or the 106 newly implemented abortion restrictions.[27]

Comprehensive Sexual Education

In relation to socioeconomic class, the access to quality reproductive education is significantly lower for the poor. The lack of quality reproductive education can result in unsafe sexual practices, and therefore may increase the rate of unintended pregnancies.

The federal government has historically supported abstinence-only programming since the early 1980s, making the potentially harmful consequences of denying young people access to information about protection during sex more relevant.[28] Abstinence-only programs have shown no correlation with a delay of sexual initiation, reduction in sexually transmitted infections (STIs), or pregnancy. In fact, abstinence-only education may be *contributing* to adolescent pregnancy in the United States.[29] In comparison, abstinence-plus programs, which promote abstinence as the best way of preventing the contraction of HIV while also encouraging safer-sex practices,[30] can reduce the incidence of STIs. About two-thirds of comprehensive sexual education programs evaluated in 2008 led to delayed sexual initiation and increased condom and contraceptive use.[31] In addition, abstinence-plus programs result in teenagers' better understanding of how to utilize contraceptives effectively.[32]

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[26] Rachel Benson and Elizabeth Nash, "Trap Laws Gain Political Traction While Abortion Clinics-and the Women They Serve-Pay the Price," njtoday.net, http://njtoday.net/2013/09/06/trap-laws-gain-political-traction/.

[27] Rachel K Jones and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2011," *Perspectives on sexual and reproductive health* 46, no. 1 (2014).

[28] Chris Collins et al., "Abstinence Only Vs. Comprehensive Sex Education: What Are the Arguments?," *What is the evidence* (2002).

[29] Kathrin F Stanger-Hall and David W Hall, "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the Us," *PLoS One* 6, no. 10 (2011).

[30] Kristen Underhill, Paul Montgomery, and Don Operario, "Abstinence‐Plus Programs for Hiv Infection Prevention in High‐Income Countries," *The Cochrane Library* (2008).

[31] Douglas B Kirby, "The Impact of Abstinence and Comprehensive Sex and Std/Hiv Education Programs on Adolescent Sexual Behavior," *Sexuality Research and Social Policy* 5, no. 3 (2008).

[32] Sylvana E Bennett and Nassim P Assefi, "School-Based Teenage Pregnancy Prevention Programs: A Systematic Review of Randomized Controlled Trials," *Journal of Adolescent Health* 36, no. 1 (2005).

Welfare reform legislation enacted by President Clinton in 1996 specifically appropriated money for abstinence education, targeting "groups most likely to bear children out of wedlock."[33] Schools are actually becoming more and more focused on abstinence-only education, with "'steep declines' in the teaching of birth control, abortion, and sexual orientation" between 1988 and 1999.[34] These trends have continued to present day: Twenty-two states along with the District of Columbia mandate sex education, but only nineteen states require that students be presented factually accurate material in their sex education.[35] Despite President Obama's efforts to favor comprehensive sex education by eliminating two-thirds of federal funding towards abstinence-only programs,[36] a study conducted in 2017 found that 44% of states still have legally mandated abstinence-only sexuality education in their public school systems.[37] These states also exhibited the highest rates of adolescent HIV and teen pregnancy.

There are, inevitably, numerous factors that play into the social context of sexual behavior. Sexual networks, formed by a person's sexual relationships, are critical in the spread of STIs with social context having the power to influence sexual behaviors and the formation of these networks.[38] Some community attributes that can influence sexual behavior include poverty, substance abuse, sex roles, sexual behavior norms, and prevalence of STIs.

One of the most prominent factors of American society is the racial divide, which "has characterized all sectors of [the U.S.] since the colonial era."[39] Due to a history of racism and discrimination, black people are more likely to live in poverty than white people, and this racial divide is reinforced through lack of access to political and economic resources.[40] Segregation concentrates poverty and negative socioeconomic influences in racially isolated groups and

[33] Collins et al., "Abstinence Only Vs. Comprehensive Sex Education: What Are the Arguments?," 5.
[34] Ibid., 7.
[35] "State Policies on Sex Education in Schools," National Conference of State Legislatures.
[36] Sloan Caldwell, "Let's Talk About Sex: The Failure of Abstinence-Only Policies in America's Public Schools," (2015).
[37] LM Elliot et al., "Association of State-Mandated Abstinence-Only Sexuality Education with Rates of Adolescent Hiv Infection and Teenage Pregnancy," *The Journal of the Louisiana State Medical Society: official organ of the Louisiana State Medical Society* 169, no. 2 (2017).
[38] Adaora A Adimora and Victor J Schoenbach, "Social Context, Sexual Networks, and Racial Disparities in Rates of Sexually Transmitted Infections," *Journal of Infectious Diseases* 191, no. Supplement 1 (2005).
[39] Ibid., S117.
[40] Ibid.

"increases the risk of socioeconomic failure of the segregated group."[41]

Race, ethnicity, and social class overlap to influence behavior as well. In the U.S., African-Americans are more likely to live in poverty, have decreased access to quality education, and to receive abstinence-only sexual education, which contributes to higher than average involvement in risky behavior and STI transmission for blacks.[42] Being more engaged in sexually risky behavior may more likely lead to unwanted pregnancy. Restrictions to abortion services and a lack of quality, comprehensive sexual education, women of color with lower socioeconomic status are disproportionately affected. This unequal access to health resources perpetuates the cycle of oppression and the racial and income divide in the U.S.

Stigmatization

Stigmatization in the sociocultural context has profound implications on mental health. Perceived stigma has been linked to "cognitive and performance deficits increased alcohol consumption, social withdrawal, and avoidance, [and] increased depression and anxiety." Societal interactions that stigmatize women who have had an abortion could "directly contribute to negative psychological experiences post-abortion."[43]

One example of a potentially stigmatizing interaction would be harassment from protesters. Harassment by anti-abortion protesters also affects women seeking an abortion and the facilities that offer these services.[44] Many abortion clinics must utilize higher security to protect both patients and staff such as metal bolt-locked doors and statement of purpose before entering the facility. In 1992, 55% of nonhospital providers reported harassment, with the incidence of harassment being positively correlated to the provider's caseload.

The relationship between region and religion can also work to create possibly stigmatizing situations. The morality of abortion is often questioned by religious groups, and with many people in rural areas being statistically more religiously observant than their urban counterparts along with being more likely of lower socioeconomic class,[45] the societal pressure against abortion

[41] Ibid., S117.
[42] Collins et al., "Abstinence Only Vs. Comprehensive Sex Education: What Are the Arguments?."
[43] Major et al., "Abortion and Mental Health: Evaluating the Evidence," 867.
[44] Henshaw, "Factors Hindering Access to Abortion Services."
[45] H Paul Chalfant and Peter L Heller, "Rural/Urban Versus Regional Differences in Religiosity," *Review of Religious Research* (1991).

experienced by women with low SES is potentially stronger and more negative. The sociocultural context can shape a woman's thought processes not only when she considers an abortion,[46] but also long after the procedure, especially if she lives in an environment with anti-abortion attitudes.[47]

On the other hand, if social messages and support groups are in place within a community to characterize abortion more positively or benignly, emotional responses are likely to improve.[48] The stigma associated with abortion dictates that women who have had abortions should feel bad about themselves and creates negative psychological experiences.[49] The sociocultural perspective emphasizes that the immediate and larger social context within which the abortion occurs can fundamentally alter women's experiences of abortion.

Mental Health Differences

Many systematic reviews have been conducted on the relationship between mental health and abortion, with the highest quality studies concluding little to no differences in mental health between women who have had an abortion and women who have not.[50] They find that "lingering post-abortion feelings of sadness, guilt, regret, and depression" are found in a *minority* of women,[51] and abortion does *not* lead to long-term mental health problems. According to research, abortion may be associated with a "small increase in risk of mental disorders;"[52] however, differences in mental health are often due to past or present social or physical conditions surrounding the unintended pregnancy and abortion.[53] Undergoing an abortion has been found to be linked with significant increases in risks of mental health problems in some studies, specifically in association with anxiety and substance abuse disorders, but the overall effect of abortion on mental health is

[46] Major et al., "Abortion and Mental Health: Evaluating the Evidence."
[47] Amanda Gelman et al., "Abortion Stigma among Low‐Income Women Obtaining Abortions in Western Pennsylvania: A Qualitative Assessment," *Perspectives on sexual and reproductive health* 49, no. 1 (2017).
[48] JoAnn Trybulski, "The Long-Term Phenomena of Women's Postabortion Experiences," *Western Journal of Nursing Research* 27, no. 5 (2005).
[49] Major et al., "Abortion and Mental Health: Evaluating the Evidence."
[50] Vignetta E Charles et al., "Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence," *Contraception* 78, no. 6 (2008).
[51] Ibid., 449.
[52] David M Fergusson, L John Horwood, and Joseph M Boden, "Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study," *The British Journal of Psychiatry* 193, no. 6 (2008): 444.
[53] Major et al., "Abortion and Mental Health: Evaluating the Evidence."

very small.[54] A prospective cohort study conducted in 2017 also found that abortion does not significantly increase the risk of common mental disorders unless the woman already has a psychiatric history.[55]

Despite overwhelming evidence that abortion does not necessarily lead to poorer mental health, many scientists are still researching the topic. Their goal may likely be to "answer politically motivated questions."[56] For example, studies with flawed methodologies consistently report negative mental health trends in women with a history of abortion.[57] Anti-abortion advocates have often used correlational studies that show that abortion leads to poorer mental health despite methodological flaws present in those studies. Abortion politics often "reflect the conflicts between…rights and responsibilities [and] private versus public morality"[58] as rhetoric manipulation has the power to alter public policy.[59] The supposed relationship between abortion and subsequent poor mental health is more related to "prior and existing contextual, psychological, and structural factors" leading up to the decision for an abortion rather than the abortion itself.[60]

Abortion is not a unitary event, in that the way a woman reacts to having an abortion varies greatly across a spectrum of populations.[61] Coping with abortion involves emotional, physical, and financial factors that inevitably vary between different populations of women. People of lower SES generally have poorer mental health, especially women who are more confined to traditional female roles.[62] Neighbourhoods with lower average SES are more exposed to dangerous environments, such as criminal activity and gun violence, and the safety of neighborhoods also contributes greatly to the mental health of residents.[63] The greater the perceived danger, the more

[54] Fergusson, Horwood, and Boden, "Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study."
[55] Jenneke van Ditzhuijzen et al., "Incidence and Recurrence of Common Mental Disorders after Abortion: Results from a Prospective Cohort Study," *Journal of psychiatric research* 84(2017).
[56] Charles et al., "Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence," 449.
[57] Ibid.
[58] Barbara Hinkson Craig and David M OBrien, "Abortion and American Politics," (1993): para. 1.
[59] Melody Rose, "Safe, Legal, and Unavailable? Abortion Politics in the United States," (2007): 25.
[60] Julia R Steinberg and Lawrence B Finer, "Examining the Association of Abortion History and Current Mental Health: A Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model," *Social science & medicine* 72, no. 1 (2011): 25.
[61] Major et al., "Abortion and Mental Health: Evaluating the Evidence."
[62] William Cockerham, *Sociology of Mental Disorder*, 10 ed.(New York, NY: Routledge, 2017).
[63] Sandra Echeverría et al., "Associations of Neighborhood Problems and Neighborhood Social Cohesion with Mental Health and Health Behaviors: The Multi-Ethnic Study of Atherosclerosis," *Health & place*

likely someone is to stay in their home resulting in social isolation, with women more likely to be negatively affected than men.[64] Because of this social isolation, residents of neighborhoods with high perceived danger may lack the social network that promotes positive mental health. Also, perceptions of poorer neighborhood safety lead to higher rates of anxiety disorder and depressive symptoms.[65]

With respect to the lack of access to abortion services, especially from the perspective of women of lower SES, having to overcome many significant obstacles to gain access to the procedure could be theorized to take a toll on mental health. With the Hyde Amendment leaving the decision of whether Medicaid covers abortion to the state and with most states deciding not to fund this medical procedure, poor women are unjustly affected.

Legislation aimed to decrease women's access to abortion fundamentally has altered the balance of equality of access and preferentially favors women with the money and social support to undergo this procedure. This shifts the focus of the legislative debate from the morality of abortion to equal access to a medical service. Therefore, blanket studies regarding the effects of abortion on mental health cannot account for the responses of a diverse population of women who have undergone the medical procedure and cannot specifically account for the all the complexities regarding the surrounding sociocultural factors.

CONCLUSIONS

With elective abortion as "one of the most common medical interventions in the world,"[66] the problem of equality of access becomes a relevant factor in the conversation regarding abortion here in the U.S. Increasing access to treatment, providing subsequent therapy options, and creating a positive environment without the weight of stigma would greatly improve the mental health outcomes of women who have had an abortion. This would be especially true for women of lower SES, whose backgrounds would be more likely to contribute to mental health issues than it would for women with higher SES.

14, no. 4 (2008).

[64] Cockerham, *Sociology of Mental Disorder*.

[65] Maureen Wilson-Genderson and Rachel Pruchno, "Effects of Neighborhood Violence and Perceptions of Neighborhood Safety on Depressive Symptoms of Older Adults," *Social science & medicine* 85(2013).

[66] Charles et al., "Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence," 449.

Many factors are at play in this conclusion such as the difficulty of reaching abortion services in geographic and monetary terms as well as the stigmatization of abortion and the women who seek the procedure. Studies investigating the relationship between mental health and abortion historically tend to under-represent women from socioeconomically disadvantaged backgrounds.[67] For that reason alone, more intensive research needs to be conducted to assess the true effects of abortion on mental health for this demographic group.

Future research should specifically represent women with lower SES who are either mothers not-by-choice or not mothers by-choice, comparing the mental health of those who have had an abortion with those who have not had the procedure. According to a 2004 study by the Guttmacher Institute, 23% of women seeking abortion cited the inability to afford to raise a child as a significant factor in their decision.[68] Conducting more longitudinal studies on the topic would allow researchers to delve into the larger sociocultural context surrounding the circumstances of abortion, understanding that the abortion experience is unique for each woman. Abortion intrinsically does not lead to poorer mental health for women; however, the social context of abortion can.

Policy recommendations in the future need to be based on sound, objective science, rather than science intended to further a political agenda. The enactment and enforcement of laws that present an undue burden to abortion access do nothing to help women make informed choices about their health, especially given that these laws are often based on misinformation regarding the mental health risks of this medical procedure. Increasing the reach of comprehensive sexual education, access to family planning services, and quality mental health services [69] would also potentially decrease some of the racial divide seen in the incidence of STIs and sexually risky behaviors, which could serve to alleviate some of the negative mental health impacts experienced by women, and people in general, of lower socioeconomic status.

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[67] Fergusson, Horwood, and Boden, "Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study."
[68] "U.S. Abortion Statistics".
[69] Ashley Wennerstrom et al., "Community-Based Participatory Development of a Community Health Worker Mental Health Outreach Role to Extend Collaborative Care in Post-Katrina New Orleans," *Ethnicity & disease* 21, no. 3 0 1 (2011).