The Prevalence and Effects of Unwanted Abortions in Canada: A Retrospective Cross-sectional Study

David C. Reardon[1,2]

1. Elliot Institute, Gulf Breeze, FL, USA
2. Charlotte Lozier Institute, Arlington, VA, USA

Abstract

Background: It is common for women to report feeling pressured into abortions. Those who abort contrary to their own values and preferences are more likely to experience more negative emotional and psychological outcomes. But the full breadth and timing of negative reactions has not been fully explored, especially among Canadians.

Methods: Portions of the Unwanted Abortion Studies were deployed in a survey of 1,141 Canadian women 41-45 years of age, inclusive, to compare the types and degree of pressures they face compared to their American counterparts. Twenty-three additional symptoms were assessed as well as a measure of when, if at all, negative post-abortion reactions were most severe.

Results: With a 98.3% completion rate, 26.7% of eligible respondents reported a history of abortion. Moderate to high levels of pressure were reported from the male partner (48%), family members (37%), other persons (33%), financial pressures (69%) and other circumstances (77%). Ninety-one percent reported moderate to high levels of pressure to abort on at least one scale. Pressure to abort was positively correlated with all negative outcomes investigated, including a self-attributed decline in mental health. The worst of negative reactions occurred immediately after their abortions for 35%, while 40% reported delayed negative reactions, including the 15% who stated that the worst effects "continue to persist, even today" an average of twenty years later.

Discussion: Most Canadian women with a history of abortion felt pressured to abort contrary to their own values and preferences. Negative reactions manifest in numerous ways, but all are associated with feeling pressured to abort. The pressures Canadian women face are similar to those reported by American women with the exception that they are somewhat more likely to feel pressured to abort by their male partners.

Categories: Obstetrics/Gynecology, Psychology, Epidemiology, Public Health

Keywords: post-abortion mental health, post-abortion adjustments, risk factors, health policy, reproductive rights, mental health, abortion

Introduction

Feeling pressured to choose an abortion is a known risk factor for more negative psychological reactions.[1–5] In a recent analysis of the Unwanted Abortions Studies over 60% of American women who reported a history of abortion also reported high levels of pressure to choose an abortion.[5] In addition, nearly 70% reported that the abortion decision was contrary to their own values and preferences.[6] These findings led to a request for us to replicate this investigation in the population of Canada.

The purpose of this investigation is to identify the prevalence and types of pressures to abort typically experienced by Canadian women. We hypothesize that the types of pressure, and their associations with negative outcomes, will be similar to those observed among American women.[5,6] In addition, we chose to investigate a large number of additional negative reactions that are reported in the literature but which have been rarely studied.[7,8] Finally, in light of reports that many postabortion reactions are delayed,[7,8] we also sought to investigate the timing of when, if at all, the worst of negative reactions are experienced.

Material and Methods

Study design and setting

This study is based on a retrospective survey including visual analog sliding scales that allow respondents to rank the degree of pressures they faced, if any, from five possible sources and to also rank the degree, if any, of ten outcomes they experienced. The exact questions, the scale labels used for each question, and abbreviations used for each question that were common to both the American and Canadian surveys are shown in Table 1.

Table 1: Survey Questions and Abbreviations Common to Both American and Canadian Samples

Abbreviation	Complete statement or question	Scale of Agreement
MalePr	I felt pressure to abort from my male partner.	Not at all | Very much so
FamilyPr	I felt pressure to abort from one or more family members.	Not at all | Very much so
OtherPr	I felt pressure to abort from someone else.	Not at all | Very much so
FinPr	I felt pressure to abort from financial concerns.	Not at all | Very much so
OtherCircPr	I felt pressure to abort from other circumstances.	Not at all | Very much so
MaternalConflict	The idea of abortion conflicted with my maternal desires.	Not at all | Very much so
MoralConflct	The idea of abortion conflicted with my moral beliefs.	Not at all | Very much so
EmotionalAttachment	My emotional attachment to the pregnancy was...	None at all | Very high
MoreSupport	If I had received more support from others, I would have continued the pregnancy.	Not at all true | Very true
MoreFinSecurity	If I had more financial security, I would have continued the pregnancy. [|Not at all true|Very True]	Not at all true | Very true

PositiveEmotions	My positive emotions regarding the abortion are . . .	None at all | Very high
NegativeEmotions	My negative emotions regarding the abortion are . . .	None at all | Very high
InterferedwLife	Thoughts and feelings about my abortion have negatively interfered with daily life, work, or relationships.	Not at all true | Very true
BetterMentalHlth	Abortion made my mental health . . .	Very much worse | Very much better

The visual analog responses were converted into numeric scores from 0 to 100. In addition, two variables were constructed from the responses: MaxPr and AvgPr. MaxPr was the maximum score reported on any of the five pressure scales (MalePr, FamilyPr, OtherPr, FinPr, OtherCircPr) while AvgPr was the computed average of the same five scales. In addition, the variable DecisionType was constructed with a value from 1 to 4, respectively, when women described their abortions as (1) "Wanted and consistent with my values and preferences"; (2) "Accepted but inconsistent with my values or preferences"; (3) "Unwanted and contrary to my values and preferences"; and (4) "Coerced and contrary to my values and preferences."

In addition, 23 symptoms elsewhere reported in the literature from postabortion counseling programs[7] were included in the Canadian survey. For each of these outcomes women asked to rate the degree "There have been times my abortion contributed to [named symptom]" on a visual analog sliding scale ranging from "not at all" to "very much." The symptoms categorized were: grief, depression, anxiety, guilt, relief, emptiness, anger, empowerment, regret, shame, unforgiveness of self, sleeping problems, uncontrollable weeping, "abortion related nightmares, flashbacks, or intrusive thoughts," drug use, alcohol use, eating disorders, suicidal thoughts, self-destructive or risk taking behaviors, "frequent thoughts of the child I could have had," "fear of sex / pregnancy", sexual dysfunctions or promiscuity, difficulty completing the grieving process.

An additional categorical question asked respondents to identify when "The worst of any negative emotions and/or mental health issues due to my abortion occurred . . ." Answers to this item were assigned a value of 1 to 5, respectively, when women answered (1) I have never experienced any negative emotions or mental health effects; (2) "Immediately", (3) "Within one year of the abortion", (4) "Were delayed, peaking more than a year later," or (5) "Continue to persist, even today." Higher numbers on this scale, abbreviated as WorstTimes, represent more delay or persistence of the worst of the negative reactions reported.

Population

The survey was electronically distributed by Cint.com, a global research platform, in January of 2024 to a subset of persons in Cint's Canadian survey panel, of approximately 2.2 million, who were identified as females between 41 and 45 years of age with a target of obtaining 1000 completed responses. Cint provided respondents who participated a small incentive with a value of less than four dollars.

The study design was approved by Sterling Institutional Review Board (ID:10225). Participants signed informed consent agreements with the survey distributor, Cint.com.

Analyses

Descriptive statistics and statistical analyses were created using JASP 0.18.3 and the figures were created using Microsoft Excel. The comparisons of the means of the scales common to both the American and Canadian Unwanted Abortion Surveys were conducted using both Independent two-sample t-tests and Welch's unequal variances t-tests.

Results

A total of 1,292 Canadians presented with an opportunity to participate electronically opened the survey. There was no pre-identification of the survey topic, and the first two questions simply asked about age and gender. A total of 71 exited the survey without answering any questions, yielding a total of 1,221 (94.5%) respondents who answered at least the first page of demographic questions. Among those respondents, 12 (1.0%) were excluded due to gender and 62 (5.3%) were excluded for being out of the required age range. Of the remaining 1,147 *eligible respondents*, 1,105 (96.3%) completed the survey, of whom 295 (26.7%) reported a history of abortion. Only this latter group was included in the following analyses.

Table 2 shows the mean scores, the 95% confidence interval of the mean scores, and the standard deviation (SD) for the both the Canadian women reporting a history of abortion and the 226 American women (USA) reporting a history of abortion who answered the same questions in a separate survey.[5,6] T-tests to check for any differences in the mean scores revealed that only the mean score for male pressure was significantly different ($t=2.6$; $p<0.01$), with Canadian women somewhat more likely to score male pressure as higher than that reported by American women. In most other respects, the experience of Canadian women appears to be similar to that of American women. Among Canadian women, 6.7% described their abortions as coerced, 15.3% described them as unwanted, 37.6% said it was "accepted but inconsistent with my values and preferences," and 40.3% reported it was "wanted and consistent with my values and preferences."

Table 2: Mean scores with 95% confidence intervals (CI) and standard deviations

Table 3

Scale	Counry	Mean	95% CI Lower	95% CI Upper	Std. Deviation
MalePr	Canada	40.0	35.6	44.4	38.3
	USA	31.3	26.7	36.0	35.4
FamilyPr	Canada	31.5	27.5	35.6	35.5
	USA	34.7	29.7	39.6	37.8
OtherPr	Canada	27.1	23.3	30.8	32.4
	USA	23.7	19.5	28.0	32.3
FinPr	Canada	58.3	54.1	62.6	37.0
	USA	54.6	49.8	59.4	36.6
OtherCircPr	Canada	64.9	60.8	68.9	35.3
	USA	64.7	60.3	69.1	33.5
MaxPr	Canada	81.2	78.1	84.2	26.6
	USA	80.3	76.9	83.7	25.7

AvgPr	Canada	44.4	41.8	47.0	22.8
	USA	41.8	38.9	44.7	21.9
MaternalConflict	Canada	46.8	42.8	50.8	35.0
	USA	46.3	41.7	50.9	35.1
MorallConflict	Canada	44.5	40.5	48.5	35.1
	USA	49.1	44.6	53.7	34.8
EmotionalAttachment	Canada	49.0	45.3	52.7	32.3
	USA	48.8	44.7	53.0	31.6
MoreSupport	Canada	45.7	41.6	49.8	35.8
	USA	41.3	36.6	46.0	35.7
MoreFinSecurity	Canada	54.3	50.1	58.4	36.5
	USA	48.5	43.6	53.4	37.5
InterferedwLife	Canada	36.9	33.3	40.6	31.7
	USA	35.7	31.4	40.0	33.0
PositiveEmotions	Canada	49.9	46.7	53.2	28.1
	USA	50.4	46.4	54.4	30.5
NegativeEmotions	Canada	46.8	43.4	50.2	29.6
	USA	50.7	46.3	55.0	33.0
BetterMentalHlth	Canada	49.8	47.2	52.5	23.4
	USA	49.0	46.0	52.1	23.4
DecisionType	Canada	1.9	1.8	2.0	0.9
	USA	2.0	1.9	2.1	0.9

The remaining analyses are restricted to the Canadian women only.

Figure 1 illustrates the distributions for each type of pressure Canadian women faced subdivided into five levels of pressure reported: little (a score of 0 to 20), modest (21-40), moderate (41-60), substantial (61-80) and high (80-100). Notably, moderate to high levels of pressure were reported from the male partner (48%), family members (37%) and other persons (33%). Overall, 35% reported a score above 80 (high pressure) and 65% reported a score above 40 (moderate pressure) on at least one of the interpersonal scales (MalePr, FamilyPr, OtherPr). These interpersonal pressures, however, were exceeded by both moderate to high financial pressures (69%) and other circumstances (77%). Most notably, 91% reported moderate to high levels of pressure to abort on at least one scale (MaxPr), with 67% reporting at least one score in the highest range, above 80.

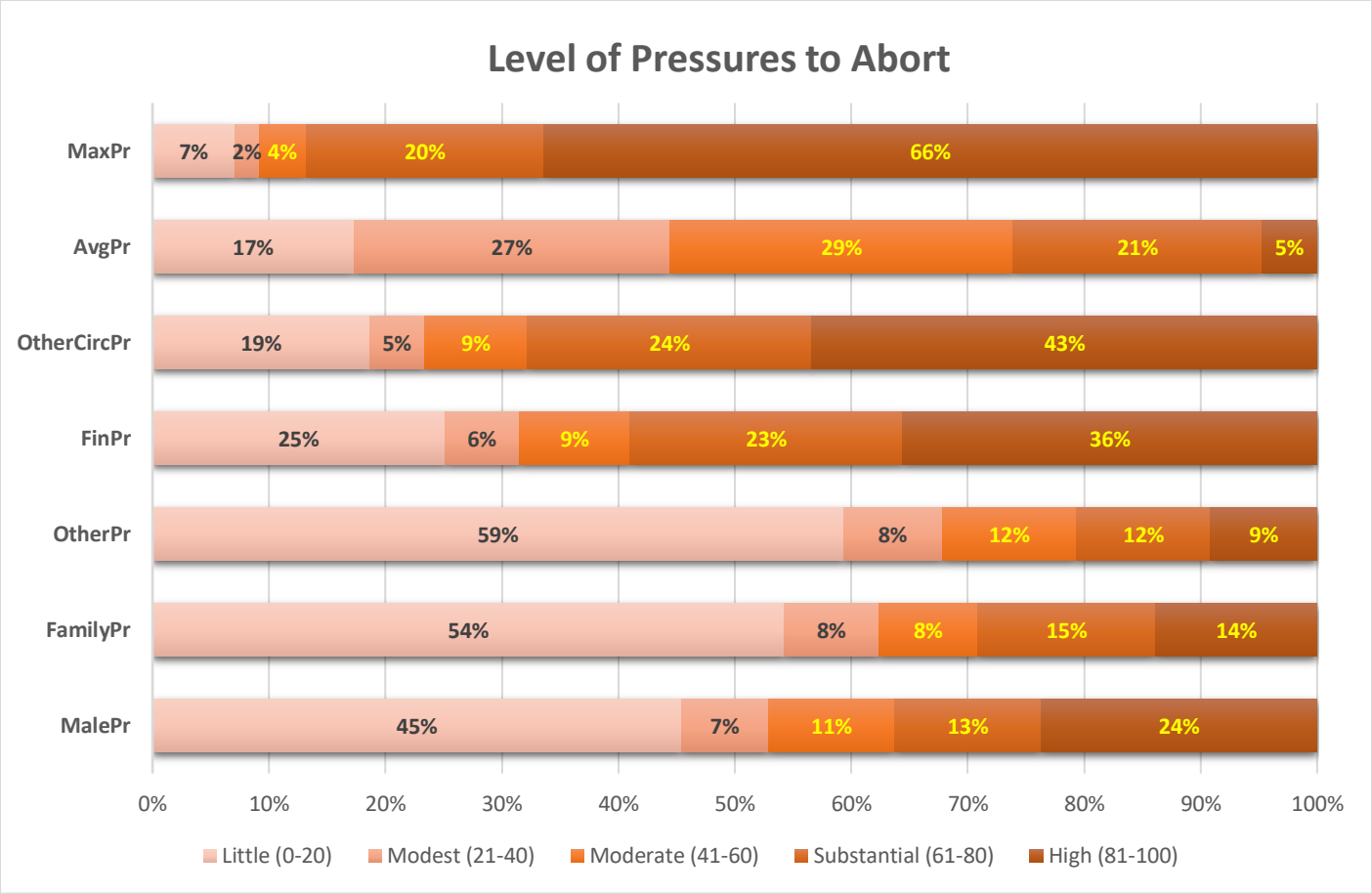

Figure 1: Degree of Pressures Reported Among Canadian Women

Table 3 shows descriptive statistics, including the mean, standard deviation, and interquartile range (IQR) for all the outcome variables examined.

Table 3: Mean scores, standard deviations, and interquartile range for outcome variables

Variable	Mean	Std. Deviation	IQR
MaternalConflict	46.57	35.02	68.0
MorallConflict	46.50	34.99	63.0
EmotionalAttachment	48.90	31.96	54.0
MoreSupport	43.80	35.80	71.0
MoreFinSecurity	51.77	36.97	75.0
InterferedwLife	36.40	32.26	59.0
PositiveEmotions	50.12	29.14	42.0
NegativeEmotions	48.45	31.12	50.0
BetterMentalHlth	49.48	23.35	28.0
Grief	60.78	34.34	59.5

Depression	57.24	35.19	64.0
Anxiety	56.20	35.19	63.5
Guilt	64.68	34.70	58.0
Relief	53.65	31.63	45.0
Emptiness	50.62	33.41	55.5
Anger	43.53	33.56	61.5
Empowerment	34.50	30.35	47.5
Regret	54.26	35.25	64.0
Shame	53.43	35.22	64.0
Unforgiveness	46.24	35.84	69.5
Sleep Problems	40.00	34.28	64.5
Weeping	40.61	34.11	65.0
Flashbacks	35.42	34.08	61.0
Drug Use	24.53	31.04	45.0
Alcohol Use	27.04	33.54	53.5
Eating Disorders	25.92	32.07	46.0
Suicidal Thoughts	22.71	29.91	38.5
Risk Taking	26.84	32.24	51.0
Child Thoughts	52.59	34.90	60.0
Fear Sex	34.65	33.51	63.5
Sex Dysfunction	26.70	31.33	50.0
Complicated Grief	39.06	34.60	66.5

Figures 2, 3 and 4 show the distribution of these outcome variables grouped into little, modest, moderate, substantial, and high degrees. Together, Table 3 and Figures 2,3, and 4 show that, on average, the most strongly experienced reactions were guilt, grief, depression, anxiety, regret, relief, shame, and thoughts of the missing child. Suicidal thoughts were the least common reaction, but they were still reported as relatively common, with 6% reporting a high degree of suicidal thoughts, and 24% reporting moderate to high levels of suicidal thoughts. However, it should also be noted that any women who completed suicide would, of course, not have been represented in our sample.

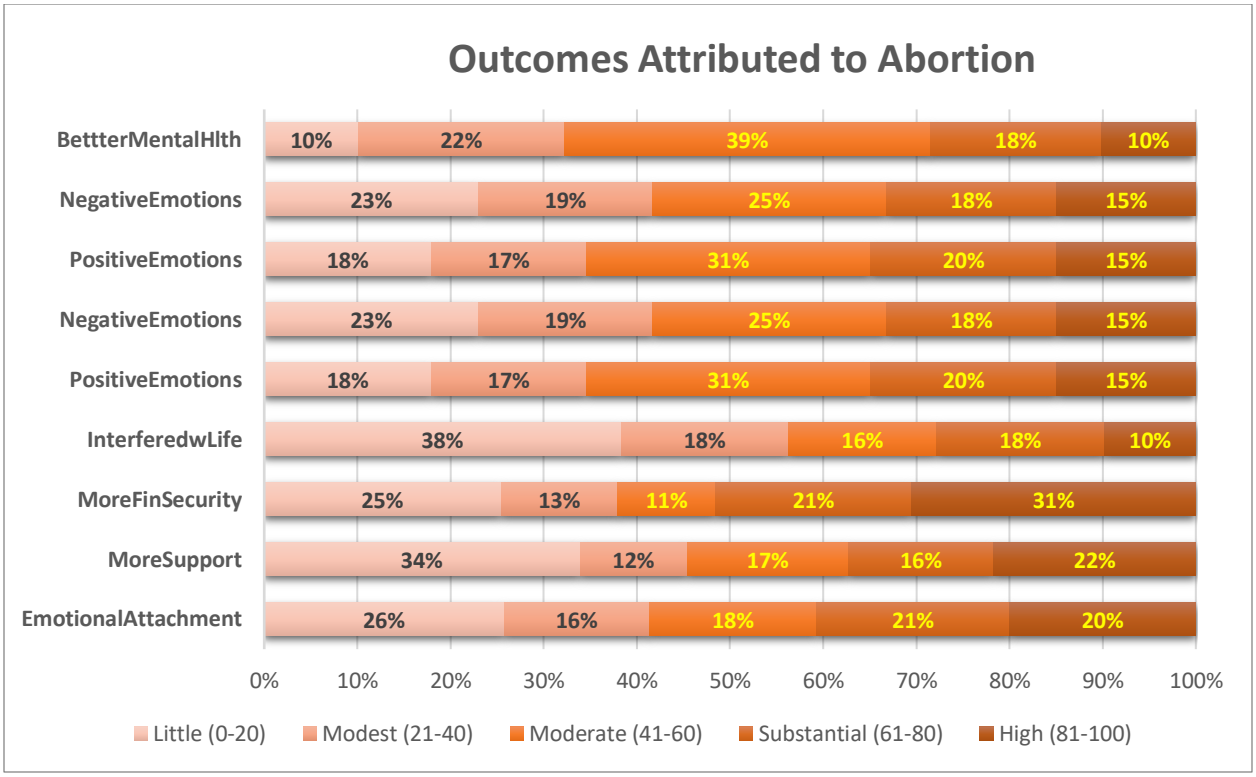

Figure 2: Distribution of responses to some outcome scales

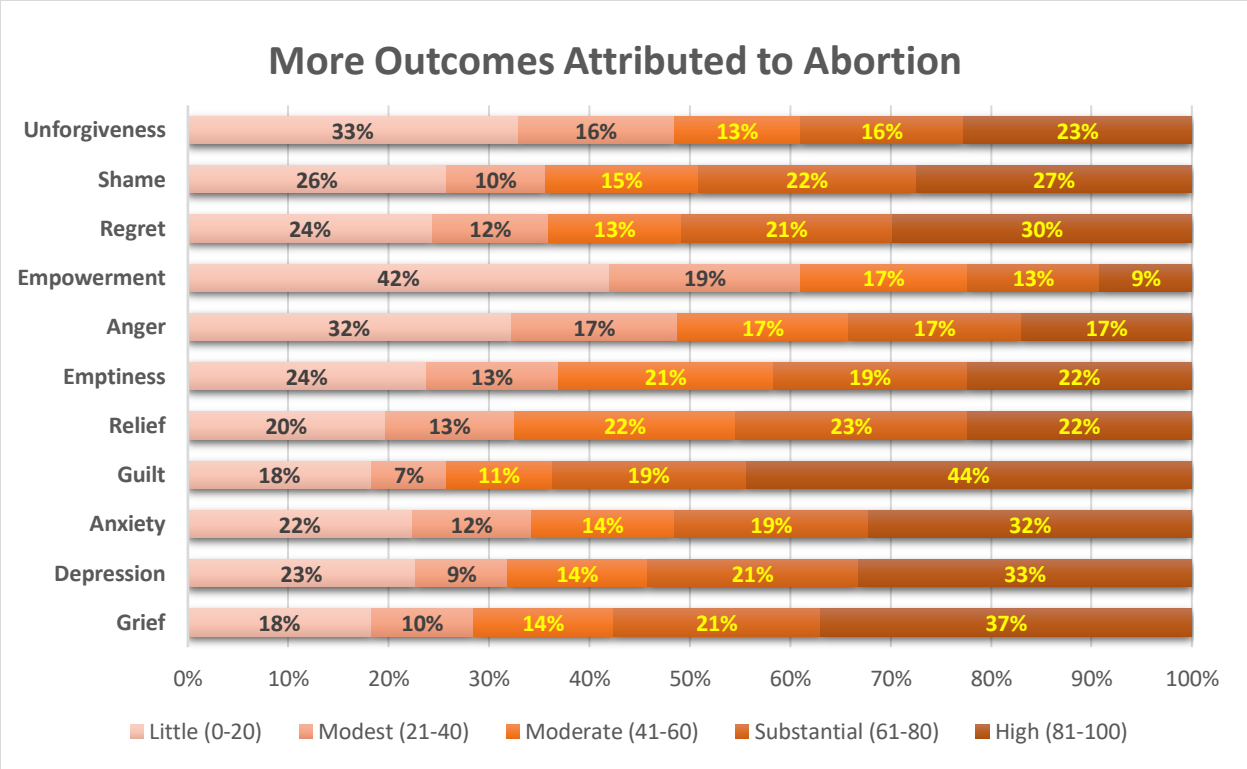

Figure 3: Distribution of additional outcome scales attributed to abortion

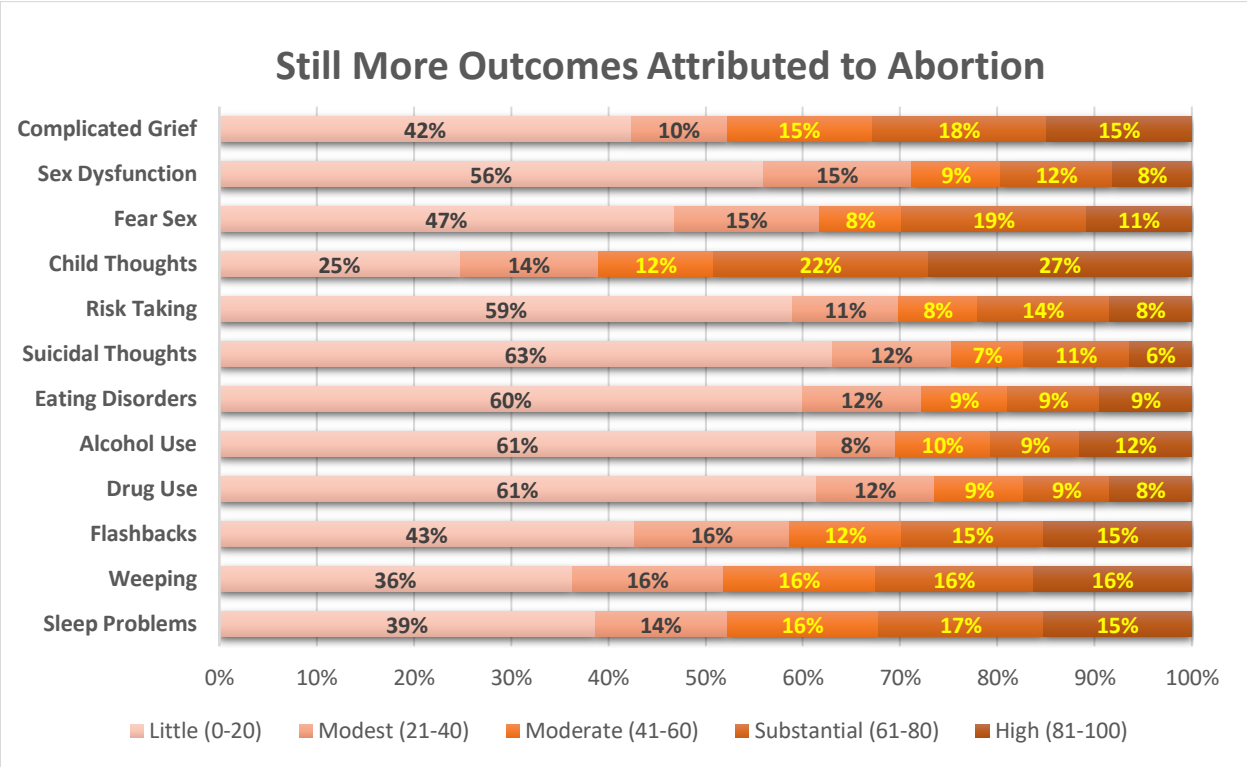

Figure 4: Distribution of additional outcome scales attributed to abortion

Table 4 shows that 35% reported that the worst of their reactions were immediately after their abortions, with 40% reporting delayed reactions, including 15% who stated that the worst effects "continue to persist, even today." Approximately 25% reported never having any negative emotional reactions. There were no significant differences between the age at first abortion and the years since the abortion and the WorstTimes outcome variable. But WorstTimes was positively correlated to DecisionType (0.16; p=0.005). Notably, nearly 60% of women who freely chose their abortions still reported at least some negative effects that they attributed to their abortions, though only 5% reported that the worst of their symptoms continue to persist today, a substantially lower rate than the women in the other three groups.

Table 4: Distributions of WorstTimes variable and their associated time frames and DecisionType

WorstTimes	% (n=295)	Age at first abortion		Years since abortion		DecisionType			
		years	SD	years	SD	Freely Chosen	Inconsistent	Unwanted	Coerced
I have never experienced any negative emotions or mental health effects.	24.8%	23.1	6.34	19.9	6.69	39.5%	12.6%	17.8%	20.0%
Immediately	35.3%	24.3	7.13	18.8	7.19	30.3%	37.8%	37.8%	45.0%
Within one year of the abortion.	14.6%	21.9	5.87	21	6.27	12.6%	16.2%	15.6%	15.0%
Were delayed, peaking more than a year later.	10.9%	22.7	8.23	20.6	8.1	12.6%	12.6%	4.4%	5.0%
Continue to persist, even today.	14.6%	22.8	7.51	20.6	7.73	5.0%	20.7%	24.4%	15.0%
All	100.00%	23.3	6.96	19.9	7.13	100%	100%	100%	100%

Table 5 shows that most forms of pressure were moderately to strongly correlated to one or more additional forms of pressure. Only pressure from other circumstances (OtherCircPr) was not significantly correlated with MalePr and FamilyPr. Notably, DecisionType was only correlated with interpersonal pressures. In addition, with the exception of OtherCircPr, all the pressure scales were significantly associated with WorstTimes, indicating a greater risk of the worst negative symptoms being delayed and/or persistent over many years.

Table 5: Pearsons correlations between pressure scales, DecisionType, and WorstTimes

Variable	MalePr	FamilyPr	OtherPr	FinPr	OtherCircPr	MaxPr	AvgPr	DecisionType
1. MalePr	—							
2. FamilyPr	0.29 ***	—						
3. OtherPr	0.28 ***	0.53 ***	—					
4. FinPr	0.26 ***	0.28 ***	0.29 ***	—				
5. OtherCircPr	0.06	0.11	0.18 **	0.34 ***	—			
6. MaxPr	0.30 ***	0.21 ***	0.19 **	0.52 ***	0.64 ***	—		
7. AvgPr	0.61 ***	0.68 ***	0.69 ***	0.69 ***	0.52 ***	0.59 ***	—	
8. DecisionType	0.25 ***	0.11	0.08	<0.01	-0.02	0.10	0.13 *	—
9. WorstTimes	0.23 ***	0.27 ***	0.17 **	0.20 ***	0.07	0.24 ***	0.29 ***	0.16 **

* p < .05, ** p < .01, *** p < .001

Table 6 shows the correlations between MaxPr, AvgPr, DecisionType and WorstTimes for all the outcome scales. This reveals that both the pressure scales, decision type and more delayed or persistent reactions are strongly correlated to most negative outcomes. Of the four positive outcomes (PositiveEmotions, BetterMentalHealth, Relief, Empowerment), only better mental health was significantly correlated, negatively, with both pressure scales, DecisionType and WorstTimes. PositiveEmotions were uncorrelated with AvgPr and WorstTimes, weakly negatively correlated with MaxPr, and strongly negatively correlated to DecisionType. Relief and Empowerment were only correlated, negatively, with DecisionType.

Table 6: Pearson's Correlations of Outcome Variables to MaxPr, AvgPr, DecisionType and WorstTimes

Outcome Variables	MaxPr	AvgPr	DecisionType	WorstTimes
MaternalConflict	0.24 ***	0.44 ***	0.38 ***	0.17 ***
MorallConflict	0.26 ***	0.41 ***	0.48 ***	0.14 ***
EmotionalAttachment	0.21 ***	0.33 ***	0.40 ***	0.20 ***
MoreSupport	0.29 ***	0.48 ***	0.44 ***	0.28 ***
MoreFinSecurity	0.36 ***	0.50 ***	0.35 ***	0.21 ***
InterferedwLife	0.20 ***	0.43 ***	0.37 ***	0.25 ***
PositiveEmotions	-0.14 **	-0.07	-0.34 ***	-0.09
NegativeEmotions	0.31 ***	0.45 ***	0.45 ***	0.21 ***
BetterMentalHlth	-0.20 ***	-0.18 ***	-0.35 ***	-0.18 ***
Grief	0.33 ***	0.35 ***	0.27 ***	0.42 ***

Depression	0.31***	0.44***	0.39***	0.39***
Anxiety	0.32***	0.50***	0.29***	0.34***
Guilt	0.37***	0.42***	0.40***	0.31***
Relief	-0.08	<0.01	-0.24***	-0.09
Emptiness	0.32***	0.47***	0.35***	0.37***
Anger	0.27***	0.40***	0.37***	0.32***
Empowerment	-0.13*	0.07	-0.22***	-0.03
Regret	0.32***	0.41***	0.40***	0.39***
Shame	0.32***	0.42***	0.37***	0.30***
Unforgiveness	0.21***	0.38***	0.43***	0.36***
Sleep Problems	0.26***	0.41***	0.34***	0.38***
Weeping	0.28***	0.40***	0.34***	0.39***
Flashbacks	0.26***	0.43***	0.33***	0.30***
Drug Use	0.18**	0.37***	0.24***	0.24***
Alcohol Use	0.20***	0.38***	0.31***	0.25***
Eating Disorders	0.18**	0.37***	0.31***	0.26***
Suicidal Thoughts	0.18**	0.40***	0.31***	0.29***
Risk Taking	0.22***	0.46***	0.29***	0.22***
Child Thoughts	0.36***	0.37***	0.36***	0.41***
Fear Sex	0.19***	0.37***	0.18**	0.24***
Sex Dysfunction	0.20***	0.37***	0.33***	0.24***
Complicated Grief	0.31***	0.43***	0.43***	0.43***

* $p < .05$, ** $p < .01$, *** $p < .001$

Discussion

These findings reveal that it is common for Canadian women to feel pressured into unwanted abortions, including abortions which conflict with their own values and preferences, which in turn are associated with higher risks across multiple negative emotional reactions, including a self-reported worsening of mental health. The pressures Canadian women face are statistically similar to those reported by American women with the exception that they are slightly, but significantly, more likely to feel pressured to abort by their male partners.

This study is an improvement upon prior research in that it investigated a greater number of symptoms that women attribute to their abortions. Of special interest was the finding that while 25% reported never having experienced any negative emotions or mental health effects, among the subset of those who do attribute negative outcomes to their abortions, 53% reported delayed reactions with 19%

reporting that the most severe reactions continue to persist, on average, over 19 years later. This finding underscores the importance of increased availability of postabortion counseling services that may help to mitigate these persistent mental health issues. In addition, women reporting no negative effects are disproportionately from the group of women who freely choose abortions according to their own values and preferences. Previous research indicates that these women may also be more likely to participate in postabortion studies initiated by abortion providers,[5,6] which may help to explain the notoriously low participation rates and non-representative findings from such surveys.[9]

A strength of this study is the extraordinarily high participation and completion rate.[10] This is likely due to at least four factors. First, Cint panelists are accustomed to completing surveys in exchange for small rewards. Second, due to the age group selected, women are being asked to reflect on abortion experiences that occurred nearly 20 years previously, when the intensity of negative feelings may have healed or declined. While 15% reported that their negative feelings are still at their worst, that is far lower than the 38% who reported that their worst feelings began immediately after their abortions. Third, this survey outreach was not associated with the respondents' abortion providers. This eliminated any emotional triggers associated with their abortion providers[7] and guaranteed women a greater sense of anonymity than they would have experienced if they had been asked to participate in a postabortion survey in an abortion clinic waiting room. Fourthly, the survey included three preamble questions designed to reduce fear of judgment by conveying an immediate understanding that many women undergo unwanted abortions.

Specifically, on a separate page appearing after the first two demographic questions, women read: "Some women feel pressured into abortions by other people (like a male partner) or by circumstances (like poverty). Do you believe the problem of women feeling pressured to have abortions is very rare, uncommon, somewhat common, or very common?" They were then asked, "How many people do you know who felt pressured to have abortions?" Thirdly, to ease the respondents into even considering a revelation of their abortion histories, women were asked: "Even if you did not go through with it, have you ever felt pressured to consider an abortion?" Only after these three questions were women directly asked if they had ever had an abortion.

Using this methodology the percentage of women admitting a history of abortion, at least in the American sample, exactly matched the estimates for this age group generated by the Guttmacher Institute, the foremost research and resource group for abortion providers.[6,11] To our knowledge, this approach has resulted in the highest participation and disclosure rate of any survey method to date.[10] Given the fact that the percent of women reporting abortions in the Canadian sample (26.7%) was even higher than in the American sample (23.7%), it appears likely that this methodology worked equally well in its Canadian iteration.

A weakness of this study is that it is cross-sectional. It captures information only at one point in time. In addition, except for the women who are reporting current symptoms, it relies on retrospective reports that may be colored by time, psychotropic medication and/or active defense mechanisms, such as reaction formation. Given these limitations, it is more likely that negative reactions are underreported rather than overreported.

Additional research is needed to investigate when and how women recover from negative emotional and mental health outcomes they attribute to their abortions. This is especially important in light of the

finding that these negative outcomes can persist at their greatest intensity even twenty years later for approximately 15% of all women with a history of abortion.

Ethics approval and consent to participate: The study design was approved by Sterling Institutional Review Board (ID:10225). Participants signed informed consent agreements with the survey distributor, Cint.com.

Availability of data and materials: In order to allow the primary research team to complete and publish additional analyses, the data analyzed will be made available from the corresponding author after May 1, 2026.

Competing interests: The author is an advocate for post-abortion counseling programs for women seeking help after unwanted or coerced abortions.

Funding: Alliance for Life Ontario and Charlotte Lozier Institute

Acknowledgements: Not applicable.

References

1. Major B, Appelbaum M, Beckman L, Dutton MA, Russo NF, West C. *Report of the APA Task Force on Mental Health and Abortion*. American Psychological Association; 2008.
2. Rue VM, Coleman PK, Rue JJ, Reardon DC. Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Medical Science Monitor*. 2004;10(10):SR5-SR16.
3. Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *SAGE Open Med*. 2018;6:205031211880762. doi:10.1177/2050312118807624
4. Broen AN, Moum T, Bödtker AS, Ekeberg Ö. Reasons for induced abortion and their relation to women's emotional distress: a prospective, two-year follow-up study. *Gen Hosp Psychiatry*. 2005;27(1):36-43. doi:10.1016/J.GENHOSPPSYCH.2004.09.009
5. Reardon DC, Longbons T. Effects of Pressure to Abort on Women's Emotional Responses and Mental Health. *Cureus*. 2023;15(1):e34456. doi:10.7759/cureus.34456
6. Reardon DC, Rafferty KA, Longbons T, Reardon DC, Rafferty KA, Longbons T. The Effects of Abortion Decision Rightness and Decision Type on Women's Satisfaction and Mental Health. *Cureus*. 2023;15(5). doi:10.7759/CUREUS.38882
7. Burke T, Reardon DC. *Forbidden Grief: The Unspoken Pain of Abortion*. Acorn Books; 2007.
8. Reardon DC. The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *SAGE Open Med*. 2018;6:205031211880762. doi:10.1177/2050312118807624

9. Reardon DC. The Embrace of the Pro-Abortion Turnaway Study. Wishful Thinking? or Willful Deceptions? *Linacre Q*. 2018;85(3):204-212. doi:10.1177/0024363918782156

10. Tierney KI. Abortion Underreporting in Add Health: Findings and Implications. *Popul Res Policy Rev*. 2019;38(3):417-428. doi:10.1007/S11113-019-09511-8

11. Jones RK, Jerman J. Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014. *Am J Public Health*. 2017;107(12):1904-1909. doi:10.2105/AJPH.2017.304042