

Understanding Decision-Making and Decision Difficulty in Women With an Unintended Pregnancy in the Netherlands

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Marieke Brauer^{1,2}, Jenneke van Ditzhuijzen¹ , Hennie Boeije¹,
and Carolus van Nijnatten¹

Abstract

Previous research indicates that a considerable number of women with an unintended pregnancy experience difficulty deciding about continuing or terminating the pregnancy. We examined the decision-making processes of women who experienced high decision difficulty and women who experienced little decision difficulty, to gain insight in the factors that contribute to experienced decision difficulty. Sixty-nine women who had an abortion, and 40 women who had decided to continue their unintended pregnancy, participated in qualitative interviews. We found that women's decision processes varied on 11 relevant criteria. The decision-making processes of women who experienced little decision difficulty differed from that of women who experienced high decision difficulty, but the decision-making processes of women who carried their pregnancy to term and the high decision difficulty abortion group were strikingly similar. Implications of our findings for future research and for professional care for women who are in need of support during decision-making are discussed.

Keywords

abortion; reproductive health; decision making; pregnancy; parenting; qualitative; the Netherlands

Introduction

In the Netherlands, about 8.5 in 1,000 fertile women per year terminate a pregnancy, and this abortion rate has been stable over the last 15 years (IGJ, 2018). Women often know whether they want to terminate or not upon pregnancy discovery (Cohan, Dunkel-Schetter, & Lydon, 1993; Husfeldt, Hansen, Lyngberg, Noddebo, & Petersson, 1995; Moore, Frohwirth, & Blades, 2011; Visser et al., 2005); however, 25% to 32% of women experience decision difficulty to some extent (Husfeldt et al., 1995; Törnbohm, Ingelhammar, Lilja, Svanberg, & Möller, 1999; Van Ditzhuijzen, Ten Have, De Graaf, Van Nijnatten, & Vollebergh, 2015; Visser et al., 2005). Other studies show that 10% to 15% of women who initially thought about having an abortion later changed their mind (Holmgren & Uddenberg, 1993; Söderberg, Andersson, Janzon, & Sjöberg, 1997). Systematic reviews concluded that abortion clients who express difficulty deciding are at increased risk for postabortion distress (Academy of Medical Royal Colleges, 2011; American Psychological Association [APA], Task Force on Mental Health and Abortion, 2008; Charles, Polis, Sridhara, & Blum, 2008). However, decision difficulty seems unrelated to postabortion mental

disorders (Van Ditzhuijzen, Ten Have, De Graaf, Van Nijnatten, & Vollebergh, 2017). Decision difficulty can be seen as a healthy response when faced with an unwanted pregnancy. It involves a dilemma with two unfavorable options; some women immediately know what to choose, whereas others need time to weigh their arguments, wishes, and emotions. Earlier research has shown that decision difficulty is not related to decision satisfaction or decision “rightness”: Most women are satisfied with the abortion, whether they experienced decision difficulty or not (Van Ditzhuijzen et al., 2015). However, it is still unclear which factors play a role in the decision-making process, for women who experience high or low levels of decision difficulty. Furthermore, it is also unknown whether the decision process is different for women who decide to terminate the pregnancy, and those who decide to carry it to term. It

¹Utrecht University, Utrecht, The Netherlands

²PsyQ Mental Health Services, Purmerend, The Netherlands

Corresponding Author:

Jenneke van Ditzhuijzen, Department of Interdisciplinary Social Sciences, Faculty of Social and Behavioural Sciences, Utrecht University, PO Box 80.140, 3508 TC, Utrecht, The Netherlands.
Email: j.m.vanditzhuijzen@uu.nl

is important to gain more in-depth insight into the decision-making process of women with an unwanted pregnancy, and how decision difficulty affects this process. IGT

There is a growing body of international literature on the post-abortion period, concluding that it is unlikely that having an abortion causes mental disorders, and that associations—if any—are explained by previous mental disorders (e.g., Academy of Medical Royal Colleges, 2011; American Psychological Association [APA], Task Force on Mental Health and Abortion, 2008; Biggs, Upadhyay, McCulloch, & Foster, 2017; Steinberg et al., 2018; Van Ditzhuijzen, Ten Have, De Graaf, Van Nijnatten, & Vollebergh, 2018). However, little research exists on the period between pregnancy discovery and the final decision, that is, the decision-making process. The available research has shown that the decision-making process regarding an unintended/unwanted pregnancy is complex and involves women's living circumstances, relationship with the sexual partner, future plans, moral considerations about abortion/motherhood, and so on (Finer, Frohworth, Singh, & Moore, 2005; Kirkman, Rosenthal, Mallett, Rowe, & Hardiman, 2010). Decision difficulty is usually measured as a unitary construct, and often with single-item measures (Broen, Moum, Bødtker, & Ekeberg, 2006; Foster, Gould, Taylor, & Weitz, 2012); however, it often seems to reflect weighing many different factors and might be multidimensional (Brauer, van Nijnatten, & Vollebergh, 2012).

The purpose of this study is to describe decision-making processes for three groups of women who have been faced with an unintended or unwanted pregnancy: (a) women who chose to have an abortion who experienced no or little decision difficulty, (b) women who opted for abortion and experienced decision difficulty to considerable or high extent, (c) women who decided to give birth after seriously considering abortion, who had experienced strong decision difficulty for which they had sought options counseling. The inclusion of the latter group is, to our knowledge, unique in studies like these. With this study design, we were able to identify characteristics of decision making within each subgroup and to detect similarities and differences between subgroups. This knowledge may provide professional counselors with useful insights about these groups.

Method

Participants

The study sample consisted of 109 women who had experienced an unintended pregnancy. Of these, 69 had decided to terminate the pregnancy and had had an abortion within 7 months prior to the in-depth interview. The other 40 women had decided to carry their pregnancy to term and participated in the study while pregnant. All women were

interviewed individually. Inclusion criteria were (a) age 18 to 45 years, (b) living in the Netherlands, and (c) sufficiently proficient in the Dutch language. Women who had or considered the abortion on medical grounds were excluded, as well as women who became pregnant again in the period between the abortion and the interview.

The women who had an abortion were recruited in a related quantitative study, the Dutch Abortion and Mental Health Study (DAMHS; for example, Van Ditzhuijzen, Ten Have, De Graaf, Van Nijnatten, & Vollebergh, 2013; Van Ditzhuijzen et al., 2017, 2018), in which 325 women participated after having had an abortion 20 to 40 days earlier. Following participation, the women were informed about the present qualitative study. Of these, 272 women expressed interest and gave their consent to be contacted.

Because our main purpose in the present study was to investigate the role of decision difficulty, we approached women on the basis of (a) the time since the abortion (no longer than 7 months ago) and (b) their level of decision difficulty about the abortion, as reported in the quantitative study. In DAMHS, decision difficulty was assessed on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*very much*). Based on self-reported level of decision difficulty, we created a low-decision difficulty abortion group (AB-LDD group) consisting of women who had selected the response options “not at all” or “a little,” and a high-decision difficulty abortion group (AB-HDD group) consisting of women who had selected the response options “much” or “very much.” Of the women contacted, one was excluded from participation because she had become pregnant again in the period between the abortion and the interview. Five women were not willing to participate, because of “lack of time” (one woman), “not interested in participation” (three women), and “afraid that the interview will be emotionally challenging” (one woman). The contact details of seven women were incorrect at the time of contact. The final number of participants in the AB-LDD group and AB-HDD group was 47 and 22, respectively.

The women who decided to carry their unintended pregnancy to term (the PR group) were recruited via a national state-subsidized nonprofit organization, the FIOM. At the time, this organization offered options counseling to women considering abortion. Women who received options counseling and met the inclusion criteria were informed about our study once their needs had been met. Only women who indicated an intention to continue the pregnancy or were still undecided were asked whether they were interested in participation. These women were contacted by the research assistants. Appointments for the in-depth interview with interested and eligible women were scheduled from the 23rd week of pregnancy (and before the 30th week), taking into account that Dutch abortion clinics will perform abortions up until the limit

of 22 weeks' gestation time (the legal limit is 24 weeks). In this way, the in-depth interview could not interfere with the decision-making process. In total, 68 women appeared to be eligible for participation during their final contact with the FIOM and gave their contact details. Of these, seven women could never be reached, seven women had changed their mind and had opted for abortion, six women were not willing to participate, six women canceled their appointment for the interview or did not appear at the appointment, and two women had had a miscarriage.

Sociodemographic data and pregnancy-related characteristics for women in the two abortion groups (AB-LDD and AB-HDD), and the pregnant (PR) group are summarized in Supplemental Table 1.

Procedure

The individual interview meetings were held in a private setting (e.g., the respondent's home). Prior to the in-depth interview, the study purposes and procedures were explained, and informed consent was obtained. The women were assured of confidentiality and the opportunity to withdraw from the interview. To ensure that the women did not feel they had to defend themselves, it was stressed that we considered all kind of reasons, thoughts, and feelings they might have to be valid. Participants were encouraged to communicate the salient features of their experiences in their own words.

The women received a gift card of €50 for participation. Interviews were conducted by trained female interviewers, and lasted between 45 and 120 minutes for women in the AB-group and between 60 and 150 minutes for women in the PR-group. The study protocol was approved by the METiGG, an independent Dutch medical-ethics board.

Materials

The in-depth interviews were guided by a topic list to ensure that all main topics were explored (see Box 1). The topics represented factors that were based on either the literature on abortion decision making, or on information gained from exchanges with an expert committee of abortion doctors and researchers. We further explored the women's feelings, thoughts, imaginings, and reasons pro-termination and pro-continuation of the pregnancy. The women were asked how strong these factors had weighed, and what factors/reasons were decisive in the final choice. All participants were asked to what extent they had experienced decision difficulty about their decision. Those who indicated having experienced decision difficulty were encouraged to elaborate on this, how they dealt with it, and how they finally made up their minds.

Data Analysis

Interviews were transcribed verbatim, and imported in NVIVO 9 (2010). After the transcripts were carefully read and reread, the material was condensed, and meaningful units were extracted. Transcripts were initially coded independently by the first author and an assistant. Subsequent interviews were coded by the first author and checked by the assistant. Differences in coding were discussed until consensus was reached. In line with the constant comparative method (Boeije, 2010), new interviews were compared with existing codes to identify similarities and differences. The codes were grouped into conceptual categories, and the interrelationships were discussed between the coders. Conceptual saturation was reached when no new categories were generated, and this was after 17 interviews in the AB-LDD group, after 15 interviews in the AB-HDD group, and after 20 interviews in the PR group. To avoid potential researcher bias, two measures were taken. First, the final codes were discussed with the entire research team. Second, to ensure consistency of our findings, we included feedback sessions with experts in the field, that is, representatives of abortion clinics, and welfare workers specialized in counseling women with an unintended/unwanted pregnancy.

When we compared the groups, we found 11 relevant criteria in relation to decision making. We described the three groups (AB-LDD, AB-HDD, and PR) based on these criteria. In addition, we systematically described how the three groups of women differed from each other on each of the 11 criteria in a matrix (Table 1). For the sake of clarity and conciseness, we used paraphrases of the women's narratives in the text body and added citations in the matrix.

Results

In Table 1, the rows present the criteria related to the decision-making process, and the columns the three groups.

Box 1. Topic List.

- Living situation and circumstances of the conception
- Timeline between suspected or discovered pregnancy and the (final) decision
- Motivation for the decision (reasons and feelings pro-pregnancy continuation and pro-abortion, decision difficulty)
- Involvement of the sexual partner, family, close relations, and professional health care in the decision making
- Attitude toward unplanned pregnancy/abortion
- Experience of the pregnancy
- Level of satisfaction about the decision(-making process)
- Decision-making concerning other important life issues

Table 1. Criteria to Distinguish Three Profiles of Women's Decision-Making Processes, Including Transcript Examples.

Criteria	AB-LDD Group	AB-HDD Group	PR-Group
Nature of decision making	Short, immediately sure <i>Actually, the first thought I had was: it's just not on. I phoned the clinic straight away.</i>	Relatively long drawn-out, wavering, struggle between head and heart <i>The decision difficulty was very strong. It was so bad, that in the evening I could decide: OK, we'll go for abortion, and then the next morning: No, we won't. That went on for a couple of weeks. I found it very difficult. I found that period very tough, because my feelings about it kept changing.</i>	Relatively long drawn-out, wavering, struggle between head and heart <i>So it was just very difficult; I kept changing my mind: "Yes, No, Yes, No." That made it very complicated. The "No thoughts" were based on the actual situation, and the "Yes thoughts" were more about a feeling. The feeling that you didn't want to lose it [the pregnancy/fetus].</i>
Evaluation of negative life circumstances	Not suitable for raising a(nother) child <i>I am really not in a position to raise a child. It's not what I want, I don't have a steady boyfriend, I have no job, I have no permanent home</i>	Not suitable for raising a(nother) child, feeling forced by circumstances toward abortion <i>My ex-boyfriend, the father, was intellectually disabled and I was afraid that the baby would be too, and that I would have to try and manage alone. I couldn't face that. If it's too much for me, how will I be able to look after my children [two existing children] properly?</i>	A reason for abortion but not decisive <i>My reason [i.e., rational thoughts] kept saying: "No, you are in the middle of your specialization training and you have your future mapped out, and you were happy with two children, and if this child should be handicapped, your life will be turned upside down. My postgraduate training is off the cards now. And my job afterward is gone too. That means I can't stay living here, and the building work has to be cancelled. A complete domino effect.</i>
Positive/maternal feelings about pregnancy	Rarely expressed —	Often present <i>In all honesty, I was delighted but at the same time I felt a kind of blind panic, like "this is impossible."</i>	Often present <i>You have the pregnancy hormones that are telling you "this is your child, it's part of you now." If you get rid of it, it would be like tearing it away, which in fact is what it is. You don't just have your leg amputated if it's still working. It's as basic as that, really. It's part of you.</i>
Fears of (negative consequences of) abortion	Absent —	Often <i>It would be just typical, that I'll get cervical cancer afterwards and never be able to have a baby again.</i>	Often <i>You sometimes hear that when girls have an abortion something goes wrong with their womb or something, and they can never have children. I think the worst thing for a woman is never to be able to have children.</i>
Abortion attitude	It's a women's right <i>I am of the opinion that if you accidentally get pregnant, you have every right to [have an abortion].</i>	Often objectionable, except in extreme circumstances <i>It's something you would never do. No, I was really against it, because you are taking life from a child.</i>	Often objectionable, except in extreme circumstances <i>I can understand why people might have an abortion. If someone is a drug addict, for instance, or homeless. Or if you know the baby will have a birth defect. Or if you got pregnant outside marriage or were raped. But I can't imagine it for someone in my situation, aged 27.</i>
Definition of pregnancy	Abstract, keeping the pregnancy at distance <i>I didn't dwell on it at all. I deliberately blocked it from my mind. If you don't bond with it, you won't miss it.</i>	Concrete <i>I also talked and sang a lot to the baby. I was consciously in contact with the baby.</i>	Concrete, increasing attachment after decision <i>The longer the pregnancy goes on, the stronger your feelings get. Because you become more aware that it's there . . . a kind of feeling that it's really mine, and that I really want to have it and do everything for it.</i>
Involvement of partner in decision making	In general, not in favor of delivery. Supportive when involved. <i>We both agreed that continuing the pregnancy and having another child was not an option.</i>	In general, not in favor of delivery. Regularly unsupportive or pressurizing, particularly in budding/unstable relationship. <i>He kept pushing for me to get rid of it. He threatened me several times. He tried everything to make me get rid of it.</i>	In general, not in favor of delivery. Regularly unsupportive or pressurizing, particularly in budding/unstable relationship. <i>He was angry when he saw the pregnancy test and spent the whole night telling me how I was destroying his life . . . he simply did not want to be a father. Then he threw me out and now I'm living with my parents for the time being.</i>

(continued)

Table 1. (continued)

Criteria	AB-LDD Group	AB-HDD Group	PR-Group
Involvement of relatives and friends in decision making	Little <i>I didn't want to be influenced by others. After all, it's you who has to raise the child, and not someone else. I felt strongly: "This is something we have to work out together, just the two of us."</i>	Yes, especially when no/unstable relation and/or unsupportive partner <i>Right then, I felt my family was the most important. He didn't want the child. He pushed me in a certain direction. He kept at me like a madman. I think that's why I decided to choose my family . . . My mother kind of put pressure on my, saying "oh, I'm going to become a grandma"—she was really thrilled about it, and my sister, and my father, too, really.</i>	Yes, especially when no/unstable relation and/or unsupportive partner <i>I had told everyone—my whole network. So the people close to me, my family and my girlfriends, I had told them everything. But they all had an opinion about it, and that opinion was, you have to make up your own mind, BUT . . .</i>
Involvement of professional care in decision making	None	Sometimes, especially with family doctor, no specialized care. <i>He [family doctor] said, "because you're having doubts, come back in 2 weeks and let me know what you have decided. If you want to come back before then, I can arrange for you to talk to someone." But the time went so quickly . . . before I had a chance to arrange that appointment, the two weeks were over and I thought, "O, shit." And then I had to decide.</i>	Yes ^a <i>Then we went to FIOM to ask for help, because we couldn't decide what to do. We didn't know whether we should keep it or get rid of it.</i>
Agency	Yes <i>This is a decision I made mostly by myself. It's good if people around you support you in your decision, but at the end of the day, it's a choice I made myself and for myself.</i>	Low; regularly hoping for a miscarriage, unwilling to make a decision, hoping that someone else decides. <i>At a certain point I began to think "I would prefer to lose it naturally, to have a miscarriage." Then it would be over. Then you wouldn't have to make that difficult decision about what to do now. The decision is made for you.</i>	Low; regularly hoping for a miscarriage, unwilling to make a decision, hoping that someone else decides. <i>I couldn't make the decision. I couldn't say "I'm going to be a mother." But I thought, if I get to the stage when abortion is no longer possible, then I will be." I didn't want to make the decision. Of course no decision is a decision too, but at least I wouldn't have made that decision.</i>
Evaluation of decision	Satisfied. No regret, because early pregnancy and unable to give a child what it needs <i>The way I see it, I have saved my baby from a lot of misery.</i>	Satisfied, but sometimes after a process of acceptance. Seldom regret. Being forced by others or circumstances. <i>I just had to. That's why I say: If things had been different, I would have chosen otherwise. At any rate, I felt I had no choice. That's why I find it easier to accept what I did than if I had just done it casually.</i>	Tough decision. Satisfied, but sometimes a process of acceptance. Never regret. Sometimes defeatist. <i>I just couldn't bring myself to do it [abortion], but I can't pinpoint any rational reason.</i>

Note. AB-LDD = low-decision difficulty abortion group; AB-HDD = high-decision difficulty abortion group; PR = unintended pregnancy.

^aAll women in the PR-group were recruited via the FIOM = a Dutch federation that (at the time) provided independent options counseling, where they had sought help with decision making.

Decision-Making Process in the AB-LDD Group

A woman in the AB-LDD group often feels panic when she suspects she is pregnant or when her pregnancy is confirmed. The pregnancy does not “feel” good/right, instead, it feels problematic. She knows almost immediately that she does not want to give birth, although she might have a future child wish. Abortion comes to mind quickly and is regarded as the only feasible solution. Now that the pregnancy is a fact, and she is convinced that abortion is the right decision, there is no time to lose. She wants to put the pregnancy and abortion behind her as soon as possible and

feels hurried by the continuous development of the embryo/fetus. Soon after the pregnancy discovery, she generally contacts her general practitioner for a referral to an abortion clinic and arranges an appointment. She finds the abortion decision tough, and may experience the whole period as emotionally challenging. Nonetheless, she is certain that abortion is the right decision.

If she is in a long-lasting stable relationship with her partner, she feels supported by him. He also prefers abortion. She does not experience any pressure from him toward abortion. If she is in an unstable or budding

relationship, she sometimes keeps it secret from the sexual partner, or just informs him about the pregnancy (decision). In that case, she does not want to involve him in the decision making. She might think of him as an unsuitable father or partner, and she wishes to raise a child within a stable relationship.

Usually, she talks with a restricted number of relatives or close (female) friends about her pregnancy/abortion decision. If she is in a long-term relationship, the decision is seen as being up to her and her partner only. She mostly chooses to involve only as few other persons as possible, since she has already made up her mind. Sharing her pregnancy and decision with others might elicit opinions by others, and she does not want to be influenced by them. However, sometimes, she keeps silent about the pregnancy because she feels ashamed.

Her abortion view is that women have the right to make this choice and that others should not judge a woman's decision to do so. Nonetheless, she stresses that women have the responsibility to prevent an unwanted pregnancy. If she has been careless in using contraception, she blames herself for having failed in proper birth control.

She finds the enforced waiting period until the abortion very long. In the meantime, she continues her daily routine. She tries to avoid dwelling on the pregnancy and abortion. When she seeks information about the abortion procedure, she usually avoids information about the embryonic development. If she chooses to see the ultrasound prior to the abortion procedure, the image confirms her view that the embryo/fetus is “(almost) nothing,” “a little worm,” “a clump of cells.”

Immediately after the abortion, she feels relieved. She quickly recovers physically and emotionally and picks up her daily activities. Often, she is convinced that she made a considered decision and did not take it lightly. She emphasizes that the abortion took place during an early stage of pregnancy. She regularly mentions that abortion at a later stage would be worse because “the more advanced the pregnancy, the more the embryo/fetus becomes a life.” Sometimes, she also stresses that she has considered the needs of the unborn child in her decision making; in the given circumstances, she would not have been able to offer the child what it needs. If she is in a long-term relationship, the abortion seldom has a (negative) impact on the quality of the relationship. If she had no relationship or only a budding or unstable one, she usually breaks up with the sexual partner.

Decision-Making Process in the AB-HDD Group

A woman in the AB-HDD group often feels panic when she discovers her pregnancy, but simultaneously, she might feel happy and proud. Often, she has a desire for

a(nother) child in the future. Sometimes, she desires a(nother) child now, but her partner does not, or her circumstances make her consider abortion. In other circumstances, she would have preferred to give birth. She had never anticipated that she would ever think of a pregnancy as unwanted. Abortion is something she never thought she would do. This relates largely to her views on abortion. Often, she views abortion as taking the life of a human and considers it, therefore, an objectionable and selfish act. Sometimes, she is not judgmental about other women having an abortion but finds it unacceptable for herself. She believes that women should take responsibility for getting pregnant unintentionally, but in her circumstances, she thinks that raising a(nother) child is almost impossible. She wonders whether she is not selfish when she chooses abortion because of prioritizing her own needs and goals and/or the welfare of her partner (and children). She feels guilty and remorseful toward the unborn child and/or toward women with an unfulfilled child wish.

Generally, she informs her sexual partner first. His opinion about the pregnancy decision and his behavior influences her decision making considerably. He usually prefers abortion and expresses this immediately. This sometimes makes her feel that she has little room to make up her mind. If she is in an unstable or budding relationship, she often involves the partner in decision making to figure out if she can count on him as a father and/or partner. However, she typically feels unsupported or even pressured toward abortion by him. He might repeatedly emphasize that abortion is the only solution; he might threaten to leave her if she continues the pregnancy or that he will not care for the child; or he breaks up with her immediately. As the decision-making process unfolds, her worries about his role in child raising increase. She begins to question his suitability as a father (and partner). The prospect of single motherhood scares her. Sometimes, especially if she is young, she (also) feels pressured by her parents toward abortion. If she has already formed a family and her partner presses her toward abortion, she is afraid that she would put her relationship and family life at risk if she were to continue the pregnancy.

She regularly changes her mind. She desires to make a considered decision. It is important for her to make “the right choice” and to stand “one hundred percent” behind that choice. However, she does not know how and when she will be completely sure. She is afraid to overlook unknown important matters, and, therefore, repeatedly weighs up the pros and cons. Sometimes she is afraid that she might decide for abortion too hastily, and might regret this afterward. Especially if she has no children, she is often afraid that if she decides for abortion, she might never have another chance to become pregnant—sometimes feared as the result of physical damage caused by

the abortion. She also fears the abortion procedure itself. Decision making feels like a race against time, because of the continuous development of the embryo/fetus. Based on her definitions of life, she sets deadlines before which she must have decided. Nonetheless, she often extends her deadline. Her indecisiveness makes her desperate.

Because she keeps having difficulty deciding, she often asks others for advice. Particularly when she does not know to what extent she can count on her partner, she involves relatives and friends in the decision making, which makes her even more undecided. Sometimes she wishes that others would make the decision for her, so that she does not have to decide for herself. She might hope for a miscarriage, because that is a natural event and would, therefore, be less serious than an induced abortion. Usually, she discusses her options with her general practitioner, but she does not often seek counseling from other professionals. She might postpone her (initial) contact with the abortion clinic.

She is often unable to distance herself emotionally from the pregnancy. She defines it as a “child,” a “baby,” although she sometimes tries to make it as abstract as possible. Sometimes, she fantasizes about (her future life with) the potential child, and her attention is drawn to baby clothes, soft toys, and so on. Regularly, she searches for information about the fetal development.

After a relatively long decision-making process, she finally decides to have an abortion. It is difficult for her to indicate one decisive reason for this final choice. She more often speaks of a process leading up to the final decision in which a jumble of factors was involved. At the moment of decision, she tends to follow her “head” rather than her “heart.” Once she has decided, she wants to get the abortion over and done with. She finds the waiting period long and difficult. Now and then, she might experience decision difficulty again. In the abortion clinic, she sometimes feels panic and reconsiders her choice again. She is very tense about the abortion. She feels uncomfortable among the other abortion clients and believes that some of them have an abortion too casually. While waiting, she sometimes hopes for a “miracle” to prevent the abortion from taking place—that her partner will suddenly give in or that staff dissuade her from having the abortion. During her intake conversation with the abortion nurse, she usually reports that she had difficulty deciding. When asked whether she feels sure now, she answers affirmative. Often, she does not want to see the ultrasound, assuming that this will make it even harder.

After the abortion, she typically has to recover physically and emotionally. She often has painful memories about the abortion procedure, although she did not feel pressured by the abortion personnel to have an abortion. For a while, she feels guilty and is disappointed in herself. She might feel sad when confronted with babies or

pregnant women. As time passes, she is better able to accept her choice—She would not have decided otherwise. Her abortion view has become milder; she has realized that falling pregnant unintentionally and having an abortion can happen to any woman. Usually, she believes that she has carefully considered whether she could raise a(nother) child, but to act on this decision felt impossible. As a legitimization, she generally argues that she felt somehow forced to have an abortion by her living circumstances or her partner. Regularly, she stresses that she never would have had an abortion in other circumstances, but that she now had no other choice. It is rarely the case that she regrets the abortion, but when she does, it is mainly because she felt forced by her partner or parents. In that case, she opted for an abortion to save her relationship/family life. Often, the relationship with the partner (who presses her toward abortion) has become strained. If she was in a new or unstable relationship, she may have ended this relationship. She considers the decision-making period and the decision itself as the hardest of her life. She stresses that she will never again have an abortion. Sometimes, she seeks professional help to learn how to cope better with the abortion.

Decision-Making Process in the PR-Group

A woman in this group feels panic when she discovers her pregnancy. The pregnancy feels problematic rather than good/right. Her initial thought is that she is unable to give birth in her current life situation. Abortion comes to mind quickly. Alternatively, she might experience happiness and joy besides the panic. In that case, she is not inclined to think about abortion, at least, not right away. Abortion may come to mind, because she expects that her sexual partner does not want a(nother) child.

The sexual partner usually prefers abortion. Similar to the women in the AB-HDD group, the partner’s opinion about the pregnancy decision and his behavior often influence her decision making significantly. Especially when she is in an unstable/budding relationship, she may feel pressured by him to choose abortion. In line with the profile of women in the AB-HDD group, she usually tries to figure out whether she can count on him as a father and/or partner. Because she often feels unsupported or even pressured toward abortion, she is concerned about his willingness to take responsibility for child-raising. This is one of the main considerations for her to consider abortion. Initially, the idea of single motherhood often scares her. Although less frequently observed, she might also feel pressured by her partner if she is in a long-term relationship. In both cases, the pregnancy (decision) puts a strain on the relationship. Irrespective of the nature and quality of the relationship with the partner, she believes more and more strongly that if she were to give in his

preference for abortion, she would never forgive him and that, sooner or later, the abortion would drive a wedge between them. Then, she reasons, she will have lost both a child and a partner. In her view, her partner focuses too much on the reasons against pregnancy continuation. Although she usually has the same practical concerns, she may also believe that some concerns are surmountable. She thinks that he is unable to put himself in her situation, for instance, because he is not affected by pregnancy hormones and/or maternal feelings. In contrast to the women in the AB-HDD-group, her belief that she also could raise a(nother) child on her own with help from others becomes stronger. Especially in the case of an unstable relationship, she involves others in decision making, and sometimes excludes her partner from further decision making.

She tends to contact the abortion clinic soon after the pregnancy discovery, sometimes followed by an appointment. This appointment follows from her initial decision to abort. However, this contact might also follow from her partner's preference for abortion. The purpose for her visit to the abortion clinic is not necessarily to have an abortion immediately but to talk about decision making with a professional or to obtain information. If she visits the abortion clinic, she often feels she is in the wrong place. She may begin to debate her initial abortion decision during or after the consultation with an abortion counselor (or with her general practitioner). She then is referred to Fiom for additional counseling. She usually contacts several professional caregivers for help during decision making.

"Something," which she cannot describe, keeps her from actually having an abortion. She feels she just cannot do it. The idea of having an abortion fills her with aversion. She tends to see her resistance to abortion as being the result of positive or maternal feelings or pregnancy hormones. She might (also) explain her resistance in terms of her abortion view. Similarly to the profile of women in the AB-HDD group, she regularly expresses her disapproval of abortion. She believes that it is only permitted in certain circumstances (e.g., rape, teenage pregnancies, homeless drug abusers, unhealthy fetus). She is not always judgmental about other women but questions whether abortion is acceptable in her situation: Her belief that her circumstances are, although not ideal, compatible with raising a child increases during decision making. She wonders whether she is not egoistic if she chooses abortion and struggles with feelings of guilt and remorse. Similar to women in the AB-HDD group, she also fears potential negative consequences of abortion.

As long as she has not made a decision, she often tries to keep the pregnancy emotionally at a distance. Like the women in the AB-HDD group, she defines the embryo/fetus as a baby, although she tries to avoid imagining it as such. She uses this strategy to prevent attachment to the embryo/fetus, which would make the

decision even harder. Sometimes she fantasizes about the potential child.

Similar to the women in the AB-HDD group, she feels hurried in making a decision. She sets deadlines before which she must have decided, but often extends these. Her indecisiveness makes her distressed, and sometimes she is unwilling to make a choice. She then hopes for a miscarriage or hopes that someone else "knows" what to decide. Like women in the AB-HDD group, she often speaks of a conflict between the head and the heart.

Usually after a relatively long decision-making process, she finally decides to give birth. Her positive/maternal feelings have outweighed her reasons against delivery. She often cannot indicate one decisive factor. In the case of a partner who puts pressure on her to have an abortion, she regularly makes her decision after he has indicated an intention to fulfil his role as father, but sometimes, she decides to give birth irrespective of whether he will be involved as the father or not. She explains that the practical concerns are surmountable. Sometimes she relates that she has realized that "the ideal circumstances" for raising a child do not exist. Once decided, she usually feels relieved and often can enjoy her pregnancy. She gives in to her feelings of attachment to the fetus, she begins to inform (more) people, and she is preparing financially, materially, and emotionally for the baby's arrival. However, it might also be that it has simply become harder for her to choose abortion. In that case, she talks about a process of acceptance in which she gradually gets used to the idea of giving birth. She may still wish that she had not become pregnant. Although she cannot really enjoy her pregnancy, she is preparing for the baby's arrival.

The duration of the decision-making process varies but is always finished long before the abortion limit of 22 weeks. Irrespective of whether she has decided to give birth or "accepted" the pregnancy, she no longer wavers. She emphasizes that she no longer has doubts about the choice, but she often worries about the future; some practical concerns that made her consider abortion are still present. She nevertheless is certain about her choice and feels no regret. She may not be fully satisfied about the decision-making process: Sometimes she feels ashamed toward the unborn child because she did not initially welcome the pregnancy and had considered abortion. She explains her unintended pregnancy and her choice to give birth in terms of "I just couldn't have an abortion," "this is the way it had to be," "you have to take life as it comes," "a baby is a miracle/gift that a woman should be grateful for."

Similarities and Differences in Decision-Making Processes

The matrix (see Table 1) shows clearly which criteria related to the decision-making process are shared in the

three groups. As can be seen in Table 1, the decision-making process of the AB-LDD group is very different from that of the two other groups, whereas the decision-making processes of the AB-HDD and PR-group are quite similar.

Almost all the women spoke of a tough and considered decision(-making process), irrespective of whether they experienced decision difficulty. Although the majority of women in all groups were satisfied with the final decision, the most satisfied women were those in the AB-LDD group. In both the AB-HDD group and the PR-group were women who had difficulty accepting their final choice.

With respect to the criterion "Evaluation of negative life circumstances," we found that all groups of women considered their life circumstances unsuitable for raising a child. The negative life circumstances, often translated into reasons for considering abortion, were largely the same across the three groups, and related to the woman herself, the potential child, existing children, her partner and important others, and financial/material matters. For women in the AB-HDD and PR-group, those circumstances could have made the decision more difficult. However, the PR-group eventually concluded that their practical concerns could be overcome. Likewise, women in the AB-HDD group who experienced pressure from their partner to have an abortion did not want to run the risk of becoming a single mother, either for themselves as well or for the potential child. In contrast, many women in the PR-group with a pressing partner came to believe that they also could raise a(nother) child on their own, if necessary with help from parents and friends. Those PR-women believed that they would always regret an abortion if they did it because of their partner's wishes.

The three groups differed from each other on the criterion "Involving professional care in decision making." Although women in both the AB-HDD and PR-group found the decision difficult, only the latter group had sought professional help with decision making. Apart from some women in the AB-HDD group, the majority did not seek additional help.

Discussion

Our main findings can be summarized as follows: (a) We found 11 relevant criteria that were mentioned by women faced with an unwanted pregnancy; (b) the decision-making process of women who experienced little or no decision difficulty and chose abortion, differed from that of women who decided to abort after having experienced considerable decision difficulty; (c) there is a striking similarity between the decision-making process of women who either have decided to terminate or carry the pregnancy to term after experiencing considerable decision difficulty.

Regardless of whether the women had difficulty deciding, they all spoke of a tough and thoughtful decision(-making process). The results show that women are keen to make the right decision about such an important issue. This challenges the idea that some women have a casual approach to abortion. It is important to stress that the majority of women were satisfied with their decision. This was especially true for those who were quickly confident about their choice for abortion. Most women who had severely debated about the decision were eventually also satisfied with their choice and stated that they would not have decided otherwise, even though some spoke of a process of acceptance. Nevertheless, these women seldom regretted their choice. As such, these data show that despite intense decision difficulty, regret afterward is rare. This is in line with other empirical findings that the proportion of abortion clients with regret is small (Charles et al., 2008; Robinson, Stotland, Russo, Lang, & Occhiogrosso, 2009). We found that the women in the AB-HDD group who felt regret had almost always felt pressure of their partner or parents to have an abortion. This corresponds with results from a study among women who experienced postabortion distress, including regret, showing that these women often felt that the abortion was not primarily their own decision (Kimport, Foster, & Weitz, 2011).

Notwithstanding our finding that most women were satisfied with their decision, there were a few women, in both the AB-HDD and the PR-group, who were not entirely confident with their decision(-making). We found that a number of women in the AB-HDD and PR-group felt they had no control over their situation/pregnancy decision and/or did not want to take responsibility for their decision; they just wished they were not in this position. Showing little sense of agency (Bandura, 2001; Paul et al., 2017), they sometimes hoped for a miscarriage or that someone else could tell them what to decide. Furthermore, in the AB-HDD group, a number of women felt forced toward abortion by their unfavorable circumstances (or by their partner). Also some PR-women showed little sense of agency and were defeatist, for example, "I just couldn't have an abortion," "this is the way it had to be," "you have to take life as it comes." These findings suggest that a small group of women (both AB-HDD and PR) is characterized by an external locus of control, and may have felt a lack of autonomy about their pregnancy decision. We also found that in both the AB-HDD and PR group, decision difficulty was often related to an unsupportive sexual partner. This finding is consistent with those of prior research, pointing to the negative impact of perceived partner pressure on decision making (Foster, Gould, & Kimport, 2012; Kapadia, Finer, & Klukas, 2011; Kimport et al., 2011; Kroelinger & Oths, 2000). Furthermore, perceived partner pressure and lack of partner support have been indicated as risk factors for

both postabortion (Academy of Medical Royal Colleges, 2011) and postpartum distress (Logsdon & Usui, 2001; Stapleton et al., 2012). On the contrary, support of partner and family is mostly highly appreciated by women (Ostrach & Cheyney, 2014). Women who feel that their decision is influenced primarily by others may need to be referred for additional counseling or support.

Our data also point to the need to provide women with an unintended/unwanted pregnancy with clear information about the pregnancy and about who has abortions. Women in the HDD group more often viewed the pregnancy as “a baby” rather than a more abstract potential baby, and earlier research has shown that framing the pregnancy like this could increase distress and further complicate the decision (Fielding & Schaff, 2004). Second, many women in the AB-HDD and PR-group conveyed stereotyped images and misconceptions about abortion clients and only thought of abortion as acceptable under extreme circumstances in which women could be hardly held responsible for getting pregnant unintentionally. Because stigma surrounding abortion might influence how women feel about their pregnancy decision, and how they cope with their feelings (Kimport et al., 2011; Kumar, Hessini, & Mitchell, 2009; Major & Gramzow, 1999; Quinn & Chaudior, 2009), and also increase post-abortion distress and physical health symptoms (O'Donnell, O'Carroll, & Toole, 2018), it is important to reduce stigmatization. Furthermore, health professionals in the field of abortion and reproductive health should pay attention to the fact that a considerable number of women hold unfounded beliefs about abortion, for example, of becoming infertile as a result.

A strength of this study is the inclusion of women who continued their unintended pregnancy to term, after an intense and difficult decision-making process, for which they sought help. The Turnaway study also included women who carried their unwanted pregnancy to term, but these women had made their decision, they wanted an abortion, but they were “turned away” (e.g., Biggs et al., 2017). The stories of women who have access to abortion but do not know what to do, women who experience strong decision difficulty, are still underrepresented in the literature. Another strength of the study is the use of in-depth interviews that enabled women to elaborate on their experience of their decision-making process. We were able to describe the complex process of decision making regarding an unintended/unwanted pregnancy for three groups of women, along the 11 criteria that came up from the interviews. The results of this study might serve as a guide for professionals who help women who are in need of support in making a pregnancy decision. The various considerations involved in the decision-making process of women who experience strong decision difficulty (i.e.,

positive/maternal feelings toward pregnancy, fears of negative consequences of abortion, negative abortion attitude, partner pressure, defining the pregnancy as a baby, experiencing little self-agency) can be assessed and discussed in clinical settings.

This study has some limitations. First, the sample was relatively homogenous in terms of ethnicity, religiosity, and educational level. Alternate sampling strategies are required to investigate whether comparable findings will emerge with more diverse samples. It is notable, however, that our findings are consistent with international research, contributing to confidence in transferability (Tobin & Begley, 2004). In addition, we have interviewed a specific group of pregnant women, that is, women who considered their unintended pregnancy as problematic and sought help with decision making. We realize that there are also many women who fall pregnant unintentionally and do not express their worries to professionals. Finally, since unwanted pregnancy is a sensitive topic, there is a chance that the results were biased because the interviewed women may have felt that they had to justify their decisions. To minimize the need for the women to defend themselves, we emphasized that we considered all kind of reasons, thoughts, and feelings they might have as valid.

Because our findings indicate that the sexual partner and the relational status with him have a great impact on women's decision making and distress during this period, future research should focus on the involvement of sexual partners in decision making, by interviewing the men themselves. Men's involvement in pregnancy decisions can be described as a balancing act between autonomy of decision making and needs of both the women and their partners (Farrell, Mercer, Agatista, & Coleridge, 2018). Given the many similarities between women in the AB-HDD and PR-group, it becomes even more important for future research to include the latter group in prospective studies on post-decisional mental well-being and coping.

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ORCID iD

Jenneke van Ditzhuijzen  <https://orcid.org/0000-0003-0560-4949>

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Author Biographies

Marieke Brauer worked as a postdoctorate researcher at the department of Interdisciplinary Social Studies, Utrecht University, when this work was completed. She now works as a clinical healthcare psychologist at PsyQ Mental Health Services.

Jenneke van Ditzhuijzen worked on her PhD on abortion and mental health when this study was completed. After that, she worked at Utrecht University, Interdisciplinary Social Sciences, as a postdoctorate researcher and senior lecturer.

Hennie Boeije worked as an associate professor in qualitative research at the Methods and Statistics Department, Utrecht University. She is currently a program manager at the Netherlands Institute for Health Services Research (NIVEL).

Carolus van Nijnatten worked as a professor at the department of Interdisciplinary Social Sciences when this study was completed, and is now a professor emeritus at Utrecht University.