ELSEVIER

Contraception xx (2011) xxx–xxx

Contraception

Original research article

How women anticipate coping after an abortion☆

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Received 6 July 2011; revised 22 October 2011; accepted 1 November 2011

Abstract

Background: There has been some study of women's emotional and psychological well-being after an abortion but no research into women's expectations, at the time of seeking an abortion, of how they will cope after the abortion.
Study Design: We abstracted counseling needs assessment forms of 5109 women who sought an abortion at a clinic in 2008.
Results: The most common emotions that women anticipate feeling after their abortion are relieved (63%) and confident (52%). A significant minority anticipate feeling a little sad (24%) and a little guilty (21%); 3.4% anticipate poor coping. Women with fetal abnormalities, women who do not have high confidence in their decision, women who have spiritual concerns about abortion, women with a history of depression, women who feel that they were pushed into having an abortion and teenagers are more likely to anticipate poor coping postabortion.
Conclusions: The vast majority of women expect to cope well after their abortion. A small number make the decision to terminate their pregnancies even though they anticipate difficulty coping after the procedure.

Keywords: Abortion; Abortion counseling; Emotional response to abortion

1. Introduction

According to recent comprehensive reviews of the literature, there is no evidence that abortion causes mental health problems among adult women who have a single, legal abortion of an unwanted pregnancy in the first trimester [1,2]. Nonetheless, the notion that women regret their decision to have an abortion and, in turn, suffer emotionally or psychologically is widespread and has influenced law and policy [3–7]. The "abortion hurts women" narrative presumes that abortion itself causes psychological problems. It contends that women are psychologically better off before an abortion and worse off after the abortion and that women, unaware of the potential harms, must be protected from them through laws and regulations [7]. Well-designed studies on women's overall psychological well-being before and after abortion, however, provide evidence that most women's well-being does not deteriorate after an abortion [8,9], and demonstrate that women's postabortion coping is affected by complex factors related to their individual characteristics and experiences, characteristics of the pregnancy and the sociocultural environment in which they live [1,10–13]. These factors include (but are not limited to) women's preabortion mental health history [1,10,14–16]; personality traits, attitudes and psychological attributes that could influence the woman's decision-making and coping (e.g., self-esteem, perception of control, self-efficacy for coping) [1,10,17–19]; violence exposure [14,16]; anticipated and actual social support [18,19]; and stigma around abortion [20].

Little is known about women's anticipated responses to abortion at the time that they are deciding whether to have an abortion or seeking abortion services. Yet, understanding who might have difficulty coping after an abortion would help direct pregnancy options counseling and referrals for postabortion care. This study explores women's self-reported anticipated emotional responses to abortion at the time they sought an abortion. We analyze patients' counseling needs assessment forms completed at intake at an abortion clinic to examine how anticipated postabortion

☆ This study was funded by an anonymous private foundation.
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0010-7824/$ – see front matter © 2011 Elsevier Inc. All rights reserved.
doi:10.1016/j.contraception.2011.11.002

emotional responses and coping differ by women's level of confidence in their abortion decision and their spiritual and moral beliefs about abortion. We examine what factors may predispose a woman to anticipating poor coping.

This study builds on previous work based on the same data set on women's degree of confidence in the abortion decision when they sought an abortion [21]. In our previous study, we found that 87% of women had high confidence in the abortion decision before receiving any counseling from the clinic, and that teenagers, African American women, women with a history of depression and women with low educational attainment were less likely to report high confidence in the abortion decision than women without these characteristics. Generally, women reported having partners, mothers or friends who were supportive of their decision; 2.2% reported being pushed into the abortion by someone else (usually either a partner or parent). Forty-three percent reported some spiritual concerns, while 4% agreed and 13% "kind of" agreed with a statement that abortion is equivalent to killing a baby that is already born. Eighteen percent of women reported that they were afraid God would not forgive them.

In this current analysis, we expect to find that a woman's anticipated coping after an abortion is associated with her confidence in decision-making. The analysis presented here complements the original findings, adding empirical data on women's expectations about coping after the procedure at the time of seeking an abortion.

2. Materials and methods

This study utilizes data abstracted from needs assessment forms and medical charts from a privately owned abortion clinic that provides about 5000 abortions annually. The clinic is located in a state that does not require parental consent or notification to provide abortion care to minor patients. All women seeking abortion services at the clinic complete a counseling needs assessment form, along with their medical history and other intake forms, at the time they present for care. The assessment form is a one-page, two-sided survey that elicits information about women's emotional state that day, their decision-making processes and the degree of certainty about their abortion decision, their mental health history, degree of social support for their abortion decision, attitudes and feelings about the abortion, emotional responses to any past abortions, and their anticipated emotional responses and coping abilities after this abortion. One particularly provocative question asks women whether they believe that abortion "is the same as killing a baby that's already born." This question is included on the form to serve as a catalyst for conversation and to identify women who have significant moral conflict regarding abortion. The form, written by Anne Baker, was adapted from a needs assessment tool created by Charlotte Taft, both nationally known experts in abortion counseling [22]. For most items on the needs assessment form, women are asked to say whether the statement is "true," "kind of" or "false." Some questions required women to check items from a list.

Patients complete the needs assessment form before meeting with a trained counselor: their responses represent women's psychological state before participating in any aspect of abortion care at the clinic. After completing the needs assessment form, each patient receives a pelvic ultrasound; learns about the abortion procedure, possible complications and aftercare; and meets with a trained counselor, who uses the needs assessment form to guide a counseling session. In addition to answering questions, confirming that patients have come to a final voluntary decision and ensuring informed consent, counselors routinely offer contraceptive information, emotional support and referrals. When appropriate, they offer referrals for post-abortion emotional support. If a counselor assesses that a woman is ambivalent about her abortion decision, is being coerced into the abortion or shows signs of being at risk of poor coping after an abortion, the counselor offers women the options of leaving to reconsider their decision and coping ability or speaking with a senior counselor to discuss their conflicted feelings. If the woman cannot resolve her ambivalence and/or the counselor remains concerned about the voluntary nature of her decision, the counselor gives the woman reading materials and referrals designed to help her with her decision-making in regards to her pregnancy options (abortion, parenting, adoption) and advises her to seek support from family, friends, a mental health professional or nonjudgmental clergy, if appropriate. If, after taking these steps, the woman still wants an abortion, she may reschedule. The abortion will not be performed that day if the woman continues to express uncertainty about her decision or ability to cope after the abortion.

Counseling needs assessment forms and medical charts of all women who presented for abortion services in 2008 were abstracted by three clinic staff members. No personal identifying information was abstracted or shared with the investigators. This study was approved by the University of California, San Francisco's Institutional Review Board.

Data abstracted from the medical record included patient age, race/ethnicity, parity and education, as well as characteristics of the pregnancy, such as gestational age, whether fetal anomalies were present and whether the abortion procedure was performed.

2.1. Measures

We examine age (under 20 years of age versus 20 and older), race/ethnicity (African American versus white/other) and highest educational attainment (no high school, high school diploma, some college/technical school, and college diploma or beyond). Abortions were categorized as occurring in the first trimester (less than 13 weeks' gestation) or in the second trimester (13 weeks or later).

We used the same definitions of confidence in the abortion decision, the extent the woman was pushed into the abortion and the presence of spiritual concerns as described in Foster et al. [21]. To summarize, our measure of confidence in the abortion decision is based on four statements: "I am SURE of my decision to have an abortion," "I want to have the baby instead of abortion," "I want to put the baby up for adoption instead of an abortion" and "Abortion is a better choice for me at this time than having a baby." We define high confidence as choosing "true" to the first and last statements and choosing "false" to the second and third statements. Low confidence is defined as choosing any other combination of answers. Our measure of whether a woman feels pressured by others to have an abortion is based on responses to the item, "I'm here for an abortion MOSTLY because someone else wants me to." We consider that a woman is being pushed into the abortion if she says "true" or "kind of" to the statement above and reports low confidence in the abortion decision. We define having spiritual concerns as saying "true" or "kind of" to "I have spiritual concerns about abortion" and "false" or "kind of" to "Spiritually, I am at peace with this decision."

The anticipated emotional responses to abortion are based on a checklist of emotions. Women were asked to indicate which of the following they thought they might feel after having the abortion: confident in the decision, relieved, happy, a little guilty, a little sad, very guilty, very sad, ashamed and angry. Women could check as many responses as they wanted.

Our measure of anticipated coping after an abortion is based on patient's selection among five responses to the question, "How do you think you'll deal with [your anticipated] feelings [after the abortion]?" The statements were not mutually exclusive; women could select more than one.

1. I'll deal with my feelings fine afterwards.
2. It might be a little hard at first, but then I'll be fine and won't regret my decision.
3. It will probably be VERY hard for me afterwards.
4. I'm afraid I'll wish I never went through with the abortion.
5. I believe I will be able to cope with this decision better than parenting or adoption at this time.

We considered women who chose the third or fourth responses to be anticipating poor coping after the abortion.

2.2. Analysis

Data were analyzed using STATA SE 11.0. We used a multivariate logistic model to examine predictors of anticipated poor coping after an abortion. Predictors include items from a woman's medical history and clinical visit as well as variables that can be known from asking women about their decision-making and attitudes, as through a needs assessment form.

3. Results

3.1. Characteristics of women seeking abortions

In 2008, 5109 women sought abortion services at the study clinic. Table 1 describes key characteristics of the study population. Consistent with the demographics of abortion patients in national studies [16], a small percentage of study participants (<9.3%) were minors under 18 years of age and 10.5% were age 18 or 19, while more than half (56%) were in their twenties and 23% were 30 years or older. Slightly more than half of the women (56%) were white and 39% were African American. The majority of study participants had at least one child (62%). Nearly a quarter of women in the sample (23%) had not finished high school, over one third (35%) of the women's highest educational attainment was a high school diploma, and almost one in five (19%) had at least a college degree. In terms of their mental health, just over 1 in 10 women (12%) reported a history of depression, and another 1 in 10 reported a history of anxiety or panic attacks.

3.2. Characteristics of abortions sought

The 5109 women who presented to the study clinic for abortion care sought a total of 5387 abortions — 94.5% sought a single abortion during the year, and 5.5% sought

Table 1
Characteristics of women seeking abortion in 2008 at study clinic

Total	5109	100%
Age		
10–17	476	9.3%
18–19	534	10.5%
20–29	2841	55.6%
30–39	1067	20.9%
40–49	121	2.4%
Missing	70	1.4%
Race/ethnicity		
African American	1984	38.8%
White/Hispanic	2867	56.1%
Asian	34	0.7%
Mixed/other	134	2.6%
Missing	90	1.8%
Parity		
0	1958	38.3%
1	1451	28.4%
2	1045	20.5%
3+	649	12.7%
Missing	6	0.1%
Education		
Less than high school diploma	1162	22.7%
High school diploma	1770	34.6%
Some college/technical school	952	18.6%
College diploma	757	14.8%
Graduate school	155	3.0%
Missing	313	6.1%
Mental health history		
Depression	599	11.7%
Anxiety or panic attacks	542	10.6%

Source: Foster et al. [21].

two abortions during that time period. Four out of five (80%) pregnancies were in the first trimester (under 13 weeks' gestation). Women under age 20 were significantly more likely to seek an abortion in the second trimester — 25% compared to 18% among women age 20 and older ($p<.05$). Thirty-seven pregnancies (0.7%) were the result of rape, and 49 abortions (0.9%) were terminations of pregnancies with fetal anomalies present (data not shown).

Three hundred and ninety (7.25%) of the 5387 abortions sought were not performed. In 2.4% of abortions sought, the woman changed her mind and left the clinic or was sent home by the counselors for further reflection and did not return. Another 1.7% of abortions sought were not performed because the gestational age of the pregnancy was beyond the clinic's limit at the end of the second trimester. Teenage women (under age 20) were significantly more likely to present beyond the gestational limit of the clinic than adult women (3.3% compared to 1.3%, $p<.05$). About 1% (1.3%) of women did not have a uterine pregnancy at the time they came to the clinic, either because they had miscarried, had an ectopic pregnancy or had not been pregnant in the first place. Fifteen women (0.25%) were referred to a different provider for medical reasons.

3.3. Anticipated emotions postabortion

For 5309 of the 5387 abortions sought (98.6%), women recorded the emotions they expected to feel after the abortion in a needs assessment form. Overall, most women (63%) anticipated feeling relief after the abortion (Table 2). Just over half of the women (52%) expected to feel confident. Many women reported anticipating some negative emotions: a little sad (24%), a little guilty (21%), very sad (6%), ashamed (6%), very guilty (4%) and angry (2%). Fewer than 1 in 10 (8%) reported anticipating feeling "happy" after the abortion.

Among the range of emotions on the checklist, positive emotions were more commonly anticipated than negative ones. Eighty-six percent of women anticipated feeling at least one positive emotion (relieved, confident or happy), and 41% anticipated feeling at least one negative emotion (a little guilty, a little sad, very guilty, very sad, ashamed or angry). Included in that latter group, 11% of women anticipated feeling at least one strong negative emotion (very guilty, very sad, ashamed or angry).

The emotions women anticipate feeling after the abortion varied based on their view of abortion and the spiritual concerns they reported having about abortion at the time they completed the needs assessment form. Anticipating a negative emotional response is clearly related to one's confidence in the abortion decision and attitudes about abortion. Regarding the very negative emotions (very sad, ashamed, very guilty and angry), women who had low confidence in their decision, women with spiritual concerns about abortion and women who thought abortion was "kind of" the same as killing a baby that's already born reported these emotions at four to nine times the rate among women who reported high confidence, who had no spiritual concerns or who did not think abortion was the same as killing. Women who said true (as opposed to kind of) to the statement that they believed abortion is the same as killing a baby that's already born were 10 to 15 times more likely to report anticipating these very negative emotions. Just under two in five women (38%) who believe that abortion is the same as killing a baby that's already born anticipated feeling relief following the abortion, compared to 65% of women without this belief.

3.4. Anticipated coping

Of the five statements about anticipated coping ("I'll deal with my feelings fine afterwards," "It might be a little hard at first, but then I'll be fine and won't regret my decision," "It will probably be VERY hard for me afterwards," "I'm afraid I'll wish I never went through with the abortion" and "I believe I will be able to cope with this decision better than parenting or adoption at this time"), 79% chose just one statement, 17% chose two, and 2% chose three. Another 2% did not choose any of these statements. The majority of women (58%) agreed with the statement "I'll deal with my

Table 2
Anticipated emotions after the abortion

		Relieved	Confident	A little sad	A little guilty	Happy	Very sad	Ashamed	Very guilty	Angry
All	*N*=5309	63%	52%	24%	21%	8%	6%	6%	4%	2%
High confidence in the abortion decision[a]	4649	65%	55%	22%	19%	8%	4%	4%	2%	1%
Low confidence in the abortion decision[a]	660	43%	27%	34%	30%	3%	23%	15%	18%	8%
Spiritual concerns about abortion[a]	2399	59%	39%	32%	33%	5%	11%	10%	8%	3%
No spiritual concerns about abortion[a]	2910	65%	62%	17%	10%	10%	2%	2%	1%	1%
Thinks abortion is not the same as killing a baby that's already born[a]	4342	65%	56%	21%	17%	9%	3%	3%	2%	1%
Thinks abortion is "kind of" the same as killing a baby that's already born[a]	705	55%	32%	41%	39%	3%	15%	13%	11%	4%
Thinks abortion is the same as killing a baby that's already born[a]	223	38%	24%	29%	25%	4%	39%	28%	33%	15%

[a] Differences in each emotion are significant at a $p<.05$ level.

feelings fine afterwards." Just under one third (31%) agreed with the statement "It might be a little hard at first, but then I'll be fine and won't regret my decision." A small minority of women expressed concern about coping with the abortion decision. Three percent agreed with the statement "It will probably be VERY hard for me afterwards," and 1% agreed that "I'm afraid I'll wish I never went through with the abortion." Just over a quarter (27%) of women read the whole list of options and chose the last one, "I believe I will be able to cope with this decision better than parenting or adoption at this time."

Based on their selection of at least one of the two statements that expressed concern about coping with the abortion decision, we consider that in 3.4% (182/5387) of abortions sought, women anticipate poor coping after their abortion. Among these women who anticipate poor postabortion coping at the onset of their visit, 25% (45/182) did not receive the procedure (not shown in table). The remaining women received the abortion after consultation with a senior counselor at one or more visits.

In Table 3, we present predictors of women's anticipated poor coping. In Model 1, we examine how characteristics that could be known from a woman's medical record (age, race/ethnicity, gestational age, mental health history, and whether the abortion is sought following identification of fetal anomaly or for a pregnancy resulting from rape) are associated with anticipated poor coping. Being a teenager (OR=2.3), being African American (OR=1.9), having a history of depression (OR=4.0), having a second-trimester abortion (OR=1.5) and seeking an abortion following identification of a fetal anomaly (OR=9.2) are significantly associated with higher anticipated poor coping postabortion.

When we include predictors in the multivariable model that one cannot know from a medical history alone but must be elicited from the woman, such as confidence in decision, attitude about abortion, social support and beliefs about God's forgiveness, a broader picture of anticipated coping emerges. In Model 2, age, a history of depression and seeking an abortion because of a fetal anomaly remain significant, but the significance of being African American and of having a second-trimester abortion do not. Low confidence in the abortion decision [odds ratio (OR)=5.0], feeling pushed to have the abortion (OR=1.8), being afraid that God won't forgive them (OR=2.9), having spiritual concerns about abortion (OR=2.2) and "kind of" thinking abortion is equivalent to killing a baby (OR=2.1) all are statistically significant in predicting anticipated poor coping. Thinking that abortion is the same as killing a baby that is already born is associated with a sevenfold increase in the odds of anticipated poor coping. Having social support for their abortion is not significant in women's prediction of how they will cope with the abortion.

Table 3
Predictors of anticipated poor coping after an abortion

	Model 1		Model 2	
	OR	95% CI	OR	95% CI
Age				
Teenager (reference: age 20+)	2.3[a]	(1.7–3.2)	1.6[a]	(1.1–2.4)
Race/ethnicity				
African American (reference: White/other)	1.9[a]	(1.4–2.6)	1.2	(0.8–1.7)
Mental health history				
History of depression	4.0[a]	(2.8–5.7)	2.7[a]	(1.8–4.1)
Characteristics of abortion				
Second trimester (reference: first trimester)	1.5[a]	(1.0–2.1)	1.3	(0.9–2.0)
Had a previous abortion (reference: first abortion)	0.4[a]	(0.3–0.6)	0.5[a]	(0.3–0.7)
Fetal anomaly	9.2[a]	(3.4–24.9)	4.6[a]	(1.4–15.6)
Rape	0.7	(0.1–5.2)	1.3	(0.1–12.5)
Low confidence in abortion decision			5.0[a]	(3.3–7.4)
Pushed into abortion			1.8[a]	(1.0–3.2)
Attitude about abortion				
Spiritual concerns			2.2[a]	(1.5–3.3)
Afraid God won't forgive			2.9[a]	(2.0–4.4)
Think abortion is "kind of" like killing a baby that is already born			2.1[a]	(1.4–3.2)
Think abortion is truly killing a baby that is already born			7.7[a]	(4.8–12.3)
Social support				
Told nobody			1.0	(0.1–8.2)
Have a supportive mom			1.2	(0.8–1.7)
Have a supportive male partner			1.3	(0.8–1.9)

CI, confidence interval.
[a] Differences in odds of poor coping are significant at a $p<.05$ level.

4. Discussion

When women make the decision to have an abortion, fewer than 1 in 10 anticipates feeling "happy" after the abortion, but most (86%) expect to feel some positive emotion, usually relief and/or confidence. About two in five women (41%) expect to have some negative emotions, usually mild feelings of sadness or guilt. Very negative emotions such as "very sad," "ashamed," "very guilty" and "angry" are uncommon, anticipated by just over 1 in 10 women (11%). Women who report having spiritual concerns about abortion, women who do not have high confidence in their abortion decision and those who either partially or completely agree that abortion is equivalent to killing a baby that is already born are much more likely to anticipate these negative emotions. And yet, even among women who believe that abortion is the same as killing a baby, most do not expect to feel very guilty or very sad.

A small minority of women presenting for an abortion (3.4%) anticipate that they will have difficulty coping after the abortion. One quarter of these women did not have the procedure at the clinic where the study took place, either because they chose not to or because the clinic would not perform the procedure given concerns about the woman's ability to undergo the abortion safely and cope with it afterwards. The remaining three quarters decided to have an abortion at that clinic after a senior counselor determined that

the women were making a firm decision that they could cope with, either at the original visit or after having returned on a different day for their procedure.

Predictors of anticipated poor coping included some that we expected (history of depression, spiritual concerns) but excluded other anticipated ones, such as lack of social support. Teenagers, women seeking abortion for fetal anomalies, women with a history of depression and women with low confidence in their abortion decision are more likely to anticipate poor coping after abortion. These factors are similar to those that describe women likely to express low confidence in the abortion decision [21].

These findings suggest that some women may benefit from additional emotional support related to their abortion. Many providers already offer pre- and postabortion counseling and referrals. Our findings suggest that postabortion counseling referrals may be particularly valuable for young women, women with fetal anomalies or a history of depression, women who have spiritual concerns about abortion, women who think abortion is the same as killing a born baby and women who had difficulty deciding to have the abortion. We note that some of these predictors can be identified through standard medical intake procedures. However, many of the significant predictors, such as spiritual concerns and decisional conflict, are not always discussed in clinical settings. These findings may be useful for providers who wish to target their existing patient assessment and emotional support practices to the patients most likely in need of them.

These data describe women's *anticipated* emotions and coping. The needs assessment form was not developed for research but for clinical care. However, the tool has gone through decades of use and revision. It is endorsed by the National Abortion Federation for being an effective tool to elicit abortion patients' counseling needs [22]. We do not know to what extent women's predictions matched their actual experience after an abortion. Support from a male partner or parent does not appear to affect women's anticipated coping. However, social support may emerge as important after the abortion. For example, positive social support might aid women who have difficulty coping, or poor social support and/or stigma might cause unexpected poor coping.

Women who seek the termination of a pregnancy with a fetal anomaly appear to anticipate more difficulty coping after the abortion. However, our data undercount the total number of such pregnancies. The total number of fetal anomalies in the data set (32) was less than a separate clinic inventory of fetal anomalies cases for 2008 (49). Small total numbers and the undercount limit our ability to understand the emotional responses of these women. More focused research is needed on the expectations and outcomes of women who have pregnancies with fetal anomalies.

These data speak to the claim that abortion hurts women [3–5], which rests on the implicit assumption that women are unaware of potential harm from abortion [7]. To fully test that assumption, how women seeking an abortion anticipate they will feel after the abortion could be compared with women's postabortion emotions and experiences. If, for example, women anticipate feeling relief and instead feel troubled and regretful, the harm claim may receive support [1,11]. If, instead, women expect difficulty but feel relief or expect to cope well and do, it would challenge the notion that abortion hurts women.

These findings about women's anticipated emotions and coping also raise important questions about how we think about women's decisional autonomy. Anticipated difficulty coping after the abortion is not sufficient grounds for limiting women's autonomy in decision-making around abortion. In this study, as in previous research [21], some women anticipate having both positive and negative emotions after having an abortion, suggesting that complex and conflicted feelings are common. Any evaluation of whether the decision to have an abortion is the right one for a given woman must take into account how she would feel about — and how her life would be affected by — carrying an unwanted pregnancy to term and raising a child or placing that child for adoption. This study suggests that even women who anticipate negative emotions may still decide that their reasons for having an abortion outweigh any potential difficulty coping after the abortion.

Acknowledgments

We are grateful to the director of counseling and the executive director of the anonymous abortion clinic for sharing these data as well as their interpretations of our results. We also thank three staff members at the clinic who abstracted the data for us.

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