

# Supporting Women Coping With Emotional Distress After Abortion



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**Abortion is common, yet stigmatized. In some cases, abortion patients may experience feelings of sadness, guilt, anger, and other signs of emotional distress after their pregnancy is terminated. This article offers guidance for counselors seeking to provide nonjudgmental support to promote adaptation and recovery among abortion patients experiencing emotional distress. A brief summary of different ways to conceptualize emotional distress after abortion is provided. Next, a general cognitive behavioral framework is introduced, and common thought and behavioral patterns that may contribute to unresolved distress are explored. The article concludes with general recommendations to promote a respectful, collaborative alliance.**

***Keywords:* abortion, abortion counseling, stigma, emotional distress, pregnancy**

Abortion is a common medical procedure. An estimated one in four women in the United States will have an abortion by age 45 (Jones & Jerman, 2017). Although prevalent, abortion is highly stigmatized and politicized. Many people understand abortion in terms of the competing rights of the fetus (to live) and the person who is pregnant (to retain autonomy over one's body and life). As such, legal abortion challenges conceptions of the nonviable embryo or fetus as having independent rights (Solinger, 2013). In the United States, abortion is more strictly regulated than any other medical procedure (Sanger, 2017), and these regulations contribute to a misperception that legal abortion is more medically dangerous than childbirth. Depending on state-specific regulations, abortion patients may be required to wait a certain amount of time after their initial clinic visit, to receive information about fetal development, or to observe fetal imagery before they are permitted to make final abortion care decisions (Sanger, 2017). Requirements like these imply that potential abortion patients are unlikely to make sound decisions without outside assistance (Norris et al., 2011), and also create different types of potential stressors depending on where a patient seeks abortion care.

Because abortion is so stigmatized, counselors and community members across many different settings (e.g., clinic volunteers, talk-line counselors) may encounter abortion patients experiencing distress after their procedures. This article offers guidance for both professional and paraprofessional counselors who are approached by a woman seeking support. The focus here is specifically on supporting a patient who has had a legal abortion procedure by a licensed health professional. Women seeking illegal abortions from unlicensed providers face additional physical and psychological risks that are beyond the scope of the current article.

Although different abortion patients will have different concerns, there are at least five general recommended aspects of after-abortion counseling (Needle & Walker, 2008). First, patients tend to disclose what happened, under what circumstances, and their broader social, medical, and family history. Second, a patient's decision-making process and knowledge about the abortion procedure before and after it occurred warrant full exploration. Third, counselors can support emotional stability by accepting and exploring a patient's feelings, including ambivalence as experienced both in the past and in the present. Fourth, spiritual and cultural issues can be addressed; these may include religious

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and familial values about abortion, parenting, and the concept of forgiveness. Finally, counselors can promote client self-care, potentially by identifying “safe” people to whom patients can disclose. When working within this broader framework, and while drawing upon best practices for pregnancy loss (e.g., Wenzel, 2017), a cognitive behavioral therapy (CBT) framework may help foster recovery. This article discusses (a) different ways to understand abortion-related distress, (b) concepts and methods from CBT that may help counselors support abortion patients, and (c) general recommendations for the respectful use of questions and language.

### Understanding Emotional Distress After Abortion

Counselors may draw upon vastly different ways of understanding how and why abortion patients experience emotional distress after abortion. In the early 1990s, Vincent Rue proposed the existence of *post-abortion syndrome* (PAS), a variant of post-traumatic stress disorder. According to Speckhard and Rue (1993), “the trauma involved in being both attached to and responsible for the death of one’s fetal child can be emotionally overwhelming, and cause a range of symptoms” (p. 5). Symptoms of distress may manifest as guilt, self-directed blame and anger, sadness, intrusive thoughts about fetal death, and problematic family relationships, among others. Speckhard and Rue suggested that in some cases, distress may fluctuate with the menstrual cycle. In other cases, distress may remain dormant until patients experience subsequent reproductive events such as childbirth or menopause. Although some find PAS to be useful in conceptualizing cases, there have been longstanding debates about its validity (e.g., Dadlez & Andrews, 2010; Edwards, 2009). PAS has not been recognized as a formal medical or psychiatric diagnosis. Furthermore, PAS is often used in political contexts to argue against abortion rights and access (Dadlez & Andrews, 2010; Kelly, 2014). That is, “pro-life” activists use PAS to argue that potential abortion patients are likely to be emotionally harmed by abortion and therefore should be protected from making the decision to seek abortion.

In contrast, British “pro-choice” activist Ann Furedi (2016) argued that abortion-related distress may be more strongly related to the circumstances that led to pregnancy and the need for abortion than the actual abortion procedure itself. Although not all abortions occur after an unwanted pregnancy, Furedi wrote that “one of the few generalizations we can make about women seeking to end an unwanted pregnancy is that they are in a place they would rather not be. An abortion is no woman’s ambition, and an unwanted pregnancy is often (although not always) a marker of a lot of unwanted things in her life” (p. 52). Furedi also posited that the right to self-determination is key to psychological well-being, and for individuals who may become pregnant, self-determination involves the ability to plan when and how pregnancy is resolved. According to Furedi, access to family planning services, including abortion, is required for individuals to live as full citizens of society as well as to provide responsibly for their families. As such, restricting access to abortion is emotionally harmful because it denies those who are pregnant autonomy over both their bodies and their lives. This position is supported by research showing that patients who are denied an abortion show greater psychological distress than those who receive an abortion (Biggs, Upadhyay, McCulloch, & Foster, 2017). Importantly, both groups showed either stable or improved symptoms after a 5-year follow-up, indicating that initial distress did not generally lead to long-term or diagnosable conditions.

Abortion-related distress also can be conceptualized within a stress and coping framework (Major et al., 2009). Most abortions occur following an unintended pregnancy, and unintended pregnancy itself is a stressor that may increase risk for both short-term distress and longer-term mental health problems (Herd, Higgins, Sicinski, & Merkurieva, 2016). Individuals experience abortion as more or less stressful depending on a number of factors, including the timing of their abortion, their reasons for the decision, the type of procedure, their personal appraisals of abortion and other options, others’

social reactions, and the broader social and cultural context (Major et al., 2009). Overall, evidence from rigorous empirical studies indicates that legal first-trimester abortion does not increase risk for mental health problems. In addition, patients who have a later abortion for a wanted pregnancy due to fetal abnormality experience similar mental health outcomes compared to patients who miscarry, experience stillbirth, or experience newborn death (Horvath & Schreiber, 2017; Major et al., 2009).

Although research data do not suggest that legal abortion typically causes mental health problems (Horvath & Schreiber, 2017), many abortion patients experience symptoms of emotional distress, and in some cases, prolonged distress. Less commonly, some abortion patients experience mental health problems after their abortion procedures. In general, patients with a history of emotional disorders such as depression and those with low social support are at greater risk for mental health problems after a pregnancy resolves either by abortion or childbirth (Major et al., 2009; Russo, 2014). Abortion-specific risk factors for emotional distress include terminating a wanted pregnancy, feeling pressured into abortion by other people, perceiving the need for secrecy, and participating in or identifying with a cultural or religious group that teaches the idea that abortion is wrong (Major et al., 2009). These abortion-specific risk factors for distress warrant attention by counselors who are seeking to support abortion patients. Assessment of these factors may help inform how the counselor understands the sources of evident distress.

### **A Cognitive Behavioral Framework**

Counselors who rely on a CBT framework help patients to become more aware of their thoughts, to differentiate between thoughts and facts, to objectively evaluate the evidence for their thoughts, and to consider making changes when warranted. For example, patients may change their thoughts after reflecting on the ways in which their thinking is incomplete or inaccurate. Alternatively, patients may change their behaviors or circumstances after reflecting on evidence that shows behaviors or circumstances to be problematic.

From a CBT perspective, emotional distress following abortion may be conceptualized as emotions that are linked to thoughts and behaviors related to the abortion experience. Identifying and talking about thoughts and behaviors that are related to strong negative emotional states can help patients who are feeling stuck and not able to move forward. Abortion patients in distress may benefit from becoming more aware of and talking through thoughts that elicit emotional distress and exploring these with a supportive listener. Cognitive behavioral therapists often use an ABC (activating event, belief, consequence) model in working with patients to collaboratively understand how patients are experiencing their lives. To illustrate, an activating event (A) might be scheduling a follow-up appointment after an abortion procedure. A thought or belief (B) might be, "I shouldn't have had sex if I wasn't ready to be a mother," and the consequences (C) of that belief may be emotional (guilt, low self-esteem), behavioral (keeping the abortion a secret), and interpersonal (feeling disconnected from loved ones after an abortion).

Behavioral avoidance is another common target of CBT interventions. It can be useful to ask about situations or events that a person has avoided since her abortion. To illustrate, attending a baby shower, interacting with young children, or going to the doctor might all be situations that a distressed abortion patient avoids. Such situations might elicit thoughts and beliefs about having had an abortion that, in turn, elicit aversive feelings. In some cases, avoidance might not be sustainable or healthy in the long-term. For instance, some abortion patients avoid sex because they worry about pregnancy and making another abortion decision. Such patients may benefit from discussing barriers to contraception use. They additionally may benefit from discussing the use of more effective methods of contraception.

Examining the evidence for ease of use and effectiveness could help prevent a future unintended pregnancy. In other cases, avoidance may be adaptive. In particular, it may be wise to avoid telling certain people about having had an abortion when the costs of disclosure are likely to outweigh the benefits. Genuine collaboration with the abortion patient is necessary to weigh the benefits of maintaining current thoughts and behaviors against the benefits of potential changes.

CBT counselors often differentiate between primary (basic) and secondary (manufactured) emotions (Resick, Monson, & Chard, 2017). Primary emotions occur as a direct result of an event. For example, an unintended pregnancy may lead to feelings of shock. The end of a pregnancy may lead to feelings of loss. Being insulted by protestors or denied access to medical care may lead to anger. Primary emotions tend to fade in intensity over time. Secondary emotions, in contrast, arise as an indirect result of an event, based on thoughts about the event. In particular, when an abortion patient thinks about having made the wrong decision, this thought could elicit guilt. When a patient thinks about how others may respond negatively to learning about her abortion, this thought could elicit worry. If different types of abortion-related thoughts are habitual or persistent, these associated emotions also will tend to persist, and the abortion patient may thus feel stuck in negative feelings. Thoughts that may not be fully accurate, constructive, or conducive to recovery, such as those described below, may be potential targets for intervention.

Some abortion patients find themselves stuck between multiple conflicting thoughts (and associated feelings). For example, an abortion patient might think, "It hurts to know I'll never be forgiven by my Lord, but there's no way that my family could manage another child," or "I'm a feminist, so there's no reason for me to feel sad." In the former case, the patient switches the focus of her thinking between her religious tradition and her perceived family obligations. In the latter case, the patient switches between thoughts about her political views and her actual experience. Regardless of their content, experiencing conflicting thoughts can be confusing and disorienting, which may add to the overall experience of emotional distress. In addition, when thoughts are in conflict, one type of thought can be used to invalidate the other, preventing a full awareness and acceptance of each. Helping the patient acknowledge and accept the existence of conflicting thoughts may reduce confusion and distress. Furthermore, considering the evidence for each thought independently may allow the patient to consider which thoughts are worth holding onto and which might be less accurate, reasonable, or conducive to healing.

### **Common Thought Patterns Associated With Abortion-Related Distress**

From a CBT approach, several specific patterns of thought may be associated with abortion-related distress. *Hindsight bias* is the tendency to use knowledge from the current situation to re-interpret past situations. Patients who exhibit hindsight bias believe they knew then what they know now, and they may assume that they have failed in some way by making the decision that they did. One approach to hindsight bias is to ask for more detail about the patient's life context and specifics of the decision-making process at the time of the pregnancy. Counselors might ask questions such as: "How did you find out you were pregnant? What were your initial reactions? Who did you tell, and why? How did they respond?" Counselors might specifically ask what the patient perceived *at the time* as the reasons to consider abortion versus the reasons not to. "If you can try to remember during that time of your life, I'm curious, what seemed like good reasons for the decision? What seemed like good reasons *not* to make this decision?" In making the decision to end a pregnancy, abortion patients tend to consider the impact of pregnancy, childbirth, and parenting on their current and future lives, health, obligations, and goals (Finer, Frohwirth, Dauphinee, Singh, & Moore, 2005). Given that many abortion patients have already given birth, many also consider the impact of pregnancy,

childbirth, and parenting on children already in the home (Jones, Frohwirth, & Moore, 2008). When this reflection is accurate, counselors could comment that the abortion patient seemed to put a lot of thought into the decision, or they might reflect hearing that the patient had considered multiple important factors. A counselor might observe that it sounds like the patient made the best decision based on the available information at hand, although some important information may not have been accessible at the time. Some patients who are not parenting children might appreciate hearing that this type of thoughtfulness seems like a quality that would allow them to be a loving and effective parent in the future, when they are ready.

Another type of thought that may be related to abortion-related distress is *belief in a just world*. Many people hold the simple belief that good things happen to good people, and thus bad things happen to bad people. For some abortion patients, an unintended pregnancy is *bad*, an unhealthy pregnancy or fetal anomaly is *bad*, or an abortion is *bad*; thus, the self is *bad*. When an abortion patient terminates a pregnancy because of outside pressures, such as when parents, a partner, or a workplace would not accept a pregnancy, childbirth, or parenting, this lack of acceptance can also lead to self-blaming thoughts. A patient may perceive herself as having made bad decisions about relationships or workplaces that do not offer her support. An important corollary of belief in a just world is that a person who is bad does not deserve to feel better or to receive support. Some abortion patients feel that they deserve to be punished, and they deprive themselves of intimacy with others. Others may believe they do not deserve to participate in self-care activities or to “indulge” in interventions such as relaxation training, mindfulness meditation, or distress tolerance.

To address belief in a just world, it can be helpful to explore how the patient developed this belief as well as to explore both supportive and disconfirming evidence. Upon reflection, many patients are likely to acknowledge that belief in a just world is a common theme in fairy tales and other lessons imparted to very young children. Likewise, patients are likely to acknowledge that accidents sometimes happen, people can make mistakes and still be good and moral, and that sometimes bad things happen to good people. Inquiring about other people who they perceive as deserving and not deserving of distress and hardship may be helpful. For example, counselors might ask patients to identify others who have “gotten away with” crimes without punishment or censure and to identify good, deserving people who have faced unfair experiences or mistreatment. In addition to these explorations, a counselor might empathize with the wish that people would get what they deserve, even if the world does not always work that way.

*Outcome-based reasoning*, a tendency to assume that emotional distress is the natural result of a bad decision, is closely related to belief in a just world. As applied to an abortion patient in distress, the end result (distress) may be thought of as reflecting the quality of the decision to terminate the pregnancy (bad). Outcome-based reasoning reflects an interest in a world that is predictable and orderly. As with belief in a just world, asking questions about the evidence for outcome-based reasoning may be helpful. Counselors could wonder aloud about times that the patient has seen good intentions lead to problematic outcomes, good behavior lead to punishment, or bad behavior lead to reward. In addition, patients using outcome-based reasoning often assume that they would feel better if they had made a different prior decision. As such, the counselor might explore with the abortion patient the possible consequences of decisions other than abortion. Useful questions might include: “What were the other options that you considered? If you instead decided to become a single parent, or to make an adoption plan, what would that look like now? What would be the consequences of these different decisions, emotionally and otherwise?” Thinking through the available options and considering all the different consequences of each may allow patients to consider the possibility that

alternative prior decisions also might have been distressing, and perhaps even more so. Patients might conclude that each possible option was likely to lead to different types of stress and challenges, some in the short term, and some in the long term.

The final type of thought pattern addressed here involves *all or none thinking*. Some abortion patients hold themselves singularly responsible for becoming pregnant, for experiencing a complicated or unhealthy pregnancy, for making an abortion decision based on reasons that now seem suspect (such as trying to please their parents or a partner, or not having enough money), or for causing the circumstances that led them to decide that abortion was the best option. One approach to this type of thought pattern is to explore what seems to be a reasonable amount of responsibility rather than hyper-responsibility. Some apparently hyper-responsible patients might appreciate hearing a reflection along the lines of, "It sounds like you played a role in the unintended pregnancy, which makes you feel badly, and it sounds like other people and circumstances also played a role."

In other cases, abortion patients assign complete responsibility for the abortion decision to other people who urged them to end their pregnancies. Careful exploration of this thought pattern is needed. Some financially or emotionally dependent abortion patients, particularly younger ones, may have faced strong pressure from parents or a partner to seek an abortion. In addition, pressuring someone into an abortion may be part of a larger pattern of coercive control or intimate violence. If an abortion patient describes being compelled by another person to abort a pregnancy, it may be helpful to screen for intimate violence specifically as well as to ask about other ways in which they feel constrained within their close relationships.

In the absence of coercive control or violence, some patients still may blame their abortion decisions on the wishes of other people. Other abortion patients may regret taking the advice of others and may hold extreme negative thoughts about themselves as well as others who influenced their decisions. In both types of cases, counselors might ask questions to help explore boundaries and assertiveness within an abortion patient's intimate relationships. It could be useful to ask when and under what conditions the patient believes it is useful to take others' feelings into account when making important decisions. It may be appropriate to reflect that it can be challenging to balance different sources of influence. Abortion patients who feel like they should have stood up for themselves or for their unborn child might benefit from considering what barriers to assertiveness they experienced and what degree of influence they want others to have over their lives. Patients might also develop a plan for acting differently in the future when they are making a personal decision that affects others in their social networks. Collaborative work with a counselor may help to promote assertiveness while also conveying to the patient that she is deserving of respect.

### **Conveying Respect for Abortion Patients**

This article has focused on ways of understanding abortion-related distress, thoughts that may be associated with abortion-related distress, and topics of conversations that might help promote recovery. Suggestions have been offered about what to listen for, possible questions to ask, and thoughts and feelings that might be reflected. This final section offers suggestions about methods of asking questions and general use of language in order to promote rapport and the patient's sense of feeling respected, understood, and validated. Most broadly, rapport between the counselor and the abortion patient is essential, and the goal should be for the abortion patient to feel both the presence of unconditional positive regard and the absence of negative judgment on the part of the counselor (e.g., Kimport, Foster, & Weitz, 2011).

**Socratic dialogue.** Socratic dialogue involves asking questions that help others come to new understandings about their thoughts, behaviors, and experiences (Padesky, 1993). Questions may allow the patient to consider new or different information that has not been considered. When an abortion patient describes patterns of thoughts that sound distressing, a counselor might ask for more information in a way that gently challenges those thoughts. At the same time, answers to the questions may reveal that the counselor had an incomplete understanding of important aspects of the situation. Because no counselor can know the unknown, questions should be asked in the spirit of mutual inquiry, with constructive curiosity, and with compassion. Questions should not be asked to interrogate or to imply that the counselor knows the correct way to think and feel. Likewise, questions should not be asked to try to elicit a specific right answer. Rather, questions are asked in a genuinely open way with the goal of eliciting more information about the events that occurred and how those events may be perceived at present. In the process of reflecting on answers to open questions, the abortion patient has the opportunity to explore whether there are alternative ways to think about an experience that are accurate, balanced, and reasonable, and that lend themselves to self-compassion and healing.

**Language related to gender, social roles, and pregnancy.** In general, to be accurate and validating, counselors are advised to use the terms that patients themselves use to describe themselves, others, and their experiences. This means listening carefully and asking open questions to learn about a person's situation and about how the patient identifies. It is advisable to listen for how the abortion patient describes their gender identity, and if they are in a partnered relationship, how the patient describes their partner's gender, because not all people who seek abortion identify as women and not all are involved in heterosexual relationships.

It is useful to listen for words that refer to the different social roles that a patient or others may occupy, including mother, father, baby, child, or fetus. Some couples immediately identify themselves as mothers or fathers when one person is pregnant. Others only identify themselves in these ways after a certain point in the pregnancy or after birth. When individuals are already parenting children, they are likely to identify themselves as mothers or parents independent of the pregnancy that ended in abortion. Reflecting the patient's own words shows respect and validation. For example, consider an abortion patient who asks, "What kind of a person fails to protect her child and instead selfishly decides to end her child's life?" In response, it is advisable for the counselor to use the word "child" (not "fetus") and to ask for more information about the decision-making process to better understand the circumstances. Additionally, it might be helpful to reflect feelings of guilt or shame and to ask about the thoughts the patient is having that connect to those feelings.

Counselors should be aware that the language that they use may reflect assumptions about whether the pregnancy was wanted or contraception was used. Although most (but not all) pregnancies that end in abortion are unintended, some unintended pregnancies are happy accidents. Additionally, some intended pregnancies become unwanted after life circumstances change, such as when a relationship ends or health problems emerge. Regarding contraception, some people who are sexually active do not use contraception or do not use it correctly, but sometimes contraception fails, and in cases of reproductive or sexual coercion, a patient may be blocked from effective contraceptive use (Chamberlain & Levenson, 2012). As such, until hearing how the patient describes the situation and how conception occurred, it is recommended to avoid referring either to the "father" of the pregnancy or to the "partner." In some cases, abortion patients who seem to feel singularly responsible for becoming pregnant make no mention of anyone else. Questions that might help identify others involved in conception could include, "Who else knows about the pregnancy?" or "Tell me about the

episode that led to you becoming pregnant.” If a patient says that the pregnancy happened because her boyfriend’s condom broke, it is validating for the counselor to refer to her “boyfriend,” but if the patient discloses that she was raped, the counselor can refer to the “perpetrator” or the “rapist.”

**Language related to politics and medicine.** Counselors are advised to avoid language that may have direct or implied connections to politics, including either “pro-choice” or “pro-life” activism. In discussing the abortion decision-making process, the term “choice” can imply connotations of being “pro-choice.” Instead, the terms “decision” and “option” can be substituted with ease. For example, “Can you tell me about how you decided to terminate your pregnancy?” or “It sounds like you picked the option that made the most sense to you at the time.” Similarly, although it is often important to explore different types of thoughts and feelings that occurred at different times, such as before and after an abortion procedure, it is best to avoid the term “post-abortion.” Because of connections between “pro-life” activism and PAS, the phrase “after abortion” can be substituted as a politically neutral and factually accurate alternative. Finally, to work effectively with abortion patients who have safely and legally terminated pregnancies, it is recommended that counselors develop a basic understanding of abortion and its terminology (Grimes & Stuart, 2010), including the difference between surgical abortion (removing the contents of the uterus with instruments, without incision) and medical abortion (ingesting pills to expel the products of conception from the uterus).

## Conclusion

Abortion patients who are in distress can be coping with stigma as well as a variety of realistic stressors and concerns. At the same time, abortion patients might be experiencing patterns of thought or behavioral avoidance that are contributing to intense or prolonged emotional distress. By applying concepts and methods from CBT, both professional and paraprofessional counselors across a variety of community settings may participate in constructive conversations with patients that foster adaptation and recovery. Counselors may collaborate with patients to help them become more aware of their thoughts and how these thoughts are related to feelings and behaviors. Conversations with supportive, nonjudgmental individuals who serve in a counseling role may allow abortion patients to reflect honestly and realistically on their past experiences and current lives. Such reflections may give way to self-compassion and may help to transform distress into feelings of acceptance and peace.

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## References

- Biggs, M. A., Upadhyay, U. D., McCulloch, C. E., & Foster, D. G. (2017). Women’s mental health and well-being 5 years after receiving or being denied an abortion: A prospective, longitudinal cohort study. *JAMA Psychiatry, 74*, 169–178. doi:10.1001/jamapsychiatry.2016.3478
- Chamberlain, L., & Levenson, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings* (2nd ed.). Washington, DC: Family Violence Prevention Fund. Retrieved from <https://www.futureswithoutviolence.org/addressing-intimate-partner-violence/>

- Dadlez, E. M., & Andrews, W. L. (2010). Post-abortion syndrome: Creating an affliction. *Bioethics*, *24*, 445–452. doi:10.1111/j.1467-8519.2009.01739.x
- Edwards, D. (2009). Post-abortion syndrome is a clinical reality: A critical and methodological reflection on the politics, biology and phenomenology of unwanted pregnancy and abortion. *Journal of Psychology in Africa*, *19*, 429–437. doi:10.1080/14330237.2009.10820312
- Finer, L. B., Frohworth, L. F., Dauphinee, L. A., Singh, S., & Moore, A. M. (2005). Reasons U.S. women have abortions: Quantitative and qualitative perspectives. *Perspectives on Sexual and Reproductive Health*, *37*, 110–118. doi:10.1111/j.1931-2393.2005.tb00045.x
- Furedi, A. (2016). *The moral case for abortion*. London, UK: Palgrave Macmillan.
- Grimes, D. A., & Stuart, G. (2010). Abortion jabberwocky: The need for better terminology. *Contraception*, *81*, 93–96. doi:10.1016/j.contraception.2009.09.005
- Herd, P., Higgins, J., Sicinski, K., & Merkurieva, I. (2016). The implications of unintended pregnancies for mental health in later life. *American Journal of Public Health*, *106*, 421–429. doi:10.2105/AJPH.2015.302973
- Horvath, S., & Schreiber, C. A. (2017). Unintended pregnancy, induced abortion, and mental health. *Current Psychiatry Reports*, *19*, 77. doi:10.1007/s11920-017-0832-4
- Jones, R. K., Frohworth, L. F., & Moore, A. M. (2008). “I would want to give my child, like, everything in the world”: How issues of motherhood influence women who have abortions. *Journal of Family Issues*, *29*, 79–99. doi:10.1177/0192513X07305753
- Jones, R. K., & Jerman, J. (2017). Population group abortion rates and lifetime incidence of abortion: United States, 2008–2014. *American Journal of Public Health*, *107*, 1904–1909. doi:10.2105/AJPH.2017.304042
- Kelly, K. (2014). The spread of ‘post abortion syndrome’ as social diagnosis. *Social Science and Medicine*, *102*, 18–25. doi:10.1016/j.socscimed.2013.11.030
- Kimport, K., Foster, K., & Weitz, T. A. (2011). Social sources of women’s emotional difficulty after abortion: Lessons from women’s abortion narratives. *Perspectives on Sexual and Reproductive Health*, *43*, 103–109. doi:10.1363/4310311
- Major, B., Appelbaum, M., Beckman, L., Duttong, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health: Evaluating the evidence. *American Psychologist*, *64*, 863–890. doi:10.1037/a0017497
- Needle, R. B., & Walker, L. E. A. (2008). *Abortion counseling: A clinician’s guide to psychology, legislation, politics, and competency*. New York, NY: Springer.
- Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma. A reconceptualization of constituents, causes, and consequences. *Women’s Health Issues*, *21*, S49–S54. doi:10.1016/j.whi.2011.02.010
- Padesky, C. A. (1993, September). *Socratic questioning: Changing minds or guiding discovery?* Invited keynote address presented at the 1993 European Congress of Behaviour and Cognitive Therapies, London. Retrieved from <https://padesky.com/newpad/wp-content/uploads/2012/11/socquest.pdf>
- Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. New York, NY: Guilford.
- Russo, N. F. (2014). Abortion, unwanted childbearing, and mental health. *Salud Mental*, *37*, 283–291. doi:10.17711/SM.0185-3325.2014.033
- Sanger, C. (2017). *About abortion: Terminating pregnancy in 21st century America*. Cambridge, MA: Harvard University Press.
- Solinger, R. (2013). *Reproductive politics: What everyone needs to know*. New York, NY: Oxford University Press.
- Speckhard, A., & Rue, V. M. (1993). Complicated mourning: Dynamics of impacted post abortion grief. *Pre- and Peri-Natal Psychology Journal*, *8*, 5–32.
- Wenzel, A. (2017). Cognitive behavioral therapy for pregnancy loss. *Psychotherapy*, *54*, 400–405. doi:10.1037/pst0000132