The decision to have an abortion in Flanders: A contextual approach

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DANKWOORD

En plots valt alles in de plooi
En lijkt het leven mooi
En niet neurotisch
Plots ben je een projectiel
Waarvan je eigen ziel zelf de piloot is

(Bart Peeters, In de Plooi)

In 2011 studeer ik af als Master in de klinisch psychologie. Ouders, schoonouders en vriend blij dat ze eindelijk van die stresskip af zijn die zich iedere kerst, iedere paasvakantie en iedere start van de zomer opsluit in haar kamer om diep in haar boeken te duiken. Jammer, maar helaas voor hen, want diezelfde zomer nog vraagt Ann mij of ik niet wil doctoreren. Vandaag kijk ik met een brede glimlach terug op de afgelopen vijf jaar. In die jaren heb ik heel wat interessante, lieve, en inspirerende mensen ontmoet, is mijn drang naar kennis en nieuwe uitdagingen nog sterker aangescherpt, en is mijn rugzak gevuld met een overdosis aan fijne ervaringen. Ik wens hierbij dan ook een aantal mensen van harte te bedanken voor hun rechtstreekse of onrechtstreekse bijdrage aan dit doctoraat.

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And if you need a good reason, I'll give you one
No lord, it seems the best is yet to come
The best is yet to come
The best is yet to come

(Novastar, The Best is Yet to Come)

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LIST OF ABBREVATIONS

AAC	Ability to Achieve Closure
APIM	Actor-Partner Interdependence Model
CASI	Computer-Assisted Self-Interviewing
CI	Confidence Interval
IMP	Involved Male Partner
LUNA	Unie van Nederlandstalige Abortuscentra
MAR	Missing At Random
MCAR	Missing Completely At Random
MP	Male Partner (who was involved in the pregnancy)
OR	Odds' Ratio
POMS	Profile of Mood States
SEM	Structural Equation Modeling
TOP	Termination of Pregnancy
TMD	Total Mood Disturbance
VAS	Visual Analogue Scale
WHO	World Health Organization

SUMMARY

Induced abortion is a highly debated topic all over the world. Although its practice has been reported upon since ancient times, moral debates about induced abortion are currently still ongoing. In addition, even today there is a huge variation of ways in how countries regulate induced abortion, ranging from total prohibition to it being legal under certain circumstances. In the introduction section of this doctoral thesis, the scientific research on induced abortion is situated at the crossroads of five different disciplines: ethics, politics, sociology, psychology, and medicine. Four questions that have dominated the scientific research in these fields are answered: (1) "Does induced abortion harms women's mental health?", (2) "Who is at risk?"; (3) "Is it safe, and acceptable?", and (4) "Why, and how do women decide to have an abortion?". To date, scholars mainly agree on the following statements. (1) Although the effect of induced abortion cannot be experimentally tested, compared to carrying an unwanted pregnancy to term, having a single first trimester[1] induced abortion is not associated with an elevated mental health risk in the long-term. However, it is, on average, associated with transient emotional distress. The level of distress is associated with various personal, interpersonal, and social factors. (2) The various factors leading to an induced abortion are all part of a complex process that develops from having potentially unprotected sexual intercourse to deciding about the outcome of the unwanted pregnancy. (3) An induced abortion when performed by educated medical staff, and in hygienic circumstances, is safe, and highly fulfills women's needs. (4) Women's main reasons for having the abortion are based on a desire to provide good parenting, with the right partner, at the right time, but women differ in how rapidly they make their decision and also differ in their feelings of uncertainty regarding having the abortion.

In **Chapter one**, we put forward that the process and outcome of the decision to have an induced abortion should be looked upon as the result of a dialectical interaction between factors at the **between-group** level, the **interpersonal** level, and the **intrapersonal** level. Based on the contextual model of social complexity by Robert Hinde (1977), we highlight the gaps in the current research looking at the decision to have an induced abortion at each of these three levels. At the between-group level, we found that information on the ratio of induced abortion decisions in a representative sample of pregnancies in Flanders (Belgium), especially in certain ethnic minority groups such as men and women from Turkish or Moroccan descent, was lacking. The latter had already been identified as vulnerable when it comes to reproductive health issues, and hence, a study of the complex interaction

[1] In this doctoral thesis, we will focus on first trimester abortions (abortions on women's request as a consequence of an unwanted pregnancy). Second trimester therapeutic abortions (e.g., because of fetal malformations) fall out of the scope of this doctoral thesis.

between the role of cultural norms on the one hand, and the role of socio-demographic vulnerabilities in this group on the other, was called upon (Chapter 2). At the interpersonal level, we found a lack of profound research on the actual role, influence, and decisional experiences of the male partner who was involved in the unintended pregnancy (Chapters 3 and 4). Both historical and practical reasons have resulted in the absence of male participants in research on induced abortion. Studying their role and experiences is, however, hugely important given the relational reality in which most abortion-seeking women exist. At the intrapersonal level, finally, we found a lack of studies on the nature of women and male partners' dialectical reflections in the decision to have an induced abortion and the role of pre-abortion counseling in this (Chapters 5 and 6). Previous scholars have mostly paid attention to the relatively high level of decisiveness in women who enter the abortion clinic, which has led some scholars to report doubts about the value of mandatory pre-abortion counseling. In Chapter one, we furthermore outline the general research questions of this doctoral thesis and the general methodology of the studies described in the different chapters.

In **Chapter two**, we examine the prevalence of unintended pregnancy, and the prevalence of induced abortion in the event of an unintended pregnancy, looking at a large population based sample of people living in Flanders. In addition, we investigate whether, and how, women and men of Turkish descent (one of the largest ethnic minority groups in this region) might be vulnerable in terms of unmet family planning goals. The results first of all indicate that despite Flanders being a region where effective contraceptives have been highly accessible for many decades now, unplanned pregnancies occur quite frequently. Results on the prevalence of unplanned pregnancy and induced abortion in the Turkish minority group demonstrate that we should take into account the fact that women and men from Turkish descent tend to have more children, at a younger age, and are more likely to wait until after they are married. In addition, it is important to acknowledge their generally lower educational status compared to the native Flemish men and women. When these contextual differences are taken into account, the unplanned pregnancy prevalence in this group (29.6%) is estimated to be equal to the unplanned pregnancy ratio in the general population (22.1%). However, in both groups, a lower educational status is associated with a higher unplanned pregnancy risk. We argue that policies should thus aim to remove the barriers to effective family planning in people with lower levels of educational attainment in Flanders in particular, including those in the Turkish minority group. We also produced data revealing that although an unplanned pregnancy is equally likely to be perceived as unwanted in the Turkish minority when compared to the general population group, the induced abortion rates in the event of an unwanted pregnancy are higher in the general population (28.7% vs. 6.4%). We highlight the possible impact of conservative social norms on motherhood and the associated role of abortion stigma in the lower induced abortion ratio found in the Turkish minority group. We outline

the possible role of stigma in the underreporting of induced abortions in the general population sample as well. Finally, we show that despite differences between the two groups in general number and timing of pregnancies, unintended pregnancies and induced abortions occur during the same phases of life in Turkish people living in Flanders as in native Flemish people. Our results emphasise the risk of comparing induced abortion rates across time, across regions or across groups of women.

In **Chapter three**, we investigate the actual role of the male partners in women's decisions to have an abortion and both partners' corresponding levels of satisfaction with these roles. Results from the sample of 173 abortion-seeking women reveal the high variety in degree of male partner's involvement in the process of deciding what to do about the unintended pregnancy. This ranges from being totally excluded (24.4%) to just being consulted by the woman (23.3%) to deciding jointly (44.3%) or even taking the lead in the decision (8%). Women in non-romantic or short-term romantic relationships are less likely to involve the male partner, and a higher degree of commitment to the male partner is related with higher odds of involving him in the decision process. Results also demonstrate that although a shared decision process about what to do about the unintended pregnancy increases the odds of a mutually shared outcome (the final decision to opt for abortion), the involvement of the male partner in the decision process does not perfectly match his share in the outcome of the decision. Hence, we demonstrate the multilevel nature of involvement of male partners in women's decision to have an abortion. According to the women, 62.5% of the decisions are a mutually shared decision to opt for an abortion. These mutually shared decisions are mostly prevalent in long- (> 5 years) and short-term (< 1 year) romantic relationships, from which we derive hypotheses about the role of pre-pregnancy communication between partners about such decisions (in long term-relationships) and the societal expectations about having an abortion (in developing relationships). The results demonstrate that it is impossible to take a one-size-fits-all approach regarding the involvement of male partners in induced abortion and highlight the important role of relational context. Women's satisfaction with the division of roles is generally high except when the male partner has a more prominent role in the decision process or outcome than the abortion-seeking woman herself. Similarly, in the sample of involved male partners (N = 52), satisfaction scores are high, except when they have the dominant role in the outcome of the decision. We reflect on the role of prevailing expectations about who should decide to have an induced abortion, both at the societal level and at a relationship level. Additionally, as both partners' satisfaction with the role of the male partner is found to be somewhat lower than satisfaction with the role of the pregnant woman, we also describe the sometimes difficult position occupied by male partners involved in the process of deciding about an unintended pregnancy. We specifically shed light on certain theoretical issues such as reproductive power, sense versus exercise of agency, and direct versus indirect influence.

In **Chapter four**, we examine the degree to which the abortion-seeking women's feelings of decisional autonomy (in terms of internal versus external motives for having the abortion) and uncertainty are associated with the actual decisional experiences of the involved male partners in a fairly large sample of 106 couples. Our results demonstrate that although women have more internal motives for having an abortion than the involved male partners, and although more internal motivation only decreases women's (and not the partner's) feelings of uncertainty, partners' decisional experiences largely run in parallel to each other. We therefore point to the fact that for both men and women, the desire to provide good parenting, at the right time, is one of the main reasons for having an abortion. We also demonstrate that both partners' levels of uncertainty regarding the abortion are partially dependent on their personal abilities to achieve cognitive closure when making such decisions. Interestingly, we found that both partners' experiences with the decision to have an abortion have an interpersonal, above and beyond an intrapersonal, base. In partners who are cohabiting, levels of uncertainty were found to mirror each other more than in partners living apart, again demonstrating the role of the relational context. Moreover, both in cohabiting partners, and in partners living apart, the degree of internal or external motivation for having the abortion expressed by each woman is associated with the involved male partner's degree of uncertainty about having the abortion, and vice versa. Given the demonstrated between-partner dependencies, as well as the outlined role of intrapersonal vulnerabilities, we reflect on the possible role of couples as well as individual pre-abortion counseling.

In **Chapter five**, we examine women and involved male partners' reports of the occurrence of dialectical thoughts (i.e., moments where they thought about carrying the pregnancy to term) in their decision to have an abortion. We explore the content of these thoughts as well their association with personal and socio-demographic factors on the one hand, and with emotional distress pre- and post-abortion on the other. Results of the pre-abortion questionnaire reveal that 61.3% of the abortion-seeking women and 46.2% of the involved male partners (a difference that was not found to be significant) report having had at least one dialectical thought. However, the frequency of these thoughts is rather low with only a minority having had more than two. These thoughts are found to be more often present in women with a higher educational level and in women with a lower ability to achieve cognitive closure. We hence demonstrate the role of general cognitive capacities and motivated ways of coping with ambivalent information in general in the occurrence of these thoughts. We put forward that, as these thoughts are not themselves predictive of higher levels of emotional distress (either pre- or post-abortion), having these thoughts is equally as likely to be adaptive as an absence of such thoughts is. Women should therefore not be forced to consciously reflect on alternatives, nor should they be asked to ignore their dialectical thoughts. We demonstrate that these

thoughts are part of a cognitive process in which women and their involved male partners anticipate, evaluate, relate to others, solve problems, and make meaning, and are hence not detrimental. Emotional distress is found to be generally higher in the women than in the involved male partners but for both groups, levels of distress seem to return to normal levels post-abortion. For women who report memories of dialectical moments during the post-abortion period, however, emotional distress is higher, highlighting the adaptive role of cognitive closure once the abortion has taken place.

In **Chapter six** finally, we describe abortion-seeking women's perceptions of the mandatory pre-abortion counseling session in Flanders, based on a large sample of 971 women. We examine the content of these sessions, the degree to which the content differs depending on women's needs and characteristics, and women's degree of satisfaction with it. Results indicate an initial hesitation with regard to the value of the session. Furthermore, women are found to differ in what they want to discuss during that session, although a need for more information is reported by almost every woman. The conversations have a standardized content (i.e., the discussion of contraceptive use, reviewing the decision to have the abortion, and general further information transfer) but are meant to be tailored to the women's needs and characteristics as well. Post-counseling satisfaction with the session is found to be high. Women tend to feel even more decisive about the abortion than they already were before and they also report feeling less emotionally distressed. We hypothesize that it is the client-centered approach of the counseling sessions that results in these positive outcomes. Based on these findings, we propose the inclusion of a tailored psychosocial conversation in standard abortion care.

In summary, our findings indicate the need to take into account various intrapersonal, interpersonal, and between-group contextual factors when studying the process as well as the outcome of the decision to have an abortion. In **Chapter seven**, we highlight the differences as well as the similarities between the decisional experiences of abortion-seeking women and the experiences of the involved male partners. In addition, we show the role of timing, the role of the specific situation in which the pregnancy occurs, and the value of client-centered psychosocial care. Based on our findings, we advocate critical reflections regarding current and future family planning policies, nuanced discussions about induced abortion and the role of men in this process, and, finally, tailored but inclusive abortion care. We furthermore discuss the different strengths and limitations of our own research in this chapter and point to future research ideas.

SAMENVATTING

Geïnduceerde zwangerschapsafbreking of abortus is een fel bediscussieerd thema over de hele wereld. Hoewel de uitvoering ervan reeds beschreven werd in de Middeleeuwen, laaien de morele discussies over abortus vandaag de dag nog steeds hoog op. Tot op de dag van vandaag zien we grote verschillen in hoe abortus in een land wettelijk geregeld wordt, gaande van een totaal verbod tot wettelijk toegelaten onder bepaalde voorwaarden. In de inleiding van dit proefschrift situeren we het wetenschappelijk onderzoek naar abortus in het midden van vijf verschillende disciplines: ethiek, politiek, sociologie, psychologie en geneeskunde. Het wetenschappelijk onderzoek vanuit deze disciplines wordt samengevat in de volgende vier vragen: (1) "Veroorzaakt een abortus psychische schade?", (2) "Wie loopt een risico?", (3) "Is abortus veilig en verantwoord?", en (4) "Waarom en op welke manier beslissen vrouwen om een zwangerschapsafbreking te laten uitvoeren?".

Onderzoekers zijn het vandaag de dag in grote mate eens over de volgende vier beweringen. (1) Hoewel het effect van een abortus op het mentaal welzijn van vrouwen niet experimenteel kan worden nagegaan, is een éénmalige eerste trimester[1] zwangerschapsafbreking, in vergelijking met het uitdragen van een ongewenste zwangerschap, alvast op lange termijn niet gelinkt aan een hoger risico op mentale problemen. Het gaat echter door de band wel gepaard met tijdelijke emotionele onrust. Hoeveel onrust dan wordt ervaren, wordt gelinkt aan intra-persoonlijke, interpersoonlijke en sociale factoren. (2) De verschillende factoren die leiden tot een geïnduceerde zwangerschapsafbreking maken allen samen deel uit van een complex proces, vertrekkend van het hebben van potentieel onbeschermde seks naar het onbedoeld zwanger zijn, tot het beslissen over de uitkomst van deze onbedoelde zwangerschap. (3) Wanneer een abortus in hygiënische omstandigheden en door een opgeleide arts wordt uitgevoerd, is het een veilige ingreep waar vrouwen over het algemeen zeer tevreden zijn. (4) De hoofdredenen van vrouwen om een abortus te laten uitvoeren, zijn terug te brengen tot de wens om een goede ouder te zijn, en dit op het juiste tijdstip en met de juiste partner. Vrouwen verschillen wel van elkaar in de snelheid waarmee ze de beslissing tot zwangerschapsafbreking nemen en ook gevoelens van onzekerheid verschillen tussen vrouwen.

In **hoofdstuk één** van dit proefschrift stellen we dat het proces en de uitkomst van de beslissing om een zwangerschap af te breken, benaderd zou moeten worden als zijnde het resultaat van de dialectische interactie tussen factoren op **groepsniveau,** op **interpersoonlijk niveau** en op **intra-persoonlijk niveau**. Gebaseerd op het contextuele model van sociale complexiteit van Robert Hinde

[1] In dit proefschrift focussen we ons op eerste trimester zwangerschapsafbrekingen (abortus op 'aanvraag' ten gevolge van een ongewenste zwangerschap). Tweede trimester zwangerschapsafbrekingen om medische redenen (bv. omwille van foetale afwijkingen) worden in dit proefschrift buiten beschouwing gelaten.

(1977), belichten we de verschillende tekortkomingen in huidig onderzoek naar de beslissing tot zwangerschapsafbreking, en dit op elk van die drie hierboven vermelde niveaus. Op groepsniveau missen we informatie over de verhouding van het aantal beslissingen tot abortus op een representatieve groep zwangerschappen in Vlaanderen (België), in het bijzonder in bepaalde etnische minderheidsgroepen zoals mannen en vrouwen van Turkse en Marokkaanse oorsprong. Deze laatste werden in het verleden immers aangeduid als kwetsbaar op vlak van reproductieve gezondheidsthema's waardoor een analyse van de complexe samenhang tussen de rol van culturele normen enerzijds en de rol van socio-demografische kwetsbaarheden in deze groep anderzijds, noodzakelijk was (hoofdstuk 2). Op interpersoonlijk niveau missen we diepgaand onderzoek naar de effectieve rol, invloed en beslissingservaringen van de mannelijke partner die bij de onbedoelde zwangerschap betrokken was (hoofdstuk 3 en 4). Zowel historische als praktische redenen liggen aan de basis van die afwezigheid van mannen in het huidige abortusonderzoek. Onderzoek naar hun rol en ervaringen is echter noodzakelijk in het licht van de relationele realiteit waarin veel vrouwen die opteren tot abortus zich bevinden. Ten slotte, op intra-persoonlijk niveau, missen we onderzoek naar de aanwezigheid van dialectische gedachten in de beslissing tot abortus bij zowel de vrouwen als de betrokken mannelijke partners alsook de rol van counseling hierin (hoofdstuk 5 en 6). Bestaand onderzoek focuste zich voornamelijk op de hoge zekerheid van vrouwen op het moment dat ze het abortuscentrum binnenstappen waardoor onderzoekers het nut van verplichte counseling in vraag hebben gesteld. In hoofdstuk één sommen we verder de algemene onderzoeksvragen van dit proefschrift op en beschrijven we het algemene opzet van de verschillende studies.

In **hoofdstuk twee** gaan we de prevalentie van onbedoelde zwangerschappen, alsook de prevalentie van geïnduceerde zwangerschapsafbrekingen in geval van een onbedoelde zwangerschap, na binnen een grote populatiesteekproef van mensen uit Vlaanderen. Daarbovenop onderzoeken we of en hoe Vlamingen van Turkse oorsprong (een van de grootste etnische minderheidsgroepen in deze regio) kwetsbaar zijn voor het niet bereiken van bepaalde doelen inzake geboorteregeling. De resultaten tonen eerst en vooral aan dat ongeplande zwangerschappen relatief vaak voorkomen, desondanks de reeds decennia lang vlotte beschikbaarheid van effectieve anticonceptie in Vlaanderen. De resultaten betreffende de prevalentie van ongeplande zwangerschappen en abortus in de Turkse minderheidsgroep wijzen uit dat het belangrijk is om rekening te houden met het gegeven dat mannen en vrouwen van Turkse oorsprong over het algemeen meer kinderen hebben en dit vaker op een jongere leeftijd en na aanvang van een huwelijk. Daarnaast is het belangrijk om in acht te nemen dat zij vaker een lager opleidingsniveau hebben dan de mannen en vrouwen van autochtone oorsprong. Wanneer men rekening houdt met deze contextuele verschillen, lijkt de verhouding ongeplande zwangerschappen in deze groep (29.6%) gelijk te lopen aan de verhouding ongeplande

zwangerschappen in de algemene populatie (22.1%). Echter, in beide groepen is een lager opleidingsniveau geassocieerd met een hoger risico op een ongeplande zwangerschap. We pleiten er dus voor dat beleidsmakers zich bovenop de huidige inspanningen zouden moeten richten op het weghalen van de verschillende barrières waarmee specifiek de lager opgeleiden in Vlaanderen geconfronteerd worden inzake gezinsplanning, inclusief diegene in de Turkse minderheidsgroep. We tonen ook aan dat een ongeplande zwangerschap even vaak als ongewenst wordt beschouwd in de Turkse minderheidsgroep als in de algemene populatie, maar dat het aantal zwangerschapsafbrekingen in geval van een ongewenste zwangerschap wel hoger ligt in de algemene populatie dan in de Turkse groep (28.7% vs. 6.4%). Vervolgens belichten we in dit hoofdstuk de mogelijke rol van de meer conservatieve sociale normen inzake moederschap en de daaraan gekoppelde rol van stigma's op abortus in de lagere rapportage van abortussen in de Turkse minderheidsgroep. Daarnaast bespreken we evengoed de mogelijke rol van stigma in de onderrapportage van geïnduceerde zwangerschapsafbrekingen in de algemene populatie. We tonen tenslotte ook aan dat, ondanks de verschillen tussen de twee groepen inzake het aantal zwangerschappen en het tijdstip waarop men zwanger wordt, ongeplande zwangerschappen en abortussen voorkomen gedurende dezelfde fases in het leven in de Turkse groep als in de algemene populatie. Dit benadrukt het mogelijke gevaar van een vergelijking van abortuscijfers over de tijd , over regio's of over groepen van vrouwen heen.

In **hoofdstuk drie** onderzoeken we de effectieve rol van mannelijke partners in de beslissing van vrouwen om een zwangerschap af te breken en de tevredenheid van beide partners met deze rollen. Resultaten in de steekproef van 173 vrouwen die opteren voor een zwangerschapsafbreking laten de grote verscheidenheid zien in de mate waarin mannelijke partners betrokken worden in het beslissingsproces aangaande de onbedoelde zwangerschap. Deze gaat van totaal uitgesloten worden (24.4%) tot enkel geconsulteerd te worden door de vrouw die beslist (23.3%) tot samen beslissen (44.3%) of zelfs de leiding nemen in de beslissing (8%). Opvallend is dat vrouwen in niet-romantische of kortdurende romantische relaties minder geneigd zijn om de partner te betrekken in de beslissing, alsook dat een hogere mate van algemene betrokkenheid op de mannelijke partner resulteert in een grotere kans dat hij ook betrokken wordt in het beslissingsproces. De resultaten tonen ook aan dat, hoewel een gezamenlijk beslissingsproces over de onbedoelde zwangerschap de kans verhoogt op een wederzijds gedeelde uitkomst (de finale beslissing tot abortus), de betrokkenheid van de mannelijke partner in het beslissingsproces niet volledig samen valt met zijn aandeel in de uitkomst van die beslissing. We tonen hiermee aan dat de betrokkenheid van de mannelijke partner in de beslissing tot abortus verschillende niveaus kan betreffen. Volgens de vrouwen zijn 62.5% van de beslissingen om voor de abortus te gaan, een door beide partners even sterk gedragen beslissing. Deze wederzijds

gedeelde beslissingen komen het vaakst voor in langdurige (> 5 jaar) en eerder kortdurende (< 1 jaar) romantische relaties, waarmee we de rol van communicatie tussen partners over een dergelijke beslissing voorafgaand aan de zwangerschap (in langdurige relaties) en de maatschappelijke verwachtingen over het beslissen tot abortus (in eerder prille relaties) zouden kunnen afleiden. Met andere woorden, we tonen met deze resultaten in het bijzonder de onmogelijkheid aan van een eenduidige benadering inzake de betrokkenheid van mannelijke partners bij abortus en verwijzen eveneens naar de belangrijke rol van de relationele context. Daarnaast zijn vrouwen in het algemeen zeer tevreden met de rolverdeling, behalve wanneer de mannelijke partner een meer prominente rol opneemt in het beslissingsproces of in de uitkomst van de beslissing dan zij zelf. In dezelfde lijn zien we dat ook in de steekproef van mannelijke partners (*N* = 52) de tevredenheidsscores over het algemeen hoog liggen, behalve wanneer zij zelf de overheersende rol hebben in de uitkomst van de beslissing. We staan stil bij, zowel op maatschappelijk niveau als op het niveau van het koppel, de rol van heersende verwachtingen omtrent wie zou moeten beslissen over een zwangerschapsafbreking. Gezien de tevredenheid van beide partners over de rol van de mannelijke partner ook iets lager ligt dan de tevredenheid over de rol van de zwangere vrouw, beschrijven we tenslotte de soms moeilijke positie van mannelijke partners betreffende de beslissing over een onbedoelde zwangerschap. We belichten hierbij in het bijzonder enkele theoretische kwesties, zoals reproductieve macht, het aanvoelen versus uitoefenen van invloed, en directe versus indirecte invloed.

In **hoofdstuk vier** bestuderen we de mate waarin vrouwen die opteren voor abortus, hun gevoelens van beslissingsautonomie (in termen van interne versus externe motieven om voor de abortus te gaan) en onzekerheid gerelateerd zijn aan de actuele beslissingservaringen van de betrokken mannelijke partners in een relatief grote steekproef van 106 koppels. Specifiek tonen onze resultaten aan dat, hoewel vrouwen meer interne motieven hebben voor de zwangerschapsafbreking dan de betrokken mannelijke partners en hoewel meer interne motivatie alleen de onzekerheid van de vrouwen (en niet die van de partners) naar beneden haalt, de beslissingservaringen van beide partners grotendeels gelijk lopen. We verwijzen hiermee naar het feit dat, ook voor mannen, de wens om in goed ouderschap te voorzien, op het gepaste tijdstip, één van de belangrijkste redenen voor de beslissing tot abortus is. We tonen ook aan dat beide partners hun gevoelens van onzekerheid gedeeltelijk afhangen van hun eigen vaardigheid om zich cognitief af te sluiten bij het maken van dergelijke beslissingen. Belangrijk hierbij is dat we vonden dat beide partners hun ervaringen met de beslissing tot abortus ook een interpersoonlijke bovenop een intra-persoonlijke grond hebben. Voor partners die samenwonen, lijken de niveaus van onzekerheid meer op elkaar dan voor partners die apart wonen, wat opnieuw de rol van de relationele context toont. Voor zowel de samenwonende partners als de partners die apart wonen, is daarenboven de mate van interne en externe motivatie

voor de abortus van de vrouwen geassocieerd met de mate van onzekerheid in de betrokken partners en omgekeerd. Gezien de aangetoonde wederzijdse afhankelijkheid tussen partners, alsook de beschreven rol van intra-persoonlijke kwetsbaarheden, staan we tenslotte stil bij de rol en/of mogelijke bijdrage van individuele en koppel counseling.

In **hoofdstuk vijf** bestuderen we de verhalen van vrouwen en de betrokken mannelijke partners over de aanwezigheid van dialectische gedachten (d.w.z. momenten van denken aan het uitdragen van de zwangerschap) in de beslissing om voor een abortus te gaan. We gaan hierbij zowel de inhoud van deze gedachten, alsook het verband met persoonlijke en socio-demografische factoren, en het verband met het niveau emotionele onrust pre- en post-abortus na. De resultaten in de vragenlijst voorafgaand aan de abortus laten zien dat 61.3% van de vrouwen die opteren voor een abortus en 46.2% van de betrokken mannelijke partners (het verschil tussen deze percentages is niet significant) aangeven minstens één zo'n dialectische gedachte te hebben gehad. Echter, de frequentie waarmee deze gedachten zich voordeden is eerder laag, met slechts een kleine minderheid van de vrouwen en mannelijke partners die rapporteert méér dan twee zo'n gedachten te hebben gehad. Deze gedachten zijn daarnaast vaker aanwezig in vrouwen met een hoger opleidingsniveau en in vrouwen die het moeilijker hebben met zich cognitief af te sluiten bij het nemen van dergelijke beslissingen. We verwijzen hierbij naar de rol van algemene cognitieve capaciteiten en gemotiveerde pogingen van omgaan met ambivalente informatie in het algemeen in de aanwezigheid van deze dialectische gedachten. We stellen dan ook dat, gezien deze gedachten op zich geen voorspeller zijn van meer emotionele onrust (noch vóór, noch na de abortus), het hebben van deze gedachten even adaptief is als de afwezigheid ervan. Vrouwen zouden dus niet verplicht moeten worden om bewust te reflecteren over alternatieve opties, noch zouden ze gevraagd moeten worden om deze gedachten te negeren. We tonen aan dat deze gedachten onderdeel zijn van een cognitief proces waarin vrouwen en de betrokken partners anticiperen, evalueren, zich verbinden met anderen, problemen oplossen, en betekenis zoeken en dus niet schadelijk zijn. De emotionele onrust is in het algemeen bij de vrouwen wel groter dan bij de betrokken mannelijke partners, maar voor beide van hen keert die onrust terug tot normale niveaus na de uitvoering van de abortus. Voor die vrouwen die na de abortus herinneringen kunnen ophalen aan dergelijke dialectische gedachten is de emotionele onrust echter hoger, wat de adaptieve rol van zich cognitief kunnen afsluiten nadat de abortus is uitgevoerd, duidelijk aantoont.

Tenslotte, in **hoofdstuk zes** beschrijven we de percepties van vrouwen op het in Vlaanderen verplichte counselinggesprek voorafgaand aan de abortus en dit op basis van een grote steekproef van 971 vrouwen. We bestuderen de inhoud van deze gesprekken, de mate waarin de inhoud varieert naargelang de noden en kenmerken van de vrouwen en we vragen vrouwen om hun tevredenheid

erover te rapporteren. Resultaten tonen een initiële aarzeling ten opzichte van de waarde van dit counselinggesprek. Vrouwen verschillen daarnaast in wat ze precies willen bespreken gedurende dat gesprek, hoewel de nood aan informatie bij ongeveer iedere vrouw aanwezig is. De counselinggesprekken hebben een standaardinhoud (d.i., het bespreken van anticonceptiegebruik, het overlopen van de beslissing tot abortus en algemene informatieoverdracht), maar zijn ook aangepast aan de noden en karakteristieken van de vrouw. De tevredenheid met het gesprek, na afloop ervan, is groot. Vrouwen voelen zich tenslotte nóg zekerder over de beslissing tot abortus dan ze voorheen reeds waren en ze voelen zich ook minder emotioneel onrustig. Hierbij gaan we ervan uit dat het de cliëntgerichte aanpak van het counselinggesprek is dat deze positieve resultaten teweeg brengt. Op basis van deze bevindingen pleiten we bijgevolg voor de inclusie van een op maat gemaakt psychosociaal gesprek in standaard abortushulpverlening.

Samengevat tonen onze resultaten de noodzaak van het includeren van verschillende contextfactoren op zowel intra-persoonlijk, interpersoonlijk als groepsniveau in het bestuderen van zowel het proces als de uitkomst van de beslissing tot abortus. We verwijzen in **hoofdstuk zeven** naar de verschillen evenals de gelijkenissen tussen de beslissingservaringen van de vrouwen die opteren voor abortus enerzijds en de ervaringen van de betrokken mannelijke partners anderzijds. Daarbovenop tonen we de rol van tijd, de rol van de specifieke situatie waarin de zwangerschap plaatsvindt en de rol van cliëntgerichte psychosociale zorg. Op basis van onze bevindingen pleiten we in het laatste hoofdstuk voor kritische reflecties inzake het huidige en toekomstige beleid rond gezinsplanning en geboortebeperking, genuanceerde discussies omtrent zwangerschapsafbreking en de rol van mannen hierin en tenslotte op maat gemaakte, maar inclusieve abortushulpverlening. Ook hebben we in dit hoofdstuk aandacht voor de sterktes en beperkingen van ons eigen onderzoek en stellen we een aantal ideeën voor toekomstig onderzoek voor.

1 General Introduction

"Do not judge a woman unless

you have walked a mile in her shoes."

(Ann Furedi, 2016)

1.1 Induced abortion: State of the art

Induced abortion, or termination of pregnancy (TOP) is a highly debated topic, both in popular and scientific literature. Worldwide and across history, political parties, both right- and left wing, placed the topic of induced abortion high on the agenda, mostly from an ideological point of view. Today, both between and within countries, there is a huge variation in accessibility of abortion as a result of abortion regulations being different around the world (Pinter et al., 2005; Sedgh, Singh, Henshaw, & Bankole, 2012). In most European countries, including Belgium, induced abortion is nowadays legal under certain constraints (Pinter et al., 2005).

The legal provision of well-organized abortion care in Belgium falls into a broader international sexual and reproductive health and rights perspective (World Health Organization, 2015). Reproductive health, as defined by the World Health Organization (WHO), includes "the *ability* to have a responsible, satisfying and safe sex life", "the *capacity* to reproduce", and "the *freedom* to choose if, when, and how many children to have" (World Health Organization, 2006). Among all other things, this implies the necessity of being informed of, and having good access to evidence based methods for fertility regulation and health care services related to pregnancy and childbirth (World Health Organization, 2006). The International Planned Parenthood Federation (IPPF), in which Belgium is represented, hence perceives family planning or birth control as a basic human right. One of the pillars for the promotion of reproductive health in Belgium has been the prevention of unintended pregnancies. Another pillar has been the provision of legal induced abortion in case of an unintended pregnancy (see beneath). Already since the second half of the 20th century, Belgian policies have made efforts to increase women's family planning opportunities (Trommelmans, 2006). One of these efforts has been the provision of feasible access to effective contraceptives. Recent examples of these efforts are the reimbursement of contraceptive costs for adolescents younger than 21 or the over-the-counter access to emergency contraception. In addition to accessibility, young Belgian women are empowered in their contraceptive and reproductive choices by the relational and sexual education provided in secondary schools. Furthermore, expert organizations in sexual health (SENSOA[1] in Flanders, the Northern part of Belgium, and "les Centres de Planning Familial" in the Southern part of Belgium) frequently setup media, health care or educational campaigns and projects to increase the awareness on family planning issues including contraceptive use. A high number of sexually active Belgian women of reproductive age are currently using effective contraceptives, most frequently the contraceptive pill

[1] SENSOA receives governmental funding for the promotion of sexual health in Flanders. The expert organization, raised in 2001, was a fusion between the Flemish organizations working on the prevention of HIV (Human Immunodeficiency Virus) and the CGOs ("Centra voor Geboorteregeling en Seksuele Opvoeding") working on family planning and birth control. The latter offered medical consultations and contraceptive counseling and played an educational role in the promotion of family planning (Trommelmans, 2006).

(Elaut et al., 2015). Furthermore, the number of teenage pregnancies is low (0.8-0.9% of the teenage girls; De Wilde, 2008). The abortion number in Belgium is one of the lowest worldwide (SENSOA, 2011).

The ultimate paradox is that in countries or regions with more restrictive abortion laws, the incidence of induced abortion is higher than in countries or regions with more liberal abortion laws, partly due to a high level of unmet need for contraception in these regions (Sedgh et al., 2012). In addition, the proportion of unsafe abortions and unsafe childbirths is high in these regions (Sedgh et al., 2012).

Despite the fact that legal battles have mostly been won, and that the medical act is proven to be safe, moral battles regarding *every* woman's right for induced abortion, are nowadays still ongoing (Furedi, 2016; Løkeland, 2004). Examples are the US, where president Donald Trump has recently reintroduced the Global Gag Rule[2]; Spain, where conservative political parties tried to restrict women's abortion rights; and also our own country, Belgium, where apparently neutral organizations attempt to spread hidden anti-abortion messages. As a consequence, a lot of women psychologically still suffer from the stigmas, and myths surrounding induced abortion which is manifested in feelings of guilt, shame or self-blame (Hanschmidt, Linde, Hilbert, Riedel-Heller, & Kersting, 2016). According to Løkeland (2004), the degree to which abortion-seeking women experience these negative emotions, is a society's cultural barometer. The moral issues on induced abortion then cut across the medical debates (such as the possibility for medical or home abortion by making use of "abortion pills") as well as the political debates (such as the proposals to change the law regarding maximal gestational limit or decriminalization of induced abortion) (Løkeland, 2004).

As will be noticed in the first part of this introduction section and as illustrated above, induced abortion is situated at the crossroads of different disciplines including ethics, politics, sociology, psychology, and medicine. Hence, it is clear that the research questions and findings presented in this doctoral thesis (with a focus on psychological and sociological issues regarding the decision to have an induced abortion) will evidently be influenced by these other disciplines as well. We will therefore briefly touch upon the historical, medical, and political context of induced abortion in Belgium.

We will start this introduction section by depicting four mainstream research questions regarding induced abortion that arose along the last three decades, and will conclude with the re-occurring role of contextual factors. In the second part of the introduction, we will present a multilevel contextual framework in which the research on induced abortion will be described as mainly occurring at one of the following levels: the between-group level, the interpersonal level, and the intrapersonal

[2] The Global Gag Rule or Mexico City Policy prohibits the disbursement of federal funding to international NGO's and agencies that provide, promote or refer to abortion services such as the United Nations Population Fund (for an overview of the impact of the Global Gag Rule, see Singh & Karim, 2017).

level. We will, based on this contextual framework, conclude with the gaps in current research on induced abortion at each of these three levels. We will then outline our research aims and the different theoretical concepts that were used in this doctoral thesis, followed by a description of the different methodologies.

Firstly however, a clear definition, a description of the subtypes, and an outline of the different indicators to measure the prevalence of induced abortion is needed. This will be followed by framing the research on induced abortion in an historical perspective.

1.1.1 Definition, subtypes, and the interpretation of the incidence of induced abortion

Induced abortion is defined as the premature, medically induced interruption of a pregnancy. It encompasses *therapeutic abortion*, meaning termination of pregnancy because of dangers for the woman's health or because of fetal disease, and *elective abortion*, meaning termination of pregnancy on a woman's request, for reasons other than maternal health or fetal disease (Jones, Wentz, & Burnett, 1988). Therapeutic abortions mostly start from an intended pregnancy, and are mainly performed during the second trimester of the pregnancy while elective abortions are typically the result of an unwanted pregnancy (which was either initially intended or unintended), and are mainly performed during the first trimester of the pregnancy.

The WHO (2014) recommends three methods for terminating a pregnancy, which should be decided upon gestational limit. The *medical method* includes the oral use of mifepristone, a medicine that blocks the progesterone hormone and weakens the wall of the uterus, combined with the vaginal or oral use of misoprostol, a medicine that induces contractions of the uterus. The subsequent use of both pills firstly results in the disruption of fertilization followed by the expel of the products of conception because of contractions. By making use of pills, medical abortion creates the possibility of home abortions, which has proven to be as safe, and effective as abortions performed in hospitals or abortion clinics (Ngo, Park, Shakur, & Free, 2011). The WHO proposes the medical method for first and second trimester induced abortions, in varying doses (World Health Organization, 2014). The *surgical methods* include (manual or electric) vacuum aspiration (VA), and dilatation and evacuation (D&E). VA is recommended for first trimester abortions (< 12 weeks of pregnancy) and includes opening the cervix with a speculum, performing a cervical antiseptic preparation, initiating a cervical block (local analgesia), dilating the cervix (when necessary), inserting a cannula, and aspiring the content of the uterus (the amniotic sac). D&E is recommended for second trimester pregnancies (> 12 weeks of pregnancy), and resembles the steps of the VA, but includes amniotomy (rupturing the amniotic sac) and instrumentally evacuating the uterus. When women are offered the choice between the medical or surgical method, they mostly prefer the medical option (Moreau, Trussell, Desfreres, & Bajos, 2011). Satisfaction is however somewhat higher for surgical abortions (Loeber, 2010).

A lot of governmental or academic institutions regularly publish reports on the national incidence of induced abortion. These numbers either stem from population based surveys, national statistics or official records from the hospitals performing induced abortions (Bankole, Singh, & Haas, 1999; Sedgh et al., 2012). Three measures are commonly used for reporting the prevalence of induced abortion: the total number of abortions obtained, the abortion rate, and the abortion ratio (Bankole et al., 1999). The distribution of the total number of abortions does reveal little information as these numbers depend on the general constitution of a population (Sedgh et al., 2012). The abortion rate on the contrary, which is the total number of abortions for every 1000 women of reproductive age (15-44) enables the examination of trends in induced abortion incidence over time or the degree to which certain subgroups of women (e.g., teenagers) have a higher incidence of induced abortion (Sedgh et al., 2012; Sedgh, Bankole, Singh, & Eilers, 2013). In 2008, the global abortion rate was 28 (Sedgh et al., 2012). Finally, the abortion ratio is the percentage of all pregnancies that end up in induced abortion (Bankole et al., 1999). It informs about how often induced abortion was the outcome of a pregnancy, other than miscarriage or childbirth. The advantage of the abortion ratio is that it takes into account the general reproductive patterns in a certain population or in a subgroup of women within that population (e.g., the generally higher number of pregnancies per woman in African countries or the generally lower number of pregnancies in older women). In 2008, the global abortion ratio was 21% (Sedgh et al., 2012). As will be argued in Chapter 2, all three measures have their own advantages and disadvantages, and the most appropriate measure should be used depending on the research question that is posed.

1.1.2 Induced abortion in an historical perspective

Women have always tried to control their fertility, and avoid (unwanted) childbirth even when induced abortion was legally prohibited or modern contraceptives were yet nonexistent (David, 1992). Ancient documents describe the use of liquids such as honey that were introduced into the vagina to induce an abortion, various herbs and drugs with a hypothesized abortifacient property, mechanical tries such as physical exercise or wearing a tight belt, and even dangerous instrumental tries such as the use of hooks (Drife, 2010). Evidently, these methods for terminating pregnancies were risky, and nearly effective, resulting in a high number of maternal deaths or other pregnancy-related morbidities (Drife, 2010). Ancient documents also seem to reveal that abortion before the 19th century was neither condemned by law nor by Christian regulations, if performed before the woman felt the first movements of the fetus (David, 1992). As a consequence of the population growth during the 19th century, the prevalence of induced abortion, and the use of traditional methods to avoid pregnancies such as sexual abstinence or coïtus interruptus, increased within the course of marriage (Drife, 2010). Around that time, induced abortion became legally prohibited in several countries, partly because of

religious and ideological constraints, but also because of power inequalities between men and women, and because of medical concerns about the safety of the method (David, 1992; Drife, 2010). Access to safe abortion was limited (David, 1992). Doctors as well as midwifes performed unlawful, and very often unsafe induced abortions (Drife, 2010). Both the women and the medical doctors or midwives could be punished with fines, imprisonment or even death penalty for clandestinely inducing termination of pregnancy at that time as well as for using or presenting contraceptives to avoid pregnancy (David, 1992). Later on, increasing evidence became available on the link between the incidence of illegal abortion and maternal death and the associated health-related costs for society (Drife, 2010). During the mid-20th century (where the second demographic transition took place), opinions eventually began to change. Three revolutions simultaneously occurred at that moment: the sexual revolution (decreased ages of sexual onset), the contraceptive revolution (the invention, spread and legalization of modern contraceptives), and the sex revolution (women as equal breadwinners) (Lesthaeghe, 2014). From then on, there was a desire for smaller family sizes, and a later onset of childbirth, partly because of women's increased educational opportunities and a higher rate of female employment, combined with a decline in infant mortality (which decreased the parental need to replace deceased children) (Doepke, 2002; Lesthaeghe, 1991; Watkins, 1998). The invention of the contraceptive pill by the Belgian doctor Nand Peeters eventually enabled women to effectively control their own fertility (Peeters, Van Roy, & Oeyen, 1960). Hence, women's reproductive autonomy was set. As a result of a growing feminist movement striving for equal rights and reproductive autonomy, in combination with an increased awareness of the problem of maternal deaths caused by clandestine induced abortions, countries finally began to legalize induced abortion under certain constraints (David, 1992; Watkins, 1998).

To date, the WHO states that all countries should enable access to safe abortion as part of a human rights perspective (World Health Organization, 2012). This encompasses the creation of comprehensive legal grounds for abortion, the provision of safe and evidence based abortion care, the elimination of barriers to the access of induced abortion, the mandatory provision of post-abortion medical care to treat possible complications, and the creation of an environment in which all women have access to sexual and reproductive health services.

It is only since the late 20th century that the scientific research on induced abortion really began to emerge. Since then, induced abortion became a highly studied topic of empirical research in different disciplines including epidemiology, anthropology, empirical bio-ethics, psychology, and medicine. In the following, the main research findings that have passed through the last three decades will be discussed. We will limit this overview to the research on elective induced abortion (and not therapeutic abortion) as this is also the focus of the doctoral thesis.

1.1.3 Mainstream research questions and answers: State of the art

In the following section, we will focus on the four mainstream research questions that came across during the last decades of research on induced abortion. These are: (1) "Does induced abortion cause mental distress"; (2) "Who is at risk for induced abortion?"; (3) "Is induced abortion safe, and acceptable?"; (4) "Why, and how do women reach the decision to have an induced abortion?". To each of the research questions posed, we will provide a brief answer based on the available research. In each of these sections, we will conclude with the important role of intrapersonal, interpersonal, and between-group context factors.

1.1.3.1 Does induced abortion harm women's mental health?

Since 1989, evidence is sought for the presence or absence of a link between induced abortion and mental health problems, despite the impossibility to experimentally test such a link (Major et al., 2009). This line of research was part of the public debate surrounding induced abortion in the United States at that time, and is mostly situated in the field of psychology. Major and colleagues outlined in their review (2009) that having a single first-trimester induced abortion for unwanted pregnancy is not associated with a higher risk on mental health problems compared to delivering an unwanted pregnancy. This review of Major et al. (2009) mirrored the findings of previous authors reporting the absence of such a link (Adler et al., 1990; Charles, Polis, Sridhara, & Blum, 2008). All of these authors brought to light that the studies in which a mental health risk of having an induced abortion was found, suffer from methodological problems. These problems are the absence of a pre-abortion measurement of mental health (to control for preexisting mental health problems), the absence of a definite or usable comparison group (such as women who needed or decided to carry an unwanted pregnancy to term), the neglect of confounding variables (such as partner related violence), the use of invalidated measures of mental health, and the use of unrepresentative samples (Charles et al., 2008). Scholars sometimes do find more mental health problems in the abortion group than in a general female population sample (Charles et al., 2008). However, whether these mental health problems precede the induced abortion or whether the induced abortion causes the mental health problems, is inconclusive based on this kind of comparative research (for an overview, we refer to Van Ditzhuijzen et al., 2017). In addition, the increased level of distress found in the abortion group might be due to various non-abortion related factors.

Other scholars have investigated the evolution in mental health along the abortion procedure. These authors compared pre-abortion levels of emotional distress with post-abortion levels of distress and found that emotional distress during the pre-abortion period is increased compared to population based levels, with anxiety being the most prevalent emotion (e.g., Bradshaw & Slade, 2003; Lauzon,

Roger-Achim, Achim, & Boyer, 2000). However, these levels of emotional distress decrease over time and have most often returned to population based levels in the post-abortion period, with positive feelings such as relief being more prevalent than negative feelings such as sadness or guilt (Bradshaw & Slade, 2003; Major, Cozzarelli, Cooper, & Zubek, 2000). Kirkman, Rowe, Hardiman, and Rosenthal (2011) then indicated an induced abortion as a sometimes distressing but overall necessary solution to the actual problem of the unwanted pregnancy. Research, also in our own country, has indeed demonstrated that women who (were obliged to) continu(ed) the unwanted pregnancy are especially vulnerable to mental health problems, in contrast to women who had an induced abortion as a solution for their unintended pregnancy (Biggs, Upadhyay, McCulloch, & Foster, 2017; Leathers & Kelley, 2000; Vandamme, Buysse, & T'Sjoen, 2013). In the American Turnaway Study of Biggs and colleagues (2017), a prospective design (with a five year post-abortion follow-up) is combined with the use of an appropriate comparison group (women who are being denied an induced abortion) to clarify the link between induced abortion and mental health. Preliminary results disconfirm the idea that induced abortion harms women's mental health (Biggs et al., 2017).

It is now commonly accepted that although induced abortion is not related to adverse mental health outcomes compared to carrying an unwanted pregnancy to term, women's experiences during the pre- and post-abortion period highly vary, and this variety should be explained by a myriad of factors (Bradshaw & Slade, 2003). Major et al. (2009) described the role of personal predisposing or concurrent risk factors such as maladaptive coping with other stressors in life or generally defined risk factors for mental health such as poverty, living in a violent relationship, or having prior mental health-problems (e.g., Van Ditzhuijzen et al., 2017). Others described the role of socio-contextual factors such as social support or abortion stigma (Rocca et al., 2015). All of these factors might interact with each other in their effect on the level of emotional distress or on the contrary, the emotional ease that is experienced by women seeking an induced abortion.

1.1.3.2 Who is at risk?

A second line of research is situated in the field of epidemiology, and deals with the question who is at higher risk for an unmet desire for birth control. It has mostly been used to inform policies about how to target family planning interventions. One of the strategies to target the women who are vulnerable to pregnancy planning failures has been the examination of the socio-demographical characteristics of abortion-seeking women (Henshaw & Kost, 1996). As outlined above, such a demographical analysis takes into account the normal distribution of women in the population with regard to age, educational status, parity, relational status, ethnicity, or religion, and investigates the over- or underrepresentation of certain subgroups of women in the abortion-seeking population (Bankole et al., 1999; Henshaw & Kost, 1996; Sedgh et al., 2013). Scholars have nevertheless shed light

on the important difference between being at risk for unprotected sexual intercourse (including non- or misuse of contraceptives), being confronted with an unintended pregnancy, and deciding for abortion in the event of an unintended pregnancy (including experiencing the pregnancy as unwanted) (Bankole et al., 1999; Rossier, Michelot, Bajos, & the COCON group, 2007; Trussell, Vaughan, & Stanford, 1999). The discrepancies between these three events relate to the important difference between behavioral and affective dimensions of family planning such as the non-use of contraceptives versus actually intending a pregnancy (e.g.,. Bankole et al., 1999; Barrett & Wellings, 2002), planning versus desiring a pregnancy (e.g., Fischer, Stanford, Jameson, & DeWitt, 1999; Vandamme et al., 2013), or finding a pregnancy unacceptable versus deciding for abortion (cfr. Aiken, Borerro, Callegari, & Dehlendorf, 2016). Research then demonstrates that socio-demographical factors might interact with each other in their indirect or direct effect on the incidence of induced abortion. For instance, higher educated women might be at lower risk for unintended pregnancy because of their higher knowledge about and higher access to modern contraceptives, but might more often decide for abortion in the event of an unintended pregnancy because of the costs of having an additional child in terms of future career or income opportunities (Bankole et al., 1999; Rossier et al., 2007). Similarly, ethnic minority groups might be overrepresented in the abortion-seeking population, not because of ethnic descent per se but because of other socio-demographical vulnerabilities (Rasch et al., 2007).

In addition to socio-demographic variables, scholars have also paid attention to relational as well as personal characteristics which are associated with the incidence of induced abortion. An example is the frequently reported link between intimate partner violence (IPV) and induced abortion for which it is unclear what the underlying mechanisms are, i.e. whether this is because the male partner prevents the woman from using contraception and/or whether the woman who is confronted with IPV more often decides for abortion in the event of an unintended pregnancy (Hall, Chappell, Parnell, Seed, & Bewley, 2014). A similar detailed pathway is unknown regarding the relationship between for instance childhood adversities (such as parental mental illness) and repeat abortion (Steinberg & Tschann, 2013), unconventional behaviors such as drug use and induced abortion (Martino, Collins, Ellickson, & Klein, 2006) or psychiatric history and induced abortion (van Ditzhuijzen, ten Have, de Graaf, van Nijnatten, & Vollebergh, 2013).

In summary, the various societal, cultural, relational, and situational contexts in which fertility related decisions occur, blur the relationship between socio-demographic, relational or personal features and the incidence of induced abortion (Santelli et al., 2003). Therefore, it is very difficult to isolate the induced abortion rates in a certain country or region from rates of unintended pregnancy, and prevalence of (effective) contraceptive use in general (e.g., Elul, 2011; Sedgh et al., 2012).

1.1.3.3 Is induced abortion safe, and acceptable?

While the two already mentioned areas of research on induced abortion are dotted with implicit or explicit policy related concerns regarding induced abortion, this third line of research deals with the more pragmatic and technical aspects of induced abortion. It is mostly situated in the field of health sciences, and deals with the question "Are different methods for induced abortion (equally) safe, and acceptable?".

Various authors have reviewed the issue of the safety of induced abortion. Results reveal that only a small minority of women suffer from medical complications following evidence based induced abortion (Raymond & Grimes, 2012; Raymond, Shannon, Weaver, & Winikoff, 2013). However, when abortion is provided in unsafe circumstances (as for instance in many Latin American or Sub-Saharan African countries) complications such as infertility, pelvic pain or genital infections are highly prevalent, and maternal deaths are common (Faúndes & Hardy, 1997).

Apart from medical safety, scholars have also gained insight into women's satisfaction with evidence based abortion care. When this care is perceived as unsatisfying, it is mostly due to one or a combination of the following factors: 1) access barriers such as unnecessary waiting times or referral periods, 2) inappropriate or too less information or counseling about what to expect, 3) judgmental or cool interactions with the staff, or 4) unforeseen medical complications although they are rare (Harden & Ogden, 1999; Makenzius, Tydén, Darj, & Larsson, 2012; Slade, Heke, Fletcher, & Stewart, 2001; Taylor et al., 2013; Zapka, Lemon, Peterson, Palmer, & Goldman, 2001). However, in general, satisfaction with evidence based care is high, and is independent of the method used or the type of healthcare provider who performed the abortion (Harden & Ogden, 1999; Taylor et al., 2013; Wu et al., 2015; Zapka et al., 2001). Degree of pain experienced by the treatment is associated with satisfaction with care but has probably more to do with the perception that the staff did everything to control the pain than with the pain itself (Taylor et al., 2013). Findings on whether satisfaction differs between primary care or general hospital settings versus specialized abortion clinics, are inconclusive (Harden & Ogden, 1999; Wu et al., 2015).

Unfortunately, data on satisfaction with abortion care in countries or regions where abortion is illegal or performed under unsafe conditions, is currently lacking.

1.1.3.4 Why and how do women decide to have an induced abortion?

A final, and extensive line of research on induced abortion is mainly situated in the field of qualitative research. It has focused on women's reasons for having an induced abortion in the event of an unwanted pregnancy, and the different emotions accompanying that decision. In contrast to the first three lines of research, scholars in this area of research have captured the idiosyncratic decisional

process of abortion-seeking women, rather than the distal determinants for, the overall effects of, or the satisfaction with induced abortion. It has been set up to fully understand the decisional experiences of the abortion-seeking women themselves. Hence, this line of research aims at optimizing psychosocial care by informing counselors and health care providers on how to deal with women making the decision to have an induced abortion.

As indicated by the review of Bankole, Sing, and Haas (1998) and according to more recent studies, most women have myriad, interrelated, and complex reasons for having an induced abortion (Biggs, Gould, & Foster, 2013; Kirkman, Rowe, Hardimann, Mallet, & Rosenthal, 2009). The most frequent cited and "basic" reason worldwide is the desire to postpone or stop childbearing. The reason why these women have unintended pregnancies although they are motivated to avoid it, is determined by factors such as lack of knowledge on or access to (modern) contraception, social norms or pressure from others regarding the non-use of contraception, (inevitable or user-based) contraceptive failure, myths about contraceptives, or ambiguity about the desire for children (Bankole et al., 1998). On top of this "basic" reason for abortion are the reasons of socio-economic nature. These include financial constraints, fear for negative impacts on career or education, not feeling able or ready to raise a child (sometimes because of physical or mental health problems), fear for negative reactions from others (for instance parents or relatives), relational constraints such as the partner not willing to have a baby, a lack of support from the partner, definite relationship problems, or worries about the care for the existing children (Bankole et al., 1998). Kirkman et al. (2009) grouped these reasons as either material reasons, woman-centered reasons or other-centered reasons, although a lot of women give reasons in each of these three categories.

As can be noticed, the decision for abortion is very often driven by the timely circumstances of the abortion-seeking woman (Biggs et al., 2013; Jones, Frohwirth, & Moore, 2013). This time-based dimension of induced abortion is particularly seen in the relationship between women's reasons for having the abortion and their socio-demographic characteristics at the moment of the pregnancy such as their age, parity or relational status (Kirkman et al., 2009). Women hence describe the pregnancy as occurring in a situation in which they feel themselves incapable of being a good parent for the unborn child (Jones, Frohwirth, & Moore, 2008; Kirkman et al., 2011). As a consequence, the abortion is seen as an act of responsibility (Kero, Högberg, Jacobsson, & Lalos, 2001). Important to note here is that women, when asked to state their reasons for the induced abortion, might give socially desirable answers as they might feel the need to justify their decision (Kirkman et al., 2011).

Abortion-seeking women are mostly very convinced of the fact that the abortion is the best option for them at this stage in their lives despite often perceiving it as difficult or painful (Foster, Gould, Taylor, & Weitz, 2012b; Kero et al., 2001; Kirkman et al., 2011; Rocca et al., 2015; Sereno, Leal, & Maroco, 2013; Törnbom, Ingelhammar, Lilja, Svanberg, & Möller, 1999). These difficult or painful

feelings partly demonstrate the social complexity of induced abortion in which ethics (prevailing, and sometimes contradictory norms and values considered by the individual abortion-seeking woman) as well as direct or indirect expectations of surrounding others are highly influential (Ekstrand, Tydén, Darj, & Larsson, 2009; Kero & Lalos, 2000; Kero et al., 2001; Kjelvsik & Gjengedal, 2011; Tornböm et al., 1999). Ambivalence, in terms of having opposing feelings or attitudes regarding the abortion, is as such perceived as normal, even in those who are already decisive about having the abortion prior to the result of the pregnancy test (Rowlands, 2008). The majority of women requesting an induced abortion then indicate to be very decisive about having the abortion as they already weighed and reviewed the decision long before they came to the clinic (Cameron & Glasier, 2013; Kumar, Baraitser, Morton, & Massil, 2004; Rowlands, 2008). Indeed, only a minority of the women requesting an induced abortion change their minds later on (Cameron & Glasier, 2013; Goenee, Donker, Picavet, & Wijsen, 2014; Söderberg, Andersson, Janzon, & Sjöberg, 1997).

Despite the majority of women being very certain about the abortion at the moment they enter the abortion clinic, women differ in how they experience or reach that decision. While some have involved others such as parents, friends, or partners in the decision-making process, others delayed the involvement of others or preferred not to involve anyone else (Tatum, Rueda, Bain, Clyde, & Carino, 2012). Similarly, while some abortion-seeking women have never considered continuing the pregnancy and decided for abortion immediately after the pregnancy test, others thought about it only at the beginning, or from time to time in the period waiting for the abortion (Tornböm et al., 1999). Hence, for some women, the unintended pregnancy was only associated with negative feelings, while others both had positive and negative feelings, or reasons for terminating as well as for continuing the pregnancy (Allanson, 2007; Tornböm et al., 1999). Similarly, for some women, taking the first abortion pill or seeing the products of conception is an existential experience that re-triggers the decision process, while others only perceive these moments as essential aspects of the medical and technical care following their decision (Stålhandske, Ekstrand, & Tyden, 2011). Few authors have aimed to gain insight into the determinants of these differences in degree of ambivalence, level of uncertainty or time needed to decide about the unwanted pregnancy. The little research available suggests the role of others in terms of social pressure or social support, the role of demographic characteristics such as age or educational level, and the role of co-occurring individual factors such as general difficulties in making decisions (Allanson, 2007; Foster et al., 2012b; Husfeldt, Hansen, Lyngberg, Nøddebo, & Petersson, 1995).

1.1.4 Conclusion: Induced abortion in context

As outlined above, women's decisional, emotional, and physical experiences with induced abortion seem to be the result of a dynamic interplay between personal, relational, situational, and

societal factors. The outcome of the decision, the emotional experience of the decision, and the satisfaction with the abortion, all together result from the interaction between factors at the intrapersonal, interpersonal, and between-group level. As will be discussed in the following section, a systemic approach in which contextual factors at each of these levels are taken into account, is the most evidence based approach to investigate women's decision to have an abortion. In this doctoral thesis, we aim to investigate the complex and interacting contexts in which the decision to have an induced abortion occurs, based on the different levels in the model of social complexity outlined below.

We focus on the following contexts:

1) The sociocultural context of pregnancy decisions in Flanders, with special attention to the role of ethnicity
2) The interactional and relational context of the decision to have an induced abortion, with special attention to the role of the male partner
3) The context of intrapersonal differences, and variations over time, with special attention to the role of counseling

1.2 The social complexity of induced abortion: A dialectical-contextual model

1.2.1 Conceptual framework

Robert Hinde's dialectical-contextual model for studying romantic relationships, is a very useful framework for studying the various interacting contexts in which the decision to have an abortion occurs (Hinde, 1997). As argued by Robert Hinde, the nature of the self is essentially social. As depicted in Figure 1, an individual's behavior—in this context, a woman's decision for abortion—is embedded in the dynamic interplay between intrapersonal psychological processes (her motives, beliefs, emotions, cognitions, and memories), the interactions with others (e.g., her conversations with others about the unintended pregnancy), the relationships with others (e.g., the current relationship with the male partner who was involved in the pregnancy), the social groups in which individuals reside (e.g., the abortion-seeking woman belonging to the group of younger women in society) and finally, the societies in which people live (e.g., the abortion-seeking woman living in a society where induced abortion is highly restrictive). Hinde (1997) then outlines a systemic model in which the individual's intrapersonal cognitions, emotions, and behavior are constantly influenced by, and do vice versa constantly influence the interactions with other individuals. Interactions between individuals influence and are in turn influenced by the relationships in which individuals reside. Relationships in which individuals reside, influence and are influenced by social group processes. Social groups are influenced by, and do in turn influence the society in which social groups reside. This dynamic interplay between

individuals, interactions, relationships, groups, and societies is strengthened by the role of socio-cultural values and beliefs, and the role of institutions and the physical environment in which all of these interactions occur. As Hinde puts forward, an analysis of behavior, emotions, or cognitions at one of these levels (such as women's feelings of uncertainty regarding the induced abortion) always needs an examination or at least recognition of the behavior, emotions, or cognitions at all of these other levels. In the following section, three levels of social complexity regarding the decision for induced abortion will be described more into detail: the intrapersonal level, the interpersonal level, and the between-group level. The lowest, intrapersonal level captures the individual needs, emotions, cognitions, and behavior of the abortion-seeking woman (i.e., the level of intra-psychic psychological processes and individual behavior in the model of Hinde). The intermediate interpersonal level captures the interactional, and relational processes in women's decision for abortion (i.e., factors and processes in the interactions between the abortion-seeking woman and surrounding others). The highest, between-group level finally includes the socio-demographic, and societal influences in women's decision to have an abortion (the level of the group and the level of society in Hinde's model). In addition to the discussion of each of these levels separately, the role of the physical environment (including the technical, and practical organization of induced abortion) and the role of socio-cultural norms, beliefs, and values (for instance the role of abortion stigma) will be described. For educational purposes, these levels will be discussed in a consecutive way although it should be noted that a discussion of factors at one of these levels is inherently influenced by the factors at all of the other levels. At each of these levels, we will discuss some theoretical concepts and we will outline the gaps in current research.

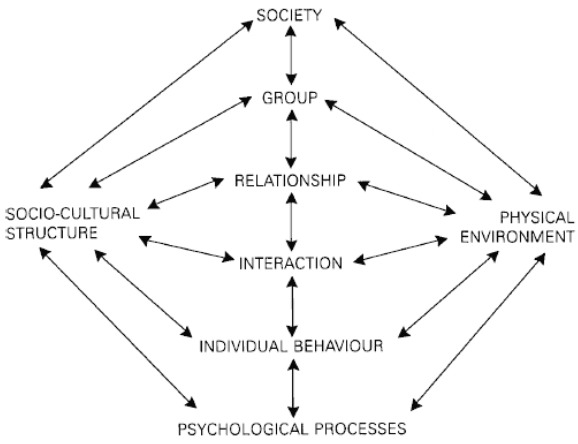

Figure 1. Levels of social complexity. Adapted from "Relationships: a dialectical perspective", by R. Hinde, 1997.

1.2.2 Induced abortion at the between-group level

Induced abortion at a between-group level has mostly been examined by sociologists. This field includes epidemiological, demographical, and anthropological research on induced abortion. It investigates the role of legality, and accessibility of induced abortion as well as the role of socio-demographic and socio-cultural factors on the cognitive, affective, and behavioral processes in the decision to have an induced abortion (see Marecek, Macleod, & Hoggart, 2017).

1.2.2.1 Legality and accessibility: The role of society and the physical environment

The map below (Figure 2) visualizes the degree to which induced abortion is either legally restricted versus permitted in countries all over the world. The green colored regions (mainly the developed countries) have no restrictions regarding the reason for seeking an induced abortion. These are the countries that legally permit abortion on women's request. The red colored countries are the countries where abortion is totally prohibited or only permitted to save the woman's life. A lot of these countries are situated in South Africa, the Middle East, and Latin America. The dark orange countries are the countries where abortion is only legal for health related reasons (either the health of the fetus, for instance in the case of fetal impairment, or the mental or physical health of the pregnant woman, for instance in the case of rape or incest). The light orange countries finally are the countries where abortion is only legal on socio-economic grounds (for instance being too young or being incapable to care for the child). The latter are countries as Great Britain, Finland, Japan or India. As stated earlier, Sedgh et al. (2012) demonstrated that in countries where abortion is prohibited or only permitted under very strict conditions, the abortion incidence is high, and the share of illegal abortions in this incidence is even higher.

Besides the differences in legal context of induced abortion, countries also differ in how abortion care and abortion services are organized. While most of the European countries have legalized induced abortion on request or for socio-economic reasons, these countries differ with regard to the maximum gestational limit at which abortion can be requested, the requirements for consent of the parents if it concerns minors, the facilities where abortions can be performed, which health care providers are able to perform the abortion, the required fee for performing the abortion, and the presence of mandatory waiting periods or pre-abortion counseling sessions (Pinter et al., 2005).

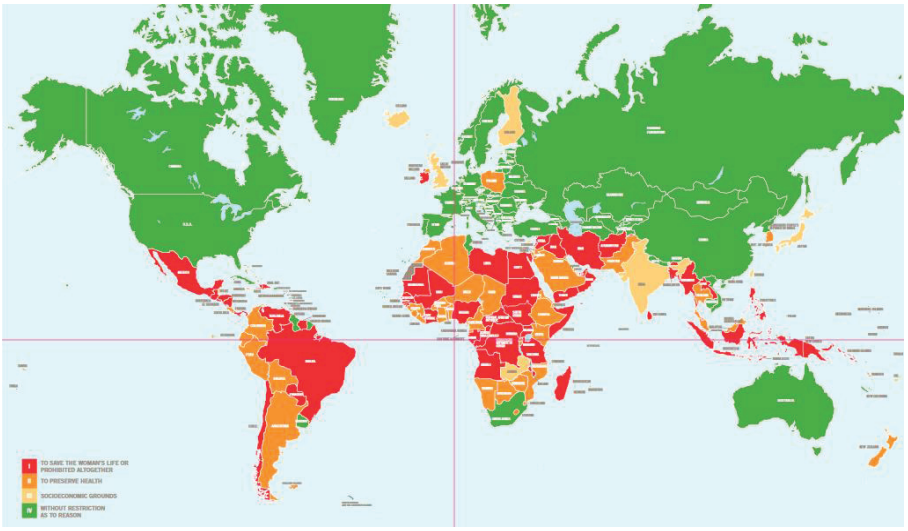

Figure 2. Differences in legality of induced abortion. Adapted from the website of the World Health Organization, www.worldabortionlaws.org.

According to the model of Aiken et al. (2016), these differences in accessibility all have a significant influence on the decisional process in the event of an unintended pregnancy. Joyce and colleagues (2009) for instance examined the effect of mandatory waiting periods and counseling sessions. They came to the conclusion that these mandatory requirements do not influence reproductive outcomes, but only result in a delay in the timing of the abortion, an increased number of women going abroad to seek the induced abortion, and a higher abortion-related cost when it concerns in-person counseling sessions (Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009). Other authors investigated the effects of the availability and related costs of services that perform second trimester abortions in a certain region. Jones and Weitz (2009) concluded that mostly the low-income women are exposed to the devastating effects of increased barriers to access induced abortion, which results in an inequality of abortion care. In addition, women who are being confronted with logistical barriers to have an induced abortion (because services are for instance only available after a long travel to a distant city) sometimes decide to carry an unwanted pregnancy to term or if they do not, they might suffer from the need to involve more people in their attempts to have the abortion than they would have liked to (Baum, White, Hopkins, Potter, & Grossman, 2016). In addition, Biggs and colleagues (2017) demonstrated that compared to those who had an abortion, women who were denied an induced abortion because of gestational limits had initially higher levels of anxiety, lower levels of self-esteem and less satisfaction with life. However, their mental health improved over time. Nevertheless, in the group who eventually gave birth to the initially unwanted child, more women suffer from depression (Biggs et al., 2017).

All of the aforementioned findings demonstrate the role of both the legality and accessibility of induced abortion on women's experiences with seeking an induced abortion.

1.2.2.2 Socio-demographic patterns: The role of the social group

The socio-demographic characteristics that have mostly been examined in relation to the decision for induced abortion in the event of an unintended pregnancy, are age, parity (number of childbirths), marital status, educational level, income, ethnicity, religion, and residence (Bankole et al., 1999). As argued above, abortion ratios (i.e., the number of abortions on the total number of pregnancies) are the most evident measure to use when examining sociodemographic patterns in the decision to have an induced abortion. Age dependent induced abortion ratios typically follow a combined "U" and a monotonic increase pattern, meaning that younger and older women more frequently decide to have an abortion in the event of a(n) (unintended) pregnancy, yet typically, that the odds of deciding for induced abortion increase with a higher age (Bankole et. al., 1999). Abortion odds are also generally higher in unmarried and/or non-cohabiting women than in married/cohabiting women in the event of a(n) unintended pregnancy in most Western countries (Bankole et al, 1999; Bettarini & D'Andrea, 1996; Rossier et al., 2007). In Asian countries however, the proportion of unmarried women within the abortion-seeking population is much lower than the proportion of married women (Bankole et al., 1999). Relational status also interacts with age as relationship issues seem to have the largest influence in the oldest age group (Sihvo, Bajos, Ducot, Kaminiski, & the COCON group, 2003). Educational level has been positively associated with the induced abortion odds in the event of an unintended pregnancy in older, and younger women, but negatively associated with it in the middle age groups (Bettarini & D'Andrea, 1996; Sihvo et al., 2003). Similarly, parity has the highest influence in the group of 25 to 34-year old women with those having one child obtaining the lowest odds of deciding for abortion in the event of an unintended pregnancy, while those with more than two children generally obtain the highest odds (Bankole et al., 1999; Sihvo et al., 2003). Ethnic differences or differences along country of residence have been reported as well, although these differences are often either enmeshed with other socio-demographic differences such as educational level, age, parity or marital status or they do not control for the differences in general number or timing of pregnancies (Bankole et al., 1999; Helström et al., 2003; Rasch et al., 2007).

The aforementioned findings suggest the need to investigate the relationship between socio-demographic characteristics and induced abortion from a life course perspective in which socio-cultural norms regarding fertility, childbirth, and parenthood in a certain country or region are definitely taken into account (Sihvo et al., 2003).

1.2.2.3 Norms, beliefs, and values: Socio-cultural influences

Research on abortion stigma has demonstrated the enormous impact of social and ethical norms, beliefs, and values regarding womanhood, and the existential role of the fetus on how women experience the decision opt for induced abortion (Kumar, Hessini, & Mitchell, 2009; Norris et al., 2011). The most evident social norm is the one that associates women to being nurturing mothers for whom sex should lead to reproduction (Kumar et al., 2009). As argued by previous authors, abortion stigma and the associated social norms, values, and beliefs can occur at the different levels outlined by the model of Hinde: *within* abortion-seeking woman and their supporters or *within* abortion health care providers, but also in interactions *between* people (e.g., women who had an abortion who do not disclose it to their friends or family), within community and institutional groups of people (e.g., a country or region lacking abortion health care providers), but also in law, and government structures (e.g., abortion laws being part of criminal codes), and in public discourse (e.g., the idea that there are good and bad reasons for having an abortion) (Kumar, 2013; Norris et al., 2011). Abortion stigma might in turn be increased by factors at all of these levels, for instance when legislative initiatives give the fetus characteristics of being a person or when abortion-seeking women feel unsupported by their relatives (Norris et al., 2011). Abortion stigma might then differ *between* groups as well as *within* groups of women or abortion care providers, and is never "universal" but rather locally, and socially shaped (Kumar et al., 2009). Shellenberg and Tsui (2012) for instance demonstrated that women living in the south of the USA experience a higher degree of abortion stigma, which is most probably due to the rather conservative, and highly religious ideas in this region, represented in the high number of people with pro-life attitudes. They also demonstrated that black adult women perceive higher abortion stigma from health care providers than black adolescents, probably demonstrating the strong effect of the social norm of motherhood when a black woman grows older.

In contrast to the social norm of women as being nurturing mothers, young abortion-seeking women might also be confronted with the opposite social norm: the idea that the unintended pregnancy should be terminated instead of being carried to term (Ekstrand et al., 2009). Indeed, as a result of the disconnection between marriage and fertility during the mid-20th century, woman's age at first childbirth rose (Lesthaeghe, 2014). Hence, becoming a mother at a very young age became rare. This might result in young women feeling social pressure for having an induced abortion in the event of an unintended pregnancy. Research has indeed demonstrated that social norms regarding whether and when to have children play a profound role in the fertility related decisions people make (Gauthier, 2015; Liefbroer & Billari, 2010; Lois & Becker, 2014).

Hence, when induced abortion is examined at one of the levels of Hinde's model, scholars should take into account the existing social and gender based norms, beliefs, and values on parenthood,

fertility, childbirth, and induced abortion itself in the country or region under study. In the following section, we therefore outline the law, and accessibility of induced abortion, and the socio-demographic patterns of parenthood and childbirth in our own country, Belgium. We conclude with an outline of the hypothesized social norms on parenthood and the hypothesized presence of abortion stigma in Belgium.

1.2.2.4 Induced abortion in Belgium

In 1990, Belgium was one of the last European countries that legalized induced abortion on women's request, partly because of a fairly large group of catholic opponents (David, 1992). The current law (which is nevertheless still included in the penal code) states that women are permitted to have an induced abortion when they exist in a state of undefined "distress" because of the unintended pregnancy (law on induced abortion of 3/4/1990; Belgisch Staatsblad 5/4/1990). The induced abortion cannot be initiated on request beyond 12 weeks of pregnancy[3], and should be performed by a medical doctor in a multidisciplinary institution where information and counseling is provided. Information provision about contraceptives, the induced abortion itself, and alternatives for having the abortion, is mandatory, as well as a waiting period of at least six days, starting from the first appointment in the health care institution that will perform the abortion. In Flanders (the northern part of Belgium) induced abortions are nowadays mostly performed in the five specialized abortion centers (part of the LUNA association, Unie van Nederlandstalige Abortuscentra), established within primary health care system, in addition to certain hospitals performing induced abortions. Flemish women have access to an abortion center within a one hour drive maximum. In the southern part of Belgium, induced abortions are mostly performed in general family planning centers (Federation Laïque de Centres de Planning Familial) where women and couples can also have contraceptive counseling, normal gynecological visits or HIV testing. Twenty-one of the forty centers perform induced abortions. These centers are associated with Gacepha (Groupe d'Action des Centres Extra Hospitaliers Pratiquant l'Avortement). In both Flanders and Wallonia, abortion-seeking women first have a non-judgmental consultation with a psychosocial healthcare provider, which is followed by a medical consultation in which pregnancy duration is determined. After the mandatory waiting period, women can have a medical abortion (up till 8 weeks of pregnancy) or a surgical abortion (up till 12 weeks of pregnancy). The latter is performed by a trained medical doctor. A follow-up visit is recommended 14 days after the abortion procedure. Abortion-seeking women who are part of a health insurance system (which is mandatory in Belgium), only pay 3 euros for the TOP in an official abortion center. In summary, induced

[3] Second trimester induced abortions are only permitted when there are health related risks for either the fetus or the woman, and when two medical doctors have given their consent.

abortion is quite accessible, and affordable in Belgium, and abortion health care is multidisciplinary, non-judgmental, and safe.

The partial legalization of induced abortion in Belgium followed a long history of political debates, a growing feminist movement since 1971 (e.g., the feminist action group “de dolle mina’s”), and polarized public opinions on the topic (Vekemans & Dohmen, 1982). While induced abortion was prohibited by law before 1990, various gynecologists yet illegally performed pregnancy terminations (Vekemans & Dohmen, 1982). It led to the imprisonment of some of these gynecologists, and the prosecution of patients, feminists, and nurses striving for women’s right on induced abortion. When the Parliament asked the King in Belgium to sign the new law on induced abortion in 1990, the King refused, and the Parliament deposed him for 36 hours to be able to confirm the new law without the King’s support.

The Belgian abortion rate in 2011, as reported by the Evaluation Commission, was 9.3 abortions per 1000 women of reproductive age (SENSOA, 2011). The abortion ratio was 13.4% (SENSOA, 2011). It is comparable to the numbers in the Netherlands, but lower than the numbers in the UK, Sweden or Eastern European countries such as Bulgaria or Romania (Eurostat, 2016; Inspectie voor de Gezondheidszorg, 2017). Belgium hence holds one of the lowest abortion odds in Europe (SENSOA, 2011). A partial explanation is the high rate of effective contraceptive use (28% of the women at risk using Long Acting Reversible Contraceptives, 50% using hormonal pills, rings or patches, and only 6% solely using barrier methods or no method at all), and the high number of women who are aware of the emergency contraceptive pill (Elaut et al., 2015). As outlined by Bajos and colleagues, there is indeed a clear link, especially among younger women, between high effective contraceptive use, and low numbers of unwanted pregnancy (Bajos et al., 2014). However, the link with induced abortion rates is less evident as the decision in the event of an unwanted pregnancy depends on various situational factors, and cannot solely be explained by the failure of effective contraceptive use (Bajos et al., 2014).

Most of the Belgian abortion-seeking women (80.5%) are evidently in the “reproductive” age range between 20 and 39 years old (SENSOA, 2011). The majority is unmarried and about half is childless (SENSOA, 2011). About 60% of the Belgian abortion-seeking women did use a contraceptive method at the moment they got pregnant. From the increasing number of teenagers in Belgium deciding for induced abortion instead of carrying an unintended pregnancy to term (although they are not overrepresented in the abortion-seeking population because of a generally low number of teenage pregnancies in Belgium) can be derived that Belgian women mostly desire to postpone childbirth at younger ages (De Wilde, 2009; SENSOA,2011). This is seen in the high number of sexually active teenagers using contraceptives to prevent unintended pregnancy nowadays (Charafeddine, 2014). As in other West European countries indeed, the total fertility rate in Belgium declined and the age at first

childbirth increased as a result of women wanting fewer children at a higher age (Devlieger, Martens, Martens, Van Mol, & Cammu, 2016). The current total fertility rate in Belgium is 1.74 childbirths per woman and mean age at first childbirth is 28.6 (Eurostat, 2016). Access to and use of affordable contraceptives in Belgium indeed increased around 1960, in contrast to countries in Central or Eastern Europe, where the contraceptive pill was much more expensive, rather difficult to access, and socially rather unacceptable (Dereuddre, Van de Putte, & Bracke, 2016a). As effective pregnancy planning opportunities increased, induced abortion has been less socially accepted as a method of birth control in case of contraceptive failure in Western Europe compared to Eastern Europe (Dereuddre, Van de Putte, & Bracke, 2016b). As reported by Dobbelaere et al. (2000) however, induced abortion is nowadays increasingly being accepted in Belgian society (Dobbelaere, Elchardus, Kerkhofs, Voyé, & Bawin-Legros, 2000).

1.2.2.5 The research gaps

Despite the National Evaluation Commission reporting on the socio-demographic characteristics of Belgian women seeking an induced abortion (SENSOA, 2011), and despite the recurrent governmental and clinical reports on the socio-demographic patterns in contraception use, pregnancy and childbirth in the Belgian population (Devlieger et al., 2016; Charafeddine, 2014), representative Belgian population data on the incidence of unintended pregnancies and the prevalence of induced abortion in case of an unintended pregnancy, are currently lacking. Gaining insight into the link between these two events is however important to be able to tailor family planning interventions in Belgium to those who are really in need. As argued above, women who are confronted with unintended, especially unwanted childbirth, are at risk for diverse impaired health outcomes (Biggs et al., 2017; Leathers & Kelley, 2000; Vandamme et al., 2013). A thorough analysis of the different steps towards abortion versus childbirth in the event of an unintended pregnancy, as suggested by Rossier et al. (2007), is as such highly useful in our own country Belgium. In this analysis, and as stated above, general social norms on the timing, and number of childbirths in Belgium should be taken into account.

In addition to the absence of these Belgian data, questions have been raised about the possible overrepresentation of ethnic minorities in the Belgian abortion-seeking population (Neefs & Vissers, 2005). As hypothesized by SENSOA (2011), this is possibly due to the socio-economical vulnerability of men and women in this group, combined with the different cultural norms on sexuality, gender, and reproduction which make them at higher risk for unintended pregnancy. However, this hypothesis has not been tested yet. Moreover, the socio-demographic profiles of abortion-seeking women with a foreign background seem to differ from the profiles of abortion-seeking women born in Belgium, which possibly depicts a general difference in timing and number of pregnancies within these groups of women.

In **Chapter 2**, we will analyze the role of ethnic descent, socio-economic disparities, and socio-demographic situations on the incidence of unintended pregnancy and induced abortion in Flanders (the northern part of Belgium). This analysis hence focuses on the between-group-level of induced abortion in Belgium.

1.2.3 Induced abortion at the interpersonal level

Examining induced abortion at the interpersonal level is mostly in the field of social and family psychology. It investigates how abortion-seeking women's cognitions, emotions and behavior are shaped by and do affect the interactions and relationships with significant others. Studies have shown that two factors at the interpersonal level have been very important for the emotional wellbeing of abortion-seeking women: the presence of social support and a feeling of decisional autonomy (Broen, Moum, Bödtker, & Ekeberg, 2005; Kimport, Foster, & Weitz, 2011; Lie, Robson, & May, 2008; Rocca et al., 2015).

1.2.3.1 The role of social support and dyadic coping

Major and colleagues were the first to examine the role of social support in women's induced abortion experiences (Major et al., 1990). They demonstrated that social support increases women's feelings of self-efficacy (the belief that they will be able to cope) which in turn decreases psychological distress following the induced abortion. Also Kimport et al. (2011) shed light on the negative effect of social support being absent on women's emotional state post-abortion. As the theoretical stress and coping perspective on social support puts forward, social support increases the individual abilities of a person to cope with a stressor such as the unwanted pregnancy or the induced abortion which in turn diminishes the negative effect of this stressor on one's mental health (Lakey & Cohen, 2000). Other authors have disentangled the different sources of social support for abortion-seeking women. As social support literature has shown, the effect of perceived support from one kind of relationship (e.g., the relationship with the male partner) might differ from the effect of perceived support from another kind of relationship (e.g., the relationship with peers) (Bodenmann, 2005; Pierce, Sarason & Sarason, 1991). While certain authors ascribed the most supportive role to mothers and friends of the abortion-seeking woman, others shed light on the supportive role of the male partner who was involved in the pregnancy (Altshuler, Nguyen, Riley, Tinsley & Tuncalp, 2016; Ekstrand et al., 2009; Jones, Moore, & Frohwirth, 2011; Kimport et al., 2011; Kjelsvik & Gjengedal, 2011). The latter support mechanisms between (romantic) partners are generally indicated as dyadic coping and it is argued that only when these dyadic coping mechanisms are insufficient, social support is sought outside the relationship, in friends, peers or parents (Bodenmann, 2005). The dyadic coping of the male partner might then consist of accompanying the woman to the abortion clinic for the induced abortion or being present at pre- or

post-abortion care facilities (e.g., Cozzarelli, Karrasch, Sumer, & Major, 1994; Kero, Lalos, & Wulff, 2010; Veiga et al., 2011), but it might also consist of supporting the woman in the outcome of her decision (e.g., Jones et al., 2011), being understanding, loving and caring for her during the abortion process (e.g., Aléx & Hammarström, 2004; Kjelsvik & Gjengedal, 2011) or taking over the care of the children (e.g., Kero et al., 2010). These different kinds of support are indicated as either more problem-focused or more emotion-focused (Bodenmann, 2005). Still other authors focused on the role of (informational, instrumental or emotional) support from the healthcare providers with whom the abortion-seeking women had contact (Harden & Ogden, 1999; Slade et al., 2001). As proposed by the model of Bodenmann (2005), this professional help very often comes at a later stage than the support from the male partners, peers, friends or parents. Importantly, the degree to which abortion-seeking women *feel* supported by significant others might differ from the *actual* support being given (Haber, Cohen, Lucas, & Baltes, 2007). To give an example, a male partner might state he would support the pregnant woman no matter what, which is then perceived by the abortion-seeking woman as being left alone in her decision process (Kjelsvik & Gjengedal, 2011). Besides the effect of social support on abortion-seeking women's emotional wellbeing, the absence or presence thereof might also affect the timing of seeking an induced abortion, in addition to the outcome of the decision (Ekstrand et al., 2009; Kapadia, Finer, & Klukas, 2011). The latter shows that women depend on surrounding others in their decision for abortion, in the behavioral as well as in the cognitive and affective dimensions of it.

1.2.3.2 Women's need for autonomy in a context of relational interdependence

Various studies have demonstrated that despite women's very often legal power in induced abortion decisions, significant others play a profound direct or indirect role in the decision process (e.g. Aléx & Hammarström, 2004; Kjelsevik & Gjengedal, 2011). Evans (2001) for instance demonstrated that male partners might directly influence a young woman's decision to have an abortion by openly stating their opinions about the pregnancy while mothers and sisters might indirectly influence the decision by their own experiences with and narratives on pregnancy, childbirth and induced abortion. Male partners might also indirectly influence the decision when the relationship with the pregnant woman is for instance new or of poor quality, or when they are, according to the women, not available or sufficient as future parents for her children (Chibber, Biggs, Roberts, & Foster, 2014). Parents might also directly influence the decision process, especially in younger women (Tatum et al., 2012). Despite others being directly or indirectly involved in the decision to have an abortion, only a small group of women feel as if the abortion is the result of external pressure from for instance partners, parents or friends (Törnbom et al., 1999). When women do feel as if their decision is not primarily theirs, they are at risk for emotional difficulties, both pre- and post-abortion (Broen et al., 2005; Kimport et al., 2011).

The previous findings first of all relate to the theoretical difference between *autonomy* and *independence* (Vansteenkiste, Niemiec, & Soenens, 2010). As argued by self-determination theory, the need for autonomy is an inherent need of all human beings (Deci & Ryan, 2000). Autonomy then refers to making volitional decisions in which external pressure from others is absent (Deci & Ryan, 2000). This fulfillment of the need for autonomy is universally beneficial, either in individualistic cultures where independence is highly valued or in collectivistic cultures, where relatedness or interdependence is more valued (Rudy, Sheldon, Awong, & Tan, 2007). The relationship between interdependence (or relatedness) and autonomy is not that these needs are opposites of each other; they mostly stand beside each other (Vansteenkiste et al., 2010). Research on induced abortion has indeed revealed that abortion-seeking women have an equal and complementary need for relatedness or dependence (feeling supported, understood and informed by relatives as well as by health care providers) and for autonomy (being able to freely decide, and choosing the abortion method that best fits the own needs) (Kjelsevik & Gjengedal, 2011; Makenzius, Tydén, Darj, & Larsson, 2013). The fulfillment of the need for relatedness can even act as an intensifier for the feeling of autonomy of the abortion-seeking women (Vansteenkiste et al., 2010). Deci and Ryan (2000) have indeed put forward that a supportive environment (which supports the inherent autonomy, relatedness, and competence needs of human decision-makers), results in an increased feeling of volition as the decision-maker is able to explore his own goals, values, and needs. These goals, values, and needs of the decision-maker might however be related to the goals, values, and needs of close others. Autonomy is as such guaranteed as long as the motivation for the decision is *perceived* as being internal (stemming from own valued goals and needs) instead of external (Vansteenkiste et al., 2010). Hence, abortion-seeking women might decide for abortion for other-related reasons such as to preserve the unborn child from growing up in a poor family, to maintain the time and space of caring for the other children, or to avoid future relational problems with the male partner, but perceive these reasons as autonomous rather than controlled by others as they might correspond with the internal need to be a good parent (Jones et al., 2008; Kero & Lalos, 2000).

Women's feelings of autonomy in the decision to have an induced abortion must be seen in a psychological reality of relational *interdependence* from others, and can be understood by the philosophical concept of relational autonomy (Nedelsky, 1989). The concept has been created by feminists as a reaction to the liberal, masculine interpretations of autonomy in terms of powerful, independent, self-in control agents who are not under the influence of other people (Nedelsky, 1989). As argued by Nedelsky, autonomy is about "being able to find and live in accordance with one's own law". Nedelsky highlights that a feeling of autonomy is shaped by our relationships with significant others in the sense that these others need to recognize our *own* values and needs (similar to what self-determination states about the relationship between social support and autonomy), but also *share*

their social norms, values and beliefs with us. Interdependence is as such a condition as well as a component of autonomy, according to Nedelsky.

1.2.3.3 The research gaps

Despite an unintended pregnancy being an inherently relational issue, occurring between two persons who had sex with each other, very few studies to date have focused on the specific role of the male partner who was involved in the pregnancy. A myriad number of reasons might be put forward for the absence of male partners in induced abortion research specifically, and in fertility related research in general (Goldscheider & Kaufman, 1996; Greene & Biddlecom, 2000). Historical and practical reasons are only two of them.

Historically, the contraceptive pill, which enabled women to prevent unintended pregnancies without involving the male partner, actually disconnected the men from the reproductive decision-making process (Darroch, 2000; Johnson & Williams, 2005). As a consequence, the focus on men in contraceptive issues has mostly been reduced to a focus on the use of condoms to prevent sexual diseases without educating them in other contraceptive methods used by the women (Greene & Biddelecom, 2000). Good contraceptive alternatives for men, other than condom use or vasectomy, are currently also absent making it even impossible for men to be solely responsible for the prevention of unintended pregnancies (Behre et al., 2016; Grimes et al., 2012; Mahmoud & T'Sjoen, 2012). Hence, the social norm is still that contraceptive use is mainly a woman's issue (Ekstrand, Tydén, Darj, & Larsson, 2007; Sharp, Richter, & Rutherford, 2015). In addition, women are still the main caregivers within the family which results in the idea that women's preferences for childbearing are paramount in fertility related decisions (Goldscheider & Kaufman, 1996). Researchers thus often thought men were of no particular interest for understanding decisions on childbearing and family planning (Greene & Biddelecom, 2000). If they were involved (directly or indirectly), they were very often perceived as being a possible barrier to the exercise of women's reproductive rights (Greene & Biddlecom, 2000). This problem related focus on men and reproductive decisions is seen in the frequent investigation of intimate violence in women seeking an induced abortion (Fisher et al., 2005; Jones et al., 2011). Regarding the decision to have an abortion in most European countries in particular, men actually have no legal rights. This results in women being seen as the ones who are primarily entitled to make the decision about what to do with the unintended pregnancy (Sharp et al., 2015). In addition, a physical gap between women and men disables men from being equally involved in the induced abortion process as the women themselves. Hence, the focus in induced abortion research has evidently been on the women as they are perceived as the actual patients and the primary decision-makers. To our opinion however, there has also been a kind of fear that studying male partners' perspectives on induced abortion would endanger women's current position of being able to decide to have an induced

abortion without the involvement of the male partner. This might be one of the main reasons for authors being reluctant to include men in induced abortion research.

On the other hand, also practical barriers have led to the exclusion of men in abortion research in particular and fertility related research in general. These are for instance the higher costs associated with interviewing both partners, and methodological concerns such as how to analyze couple level data (Goldscheider & Kaufman, 1996; Greene & Biddlecom, 2000). In addition, in the context of induced abortion, only one fourth of the male partners are present during the women's procedure in the abortion clinic, which makes it very difficult to examine *all* men involved in unwanted pregnancies (Becker, Bazant, & Meyers, 2008). Only a very few scholars have paid attention to these male partners' own experiences with the decision to have an induced abortion (e.g., Holmberg & Wahlberg, 2000; Kero, Lalos, Högberg, & Jacobsson, 1999; Naziri, 2007; Reich, 2008).

When the focus in induced abortion research *was* on the male partner, it was mainly on his role as being a source of support for the abortion-seeking woman (e.g., Cozzarelli et al., 1994; Jones et al., 2011). Scholars who focused on the more relational-dyadic issues of induced abortion, often took the same perspective as in the "abortion impairs mental health"-framework, and sought for (mostly negative) relational effects of the induced abortion (Coleman, Rue, & Spence, 2006). These studies are evidently characterized by the same methodological flaws as described earlier (no control for pre-abortion relational difficulties, no examination of confounding factors, no well-defined comparison groups…). Relational concerns or difficulties pre-abortion might indeed impair the emotional wellbeing of women post-abortion (Lauzon et al., 2000). Still other scholars have investigated the male partners' indirect role in the decision to have an abortion. Chibber et al. (2014) investigated women's partner related reasons for induced abortion such as the lack of support from the male partner for having the child. Others looked at the association between relational status and quality, the perception of the pregnancy as being unwanted, and the subsequent outcome of that pregnancy (Kroelinger & Oths, 2000; Zabin, Huggins, Emerson, & Cullins, 2000; Zavodny, 2001). Hence, despite certain scholars including *both* partners in the research on childbearing decisions (Miller, Severy, & Pasta, 2004; Stein, Willen, & Pavetic, 2014; Testa, Cavalli, & Rosina, 2012), to our knowledge only one study has focused on the male partners' actual role in the decision to have an abortion, as perceived by himself *and* the abortion-seeking woman (Costescu & Lamont, 2013).

As a consequence, a truly relational-interactional perspective to study the decision to have an abortion from both partners' perspectives, is currently absent. Relational processes and variables which are especially linked to heterosexual relationships such as gender (a between-group variable), relational interdependence, and commitment (variables at the relational level), or power division, equity, dyadic communication and conflict (variables at the interactional level) have to date mostly been neglected in induced abortion research. In **Chapters 3 and 4**, we will outline relational concepts,

frameworks, and models from which we will derive hypotheses on the actual role and influence of the male partner involved in the pregnancy, in the process of deciding to have an induced abortion. As such, we aim to provide critical and nuanced scientific evidence or counterevidence for the increased demand for involvement of the male partner in reproductive health issues, including induced abortion (e.g., Altshuler et al., 2016). As suggested by the anthropological study of Dudgeon and Inhorn (2004), we hereby take into account factors at the between-group-level such as the existing power and equality structures related to gender in Belgium.

1.2.4 Induced abortion at the intrapersonal level

The examination of induced abortion at the intrapersonal level is mostly in the field of cognitive-behavioral psychology and seeks to explain differences in how women go through the abortion procedure by looking at individual beliefs, coping abilities and mental health vulnerabilities. Differences in emotional wellbeing pre- or post-abortion are sought in general difficulties in coping with stress, or general risk factors for mental health problems. Others have reported on women being different in terms of the degree of ambivalence they feel towards the pregnancy, pre-or post-abortion.

1.2.4.1 Individual beliefs, coping, and general mental health

Various studies have shown that personal beliefs and characteristics might place certain women at higher risk for pre- and post-abortion emotional difficulties. To set an example, perceiving the fetus as human, is associated with poorer post-abortion mental wellbeing (Conklin & O'Connor, 1995). Believing that abortion is killing or that God will not forgive you, is related to a lower level of confidence in the decision to have an abortion (Foster et al., 2012b). Major and colleagues demonstrated the effect of women's general level of self-esteem and their general attachment style on the degree to which women perceive the induced abortion as either negative or positive (Major, Richards, Cooper, Cozzarelli, & Zubek, 1998). These appraisals in turn predicted coping behaviors such as social support-seeking, and as such affected women's emotional adjustment post-abortion (Cozzarelli, Sumer, & Major, 1998). Hence, these scholars assign a central role to women's individual cognitions (i.e., how they appraise the induced abortion) and their subsequent coping behavior in the process of deciding to have an abortion, even in the effect of factors at the interpersonal level such as the role of social support (Major et al., 1990).

Various authors have also demonstrated the impact of women's mental health prior to the abortion on the distress associated with the decision to have an abortion, both during and after the pregnancy termination. Women with prior mental-health problems *anticipate* doing worse in the post-abortion period (Foster, Gould, & Kimport, 2012a) but also *actually* do worse (Cameron & Glasier, 2013; Lauzon et al., 2000; Major et al., 2000).

1.2.4.2 Ambivalent cognitions and emotions about the pregnancy

In addition to general personal beliefs and characteristics, such as spiritual and religious views on induced abortion, general coping behavior, or pre-abortion mental health problems, scholars have also shed light on the role of women's specific cognitions and emotions associated with the unwanted pregnancy.

For the overall majority of abortion-seeking women (86%), the pregnancy for which they seek abortion, is clearly unintended and most of them are very convinced of having the abortion (Cameron & Glasier, 2013). For those who decide to terminate a pregnancy which was initially intended, as well as for those who are ambivalent or unconfident about the decision to terminate the pregnancy however, emotional wellbeing pre- and post-abortion might be impaired (Cameron & Glasier, 2013; Lauzon et al., 2000).

To date, ambivalence in abortion-seeking women has been defined in various ways, ranging from being ambivalent about the decision (e.g., Cameron & Glasier, 2013) to having ambivalent attitudes or cognitions about induced abortion in general (e.g., Aléx & Hammarström, 2004) to having ambivalent feelings regarding the current pregnancy (e.g., Kero & Lalos, 2000). These differences in how ambivalence is defined, have led to conflicting findings regarding the value versus the detrimental effect of ambivalence in women seeking an induced abortion (Kero & Lalos, 2000; Lauzon et al., 2000; Rowlands, 2008). Research on the determinants for this ambivalence is furthermore scarce and has mostly been a-theoretical (Foster et al., 2012b; Husfeldt et al., 1995).

1.2.4.3 The research gaps

Based on the aforementioned findings on women's generally high certainty regarding having the abortion, the lack of an increased risk of mental health problems following a single first trimester induced abortion compared to carrying an unwanted pregnancy to term, as well as the mostly transient nature of emotional distress associated with the induced abortion, scholars have advocated the sole provision of pre-abortion counseling or support to those women with an increased risk for emotional difficulties post-abortion (Baron, Cameron, & Johnstone, 2015; Foster et al., 2012b; Kumar et al., 2004; Rowlands, 2008). These authors discourage mandatory pre-abortion counseling. Research on how women themselves perceive this pre-abortion counseling, and how this counseling is related to their own cognitive and emotional state, is however almost non-existent (e.g., Baron et al., 2015). Hence, **in Chapter 6**, the role, value, and content of pre-abortion counseling as organized in Flanders (where it is mandatory but client-centered, and non-judgmental) is examined from the perspective of the abortion-seeking women themselves.

In addition to the aforementioned definitional issues, a theoretical analysis on the determinants and the value of ambivalent cognitions in the decision to have an abortion, is currently absent. Furthermore, the topic of ambivalence has to date mostly been investigated from the perception of the women, and much less from the perception of the male partners who were involved in the pregnancy (Kero & Lalos, 2000). As male partners influence women's perceptions on the intent and desire for a pregnancy (as reported by Kroelinger & Oths, 2000; Zabin et al. 2000), research on their own ambivalent cognitions regarding the decision about what to do with the unintended pregnancy, is highly valuable too. Hence, as outlined in **Chapter 5**, both women and male partners should report on their own dialectical moments in the decision to have the abortion, in order to come to a more thorough understanding of how abortion decision-making in couples actually occurs.

1.3 Research objectives

1.3.1 General research aims

In this doctoral thesis, we aim to add to the literature on induced abortion by filling some of the gaps in current research on the role of context, at each of the levels in the model of Hinde. These gaps are:

1) data on induced abortion decisions in Flanders (Belgium), especially in ethnic minority groups, and the complex role of social norms regarding the general timing and number of pregnancies interacting with sociodemographic situations in the prevalence of induced abortion (Flemish and sociocultural context; between-group level)
2) the role, influence, and decisional experiences of the male partners who were involved in the unintended pregnancy (interactional and relational context; interpersonal level)
3) the nature of cognitive dialectical reflection and the role of pre-abortion counseling in the decision to have an induced abortion (context of intrapersonal differences, and variation over time; intrapersonal level).

We thus focus on a deeper understanding of the complex and interacting contexts in which the decisional process occurs.

Despite each of the chapters mainly focusing on one of the levels in the model of Hinde, factors at the other levels are either taken into account or intertwined with the factors at the level under study. For instance in Chapter 3, the focus is on the interpersonal level as it concerns questions about power division between the two partners involved in the pregnancy, and the role of the relational context in this. However, as we also report on both partners' individual level of satisfaction with the division of roles, the intrapersonal level is involved as well. Similarly, in Chapter 4, the focus is on the level and process of interdependence between partners' experiences with the decision to have the

abortion (the interpersonal level). However, as we also examine the impact of individual difficulties in decision-making in general, the intrapersonal level is represented too. In Chapter 6, the focus is on the intrapersonal level as it examines women's individual perceptions and feelings regarding pre-abortion counseling. However, as the counseling exists in the very specific context of Flanders, where abortion care is highly affordable, accessible, and safe, the between-group level and the role of the physical environment is taken into account too. Also the interpersonal level is included because counseling evidently occurs between the woman and the health care provider who is responsible for the counseling session.

In Chapters 3, 4, and 5, clear hypotheses stemming from general psychological theories on decision-making, will be tested in the specific context of the decision to have an induced abortion. In Chapters 2 and 6, the focus is more on issues with a direct relevance for clinical practice and policy. The focus of each of the chapters is on decisional variables, rather than on emotional wellbeing variables. As such, we meet the demands for theoretical frameworks other than the existing stress and coping models. By focusing on the decisional process *between* the unintended pregnancy and the induced abortion, we follow the ideas of Buysse and colleagues on the value of *process* beyond *outcome* research (Buysse, De Mol, & Verhofstadt, 2008). Where emotional wellbeing or distress is used as a variable, it is because of its possible link with the decision-making *process* (Bradshaw & Slade, 2003).

1.3.2 General methodology and samples

As one of the gaps in induced abortion research concerns the role and experiences of the male partners who were involved in the pregnancy, four of the five chapters include data from these male partners (see overview of the studies in Table 1). All of the data stem from survey research. Although surveys have their limitations, they provide the best means to test hypotheses and to make valid statements about the role of specific contextual factors in abortion decision-making. The possibility to test (theoretical) hypotheses and to generalize findings to the population level, is absent in qualitative research such as in interview or focus group studies. Given that induced abortion is a highly researched topic in different disciplines, the current knowledge about it is already quite advanced. However, most of that research is either a-theoretic, or is based on more intrapersonal theories such as the stress and coping perspective. Hence, qualitative research is less appropriate here, and quantitative research that creates the opportunity to include specific decision-making variables, is highly valuable. As we wanted to capture women's and involved male partners' subjective experiences with the decision-making process, we did not use observational methods. For four of the five studies described in this doctoral thesis, participants were recruited in the five multidisciplinary abortion centers in Flanders (see overview of studies below). As reported by SENSOA, more than 80% of the elective induced abortions

in Flanders occur in an abortion center, which makes it the most viable setting for recruiting a representative study sample (SENSOA, 2011).

In all of the surveys in which data on women's and men's experiences with the decision to have an abortion were collected, we explicitly avoided stigmatizing questions or language. In the survey described in Chapter 2 for instance, we did not ask whether a woman or man had ever had an induced abortion (which would induce the idea that you belong to either the group that has ever experienced an abortion versus to the group that has never experienced this). In contrast, we examined for each pregnancy separately, what the outcome of this pregnancy was (either miscarriage, childbirth or abortion). Moreover, to almost all the questions we asked, we added the following sentence: "There are no right or wrong answers, please answer how you feel/think/experience it right now".

1.3.3 Chapter 2. The sociocultural and sociodemographic context of induced abortion in Flanders

In Chapter 2, we examine the prevalence of unintended pregnancy, and the prevalence of induced abortion in the *event* of an unintended pregnancy, in a large population based sample of people living in Flanders. In addition, we investigate whether, and how Turkish minority groups living in Flanders (the largest group of ethnic minorities in this region) might be vulnerable to unmet birth control goals (either a higher rate of *unplanned* pregnancy or a lower rate of induced abortion in the event of an *unwanted* pregnancy). We especially focus on the socio-economic vulnerabilities of this group and the specific social norms regarding timing and number of pregnancies in Turkish culture. The analysis is situated at the between-group level of Hinde's model as it combines factors at the social group level with factors at the society level, intertwined with social norms, values and beliefs on pregnancy, and childbirth. The study uses the data from two large scale population-based studies on sexual health in Flanders (the SEXPERT-study; Buysse et al., 2013). The data were gathered via home-based face-to-face interviews. Both the general population sample and the Turkish minority sample contained people with at least one pregnancy experience. Pregnancies along the life course of individual men and women, were the unit of analysis.

Table 1. Overview of the different chapters and the studies used in these chapters					
	Chapter 2	**Chapter 3**	**Chapter 4**	**Chapter 5**	**Chapter 6**
Study	Sexpert	Longitudinal (diary) study	Longitudinal (diary) study	Longitudinal (diary) study	Counseling study
Design	Cross-sectional Population based survey	Cross-sectional Pre-abortion survey 2 (online)	Cross-sectional Pre-abortion survey 1	Longitudinal Pre- and post-abortion survey (online)	Longitudinal Pre- and post counseling survey
Sample(s)[4]	General population sample (*N* = 706) Turkish minority sample (*N* = 162)	Sample of abortion-seeking women (*N* = 176) and involved male partners (*N* = 52)	Couple sample of abortion-seeking women and involved male partners (*N* = 106)	Sample of abortion-seeking women (*N* = 183 pre; 100 post) and involved male partners (*N* = 52 pre; 25 post)	Sample of abortion-seeking women (*N* = 971)
Response rate (RR) and dropout rate (DR)	RR: 39% and 57% of eligible respondents respectively	RR: 40.4% and 42.3% of the respondents who participated in pre-abortion survey 1 (DR: 59.6% and 57.7%)	RR: 38.2% of eligible female respondents and 35.7% of eligible male respondents	RR: 54% and 48% of the respondents who participated in pre-abortion survey 2 (DR: 46% and 52%)	RR: 47% of eligible respondents
Selection of sample	14 to 60-year olds with at least one pregnancy experience (except those who still attend school)		Women and male partners where the partner participated as well		
Data	Multilevel data (pregnancies within individuals)	Quantitative data at the individual level	Quantitative data at the couple level	Qualitative and quantitative data at the individual level	Quantitative data at the individual level
Inclusion of men	Yes (individual men)	Yes (male partners)	Yes (male partners)	Yes (male partners)	No

[4] Where possible, we made comparisons with reference or control groups. We used (1) an own recruited control group of pregnant couples who intend to carry their pregnancy to term, (2) a reference group of Flemish men and women in established romantic relationships, and (3) a reference group of non-distressed women.

1.3.4 Chapter 3. Partners' different ways of sharing the decision to have an abortion

The analysis outlined in Chapter 3 is situated at the relational-interactional level, and aims at depicting the different relational contexts in which induced abortions occur, and demonstrating the male partners' actual shares in women's decision to have an induced abortion. We examine the relational determinants for his role in the decision and investigate the degree to which both partners are satisfied with the division of roles. We do this by making use of existing models on shared (reproductive) decision-making in couples and families (Godwin & Scanzoni, 1989; Zeiler, 2007). These models explicitly make a distinction between the dyadic process versus the dyadic outcome of a decision, meaning that one can be engaged in the decision process (for instance the male partner being able to state his own thoughts about the pregnancy) without really acting on that decision (for instance the woman who decides for abortion while the male partner wanted to continue the pregnancy). These models link the degree to which one of the partner possesses or ascertains power in the decision, to the relational context of the couple (e.g., Simpson, Farrell, Oriña, & Rothman, 2015) as such adopting a core relational perspective to the decision to have an abortion. The study uses the data of a longitudinal study on women's and involved male partners' experiences with the decision to have an induced abortion (see overview of the study in Figure 3). Participants were recruited in the five Flemish abortion centers during a nine months period[5]. The study consisted of four fixed data points (prior to the pre-abortion counseling session, the day after the counseling session, the evening following the induced abortion, and two weeks post-abortion) and an additional diary component (which is out of the scope of this doctoral thesis). This study is based on the second part of the study, where both partners separately filled out an online questionnaire about their relational experiences with the decision to have an abortion. Partners' reports on shared decision-making were analyzed separately to enable an analysis on the complete sample of participating women, including those where the male partner did not participate in the study.

1.3.5 Chapter 4. The decision to have an abortion from both partners' perspectives

In Chapter 4, we aim to examine how women's and male partners' decisional experiences in terms of how autonomous and how uncertain they feel about the decision to have an abortion, are associated with each other. We do this by using the Relational Interdependence Theory (Rusbult & Van Lange, 2003), which predicts that abortion-seeking women's decisional outcomes do not only depend on their own motives (which is predicted by Self-Determination Theory (Deci & Ryan, 2008)), or their own abilities for decision-making (see also chapter 5), but are also associated with the male partners'

[5] Women were requested to invite the male partners who were absent during the first visit to the abortion center but who were yet aware of the planned abortion, to participate in the study as well.

motives for having the abortion. As such, in this chapter, the interpersonal, above and beyond the intrapersonal nature of decision uncertainty is examined. We explicitly explore how the level of interdependence between the experiences of the abortion-seeking women and those of the involved male partners depends on the actual living situation of the couple. The chapter is as such also situated at the interactional-relational level in the model of Hinde but has, in contrast to Chapter 3, a within-couple focus (i.e., the association between the experiences of the abortion-seeking women and the involved male partners).

In this chapter, we use the data of the first part of the longitudinal study outlined in Figure 3. In this first data wave, both partners simultaneously filled out a paper-and pencil questionnaire about their individual experiences with the decision to have the abortion in the waiting room of the abortion center (except the male partners who were absent during the first visit, who filled it out online). While Chapter 3 describes an analysis on the female and male data separately, this study uses a couple sample. Hence, in this chapter, we only use the data of the women for whom the male partner participated in the study as well. In the couple sample, partner effects, above and beyond actor effects of feelings of autonomy are investigated. We therefore make use of the Actor Partner Interdependence Model (Cook & Kenny, 2005).

1.3.6 Chapter 5. The presence of dialectical thoughts in the decision to have an abortion

In this chapter, we describe the nature of cognitive dialectical thoughts in the decision to have an abortion, in a sample of abortion-seeking women, as well as in a sample of involved male partners. These dialectical thoughts refer to moments where thoughts about carrying the pregnancy to term came to the participants' minds. Based on the intrapersonal Cognitive Closure Theory (Kruglanski & Webster, 1996), we hypothesize that the report of these moments is not maladaptive per se, but is rooted in people's general abilities or difficulties for closing the mind to ambiguous or ambivalent information. With this study, we aim to deepen and nuance the knowledge on the topic of ambivalence in the research on induced abortion. A *process*-oriented, instead of an *outcome*-oriented approach of ambivalence is used here.

In this study, we make use of the pre-post-abortion data in the longitudinal survey study outlined above (see Figure 3 below). The data of both partners were analyzed separately. The analysis includes qualitative data (the content of the dialectical thoughts) as well as quantitative data (the association with degree of emotional distress).

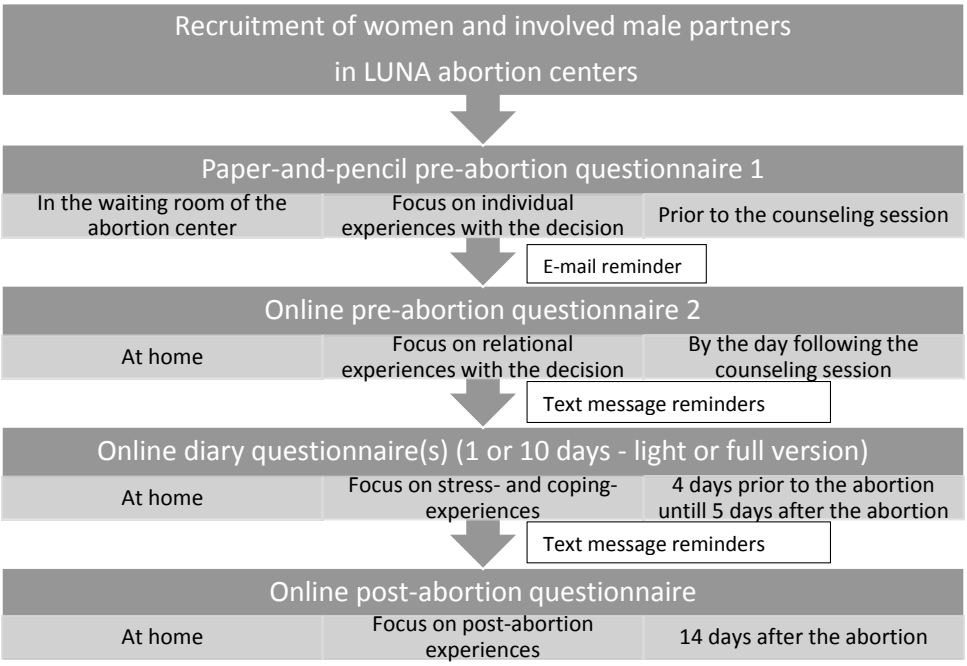

Figure 3. Overview of the longitudinal (diary) study used in Chapter 3, 4, and 5[6].

1.3.7 Chapter 6. The value of pre-abortion counseling

In the last chapter, we aim to explore women's own perceptions of the mandatory pre-abortion counseling session in the Flemish abortion centers, both prior to the session and after the session. We explore the degree to which they assign value to this counseling session, and investigate the content of the session. We examine how the content is adapted to the socio-demographic characteristics and the individual needs of the abortion-seeking women, and investigate whether decision certainty and emotional wellbeing increase following the counseling session. As such, we aim to add the literature on the value of pre-abortion counseling for women seeking an induced abortion in Flanders. In this study, we used survey data of women who entered one of the five Flemish abortion centers. Both prior to, and after the counseling session, a paper-and pencil questionnaire was filled out.

[6] Within the context of this doctoral thesis, we only used the pre-and post-abortion data on the decisional variables. The diary data, with a focus on stress- and coping-experiences, are out of scope of this doctoral thesis.

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2 The sociocultural and sociodemographic context of induced abortion in Flanders

Based on Vandamme, J., Buysse, A., Loeys. A., Elaut, E., Dewaele, A., & T'Sjoen. G. Unintended pregnancy and induced abortion in Flanders, Belgium: Does ethnicity matter?

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ABSTRACT

Objective. Representative data on the prevalence of unintended pregnancies and induced abortions in Flanders are currently lacking. This study examines whether, and how Turkish minority groups living in Flanders, Belgium, might be vulnerable in terms of unmet family planning goals, and as a consequence, impaired mental health.

Methods. Through home-surveys, a large population based sample of men and women living in Flanders and a representative subsample of people of Turkish ethnic descent, aged between 14 and 60 years, reported on all pregnancies they ever had experienced (*N* = 1687 and 453 pregnancies respectively). A Multilevel Analysis was used to assess the role of within-subject predictors of unintended pregnancy and induced abortion (age, marital status, and number of biological children at the timing of pregnancy), and between-group predictors, being ethnic descent and socio-economic status.

Results. After accounting for differences in educational level and general timing and number of pregnancies, the prevalence of unplanned pregnancy was equal in both samples (22.1% and 29.6% respectively). Unwanted pregnancy rates were also equal, while induced abortion rates in the event of an unwanted pregnancy were higher in the general population (28.7% vs. 6.4%). In both groups, lower educational level was associated with higher rates of unplanned pregnancy, and the probability of a pregnancy being unintended and terminated differed along age, number of previous childbirths, and marital status.

Conclusion. Low educational level seems to be a risk factor for unplanned pregnancy while ethnic descent itself is not. Unintended pregnancies and induced abortions occur during the same phases of life in Turkish Belgians as in native Flemish people. Abortion stigma might be higher in the Turkish minority sample.

INTRODUCTION

Worldwide, effective family planning is an important feature of a woman's reproductive health. Women all over the world use contraceptives to prevent unintended pregnancies and in cases of an unintended pregnancy, induced abortion is an option for many of them (Sedgh, Singh, Henshaw, & Bankole, 2012). A huge number of international studies have mapped the groups of women who are vulnerable to unmet family planning needs, by either solely reporting disparities in unplanned pregnancy rates (reflecting pregnancy intent) or induced abortion rates (reflecting pregnancy outcome) or by reporting differences in the prevalence of unintended birth, which is a combination of both. Since unintended, especially unwanted pregnancies carried to term are risk factors for both parents' as well as the future children's mental (and physical) health, research on pregnancy intent and induced abortion in a country or region is highly valuable (David, 2006; Leathers & Kelley, 2000).

From these studies, ethnic minority groups have frequently been cited as vulnerable for unmet family planning needs, although this has partially been explained by their often deprived socio-economic circumstances (Eskild, Nesheim, Busund, Vatten, & Vangen, 2007; Finer & Henshaw 2006; Rasch et al., 2007). In Flanders (the northern, Dutch-speaking part of Belgium, which has about six million inhabitants), the largest groups of non-European immigrants come from Turkey and Maghreb countries such as Algeria, Morocco, and Tunisia (Pelfrene & Van Peer, 2014). More particularly, where policy, media, and public opinion are concerned, these are the most debated and visible of all ethnic minority groups in Flanders (Levecque, Lodewyckx, & Vandeneede, 2006). Although studies show that these groups might be vulnerable in terms of sexual and reproductive health (Hendrickx, Lodewijckx, Van Royen, & Denekens, 2002; Levecque et al., 2006), little is known about how the prevalence of unintended pregnancies and induced abortions in Flanders might be influenced by ethnicity on the one hand, or the socio-economic and socio-demographic context in which pregnancy decisions take place on the other. This study tries to clarify these relationships based on unique representative data from a group of Turkish and native Flemish participants.

Ethnic Minorities and Health Outcomes

Immigrants and ethnic minorities suffer from poorer mental and physical health (e.g., Levecque et al., 2006; Levecque, Lodewyckx, & Vranken, 2007; Missinne & Bracke, 2012). Across Europe, socio-economic conditions and experiences of ethnic discrimination are important risk factors that explain depressive symptoms when natives are compared with ethnic minorities (Missinne & Bracke, 2012). A review of several studies by Levecque and colleagues (2006) shows that Turkish immigrants in Flanders indeed have poorer mental and physical health or follow less healthy life styles than natives. Regarding

reproductive health, however, little is known about whether ethnic minorities in Belgium are at higher risk, and, if so, why this is the case.

Flemish reports on induced abortion have highlighted the overrepresentation of African immigrants in the abortion-seeking seeking population (Neefs & Vissers, 2005). However, a clear understanding of this overrepresentation is currently lacking. Some studies have shown that Moroccan and Turkish ethnic minorities report the lowest use of contraceptives in comparison with natives and other ethnic minorities in Flanders (Levecque et al., 2006). For Moroccan married women, unintended pregnancies might be associated with a lack of knowledge of their own body functioning, as well as low knowledge of the use of contraceptives (Hendrickx et al., 2002). In contrast, Elaut and colleagues (2015) showed that rates of effective contraceptive use in the Turkish minority group were comparable to those in the general Flemish population. Knowledge on emergency contraception was however found to be lower in this group. Lack of knowledge about contraceptives, sexually transmitted diseases (STDs), and human immunodeficiency virus (HIV), as well as cultural beliefs and social norms (e.g., a "double morality" about premarital intercourse: women are expected to remain virgins until marriage, whereas men are not; the social norm of marriage as the onset of childbearing; or childbearing as a woman's natural duty) might complicate decisions about pregnancy and childbirth in Turkish and Moroccan people (Boyacioğlu & Türkmen, 2008; Hendrickx et al., 2002; Schoenmaeckers, Lodewijckx, & Godeyne, 1999). These results indicate the need to disentangle the possible underlying issues that mean that ethnic minorities might be at higher risk for unmet family planning needs.

The Context of Pregnancy Decisions

Induced abortion can be seen as the ultimate end-point of a pregnancy decision chain, preceded by experiencing the pregnancy as unintended, which in itself is preceded by having (unprotected) sex which resulted in a pregnancy (Rossier, Michelot, Bajos, & the COCON group, 2007). Examining the prevalence of induced abortion as such requires a simultaneous analysis of the prevalence of unintended pregnancies as well as an investigation of decision-making contexts regarding pregnancy in general.

Previous studies on patterns of postponing and stopping behavior (either postponing first childbirths or preventing future births) have demonstrated that life course and conditions within specific life phases, influence the decisions made about pregnancy and childbirth (Bankole, Singh, & Haas, 1998). Pregnancies are more frequently unintended and terminated when parents' psycho-social circumstances are not yet or are no longer sufficient for giving birth. This mostly happens when relationships are less stable, when the family size is no longer manageable, or when people are very young or relatively old (Bankole, Singh, & Haas, 1999). Also, every decision to opt for an abortion is a unique one, determined by factors that are present at that specific moment in the couples' lives

(Rowlands, 2007; Weitz & Kimport, 2011). Context variables that have consistently been indicated as important for pregnancy decisions are age, relationship status, family size, and socio-economic conditions. All of these variables might have opposite and synergistic effects on the unintended pregnancy risk in comparison with decisions about that unintended pregnancy (Bajos et al., 2014). For instance, although 40-year old women are less fertile and as such less vulnerable to unplanned pregnancies, the proportion of this group terminating an unplanned pregnancy is high (Bankole et al., 1999). Another example shows that although people with low educational levels are at increased risk of ineffective contraceptive use, and as such are more vulnerable for unplanned pregnancies, carrying that pregnancy to term is more likely for them than induced abortion (Rossier et al., 2007). Because of the complex interplay between ethnic descent, socio-demographic circumstances, unintended pregnancy, and induced abortion, dotted by cultural beliefs and social norms on childbirth and fertility, the isolated relationship between ethnic descent and induced abortion rates might not reveal the full picture (Eskild et al., 2007). Therefore, when disparities in unintended pregnancy or induced abortions rates related to ethnic descent are examined, attention should also be paid to differences in socio-demographic and socio-economic contexts in which pregnancies occur, such as the vulnerable position of Turkish immigrants in the educational or labor system, an issue that is often put down to language barriers (Hartmann, 2016; Wets, 2006).

On the other hand, differences in reproductive decision-making processes might also relate to ethnicity. Research, for example, shows that Turkish women tend to conceive their first child soon after their first marriage, which is related to lower use of contraceptives at younger ages compared to native peers in Belgium or the Netherlands (Lodewijckx, 1997; Loeber, 2008). This earlier start in childbearing is reflected in a higher rate of teenage pregnancies (Jacquemyn et al., 2012). This is probably due to the more traditional views on fertility and marriage in Turkish couples: Turkish women want to prove their fertility soon after marriage and are consequently more dedicated to motherhood and childbearing at young ages compared to native Flemish women (Schoenmaeckers et al., 1999). Turkish people also tend to stop having children earlier, which is reflected in a low number of deliveries after age forty. The above-mentioned differences in reproductive decisions are also reflected in the profiles of women seeking abortions: Turkish women are mainly older, live with larger families, and are more likely to be married than abortion-seeking women of Flemish descent (Neefs & Vissers, 2005). The abovementioned differences reveal the necessity of looking at pre-existing differences in socio-demographic profiles of pregnant women (such as general timing of pregnancies or overall number of lifetime pregnancies) when comparing unintended pregnancy and induced abortion rates between innate women and women from a Turkish minority group.

We conclude that there is no straightforward evidence for poorer reproductive health in Turkish immigrants living in Flanders, although we predict that lack of knowledge about reproductive health as well as cultural beliefs and social norms might underpin and exacerbate vulnerabilities related to reproductive health which might in turn affect their mental and physical health. Also, the existing data often lacks quality and is mostly based on non-representative samples. In this study, we examine how both ethnicity and context-related variables, influence the prevalence of unintended pregnancy and induced abortion in Flanders. We rely on unique and representative data from a group of Turkish and native Flemish participants.

Hypotheses

In this study, we test the hypothesis that after having taken into account existing differences in general timing, and overall number of pregnancies between Turkish and Flemish participants—which we expect to differ because of differing social norms on fertility and childbearing—the unintended pregnancy odds and induced abortion odds in case of an unintended pregnancy will be equal, and socio-economic and socio-demographic circumstances within both groups will have larger effects on rates of unintended pregnancy and induced abortion than ethnicity itself. This was achieved by making use of two large-scale population-based surveys.

We first examined the overall prevalence of unplanned pregnancies, unwanted pregnancies, and induced abortions in both samples and investigated significant differences between the Turkish minority and general population sample.

Secondly, we examined whether pregnancies take place at different times and in different situations within the life course of Turkish versus native Flemish participants (Lodewijckx, 1997; Loeber, 2008). In particular, we hypothesized that pregnancies in Turkish people mainly take place at younger ages, and mostly during the relationship phase of first marriage or cohabitation. In addition, we assumed that the total number of pregnancies would be higher in Turkish participants. We also examined whether the Turkish participants in our study are indeed socio-economically vulnerable in terms of education and income (Wets, 2006).

Subsequently, we examined how the prevalence of unintended pregnancy and induced abortion varies along the life stages of both Turkish and native Flemish participants. We hypothesized that in both groups, pregnancies would be more likely to be unplanned, unwanted, and terminated when they occur at “unaffordable” time periods (in relatively young and old ages, during non-cohabitation or outside of marriage, and in already large families; Bankole et al., 1999).

Next, based on previous research on the effect of vulnerable socio-economic positions, we tested the hypothesis that in both groups, lower educational levels increase the unintended pregnancy

odds (e.g., Wellings et al., 2013) and decrease the likelihood of seeking an induced abortion in case of an unintended pregnancy (e.g., Rossier et al., 2007).

Finally, we tested the main hypothesis that after having taken into account group and situational effects (socio-economic circumstances and socio-demographic contexts of pregnancies) on pregnancy intent and pregnancy outcome, the overall prevalence of unintended pregnancy and induced abortion between the two groups would be equal.

METHOD

Sample and Design

This study draws on data from two surveys: ”Sexual Health in Flanders” (SEXPERT I study) and ”Sexual Health of Ethnic Minorities in Flanders” (SEM study). Both were large-scale representative surveys on sexuality, sexual health, and relations in Flanders (the northern, Dutch speaking part of Belgium) (Buysse et al., 2013).

Respondents for the SEXPERT I-study (general population sample) were people of between 14 and 80 years of age who were randomly drawn from the Belgian National Register. It used a stratified sample, meaning that one-third of the sample consisted of young people (aged 14 to 25), one-third of respondents were from the middle age group (aged 26 to 49), and one-third represented the oldest group (50 to 80 years old). Data were collected between February 2011 and February 2012. The general population sample consisted of 909 men and 916 women and the response rate was 39% of the eligible respondents. For current analyses, only the 14 to 60 year olds (*N* = 838 women and 746 men) were selected, in order to enable comparisons with data in the SEM study.

Data for the SEM-study were gathered in a population-based probability sample drawn from the two largest, non-Western, ethnic minorities in Flanders: people of Turkish or Moroccan descent. Therefore, Primary Sampling Units (PSUs), i.e., the Flemish municipalities were selected. By ordering and systematic sampling, we ensured that the chance of a municipality being selected was proportional to the number of inhabitants meeting the criteria for eligibility (Belgian nationality with at least one parent born with the Turkish or Moroccan nationality). Between December 2011 and February 2013, respondents between 14 and 60 years old were recruited. Since a very low response rate (26%) was obtained in the subsample of Moroccan descent, we only proceeded with the subsample of 14 to 60 year old respondents from Turkish descent (*N* = 280 women and 152 men, response rate: 57% of eligible respondents) for further analyses.

The data were gathered via face-to-face interviews, but all sensitive information, i.e., a wide range of sexual health characteristics, was gathered in a CASI (computer-assisted self-interviewing)

set-up, so that respondents never had to share private information about their sexual health with the interviewer. In the module "reproductive health", women as well as men were questioned about their experiences with pregnancy and childbirth. As previous studies have mostly relied on only women's reports of pregnancy intent and outcome, we also included male responses on this topic, although no explicit attention is paid to gender in this paper. Female virgins aged less than 26 years old were excluded for this module because of the irrelevance of pregnancy and childbirth decisions for them.

In the general population sample, we selected men and women with at least one pregnancy experience and who were no longer attending school (to allow approximation of the effect of educational level). This group is the final population-based study sample. It consisted of 416 women and 290 men[1] (*N* = 706; 44.6% of the original sample). Mean age was 43.7 years (*SD* = 9.9).

In the Turkish minority sample, we also selected respondents with at least one pregnancy experience who were no longer attending school. This was the final Turkish minority study sample. It consisted of 121 women and 41 men *(N* = 162; 37.5% of the original sample). Mean age was 38.6 years (*SD* = 7.9).

Measures

Second level socio-economic predictors: Income, and educational level.

In both groups, respondents were asked to report their highest level of educational attainment, split up into four categories, ranging from *no formal education or primary school level* to *tertiary educational level* (Bachelor/Masters diploma).

Subjective income level was questioned with a 7-point Likert scale ranging from 1 (*very difficult to live comfortably*) to 7 (*very easy to live comfortably*). For the current analyses, income level was recoded into three categories (*difficult*, *not particularly difficult*, and *easy to live comfortably*).

Number of pregnancies.

In both samples, women were asked how many times they had ever been pregnant. Men were asked how many times they had got a woman pregnant. They were able to indicate: *I do not know the exact number of pregnancies*.

Outcomes: Pregnancy planning, desire, and outcome.

For each pregnancy experienced by a respondent–from the first up to the tenth–respondents were asked about whether or not the pregnancy was planned (with options being *planned* or

[1] Due to a technical artefact in the filtering system of our questionnaire, men who did not have a romantic partner at the moment of the survey were excluded from the reproductive health module.

unplanned), and the perceived desire for that pregnancy (with possible answers *wanted*, *initially unwanted, but later wanted*, and *unwanted*; the latter two were combined under the label "unwanted at the time of the pregnancy"; Fischer, Stanford, Jameson, & DeWitt, 1999). Outcome of the pregnancy could be reported as *carried to term*, *miscarriage*, *medically induced termination* or *induced abortion*. For the current analyses, these outcomes were recoded into "induced abortion" or "other" to focus on the outcome of first trimester unintended pregnancies decided on by the respondent.

First level socio-demographic predictors: Age, marital status, and parity (number of biological children) at the time of pregnancy.

Age, marital status, and parity (number of biological children) at the moment of the pregnancy were calculated by making use of respondent's year of birth, and reported years of (first, second,…) marriage, cohabitation, divorce or being a widow (in the module "background information"), year in which the respondent learned about the pregnancy, and number of previous pregnancies that had been carried to term (in the module "reproductive health").

Marital status at the time of pregnancy was split up into four categories: *before first cohabitation or marriag*e; *during first marriage or cohabitation*; *during later (second, third…) marriage or cohabitation*; or *during a phase of non-cohabitation or marriage (being single, divorced, widowed)*. For 16% of the pregnancies, status at that time could not be calculated because of missing data.

Statistical Analysis

In the population based study sample (*N* = 721), 1687 pregnancies were reported with a mean of 2.4 (*SD* = 1.3) pregnancies per respondent. In the Turkish sample (*N* = 169), 453 pregnancies were reported with a mean of 2.8 (*SD* = 1.4) pregnancies per respondent. Year in which the pregnancy occurred, ranged from 1966 to 2012[2]. Since pregnancies are nested within individual respondents, the analytical model contained two levels: the pregnancy level (level 1) and the level of the individual respondent (level 2). The outcome variables unplanned, unwanted pregnancy, and induced abortion were situated at the pregnancy level as well as the predicting variables age, number of biological children, and marital status. Educational level, income, and ethnic descent were situated at the level of the individual respondent.

[2] For an overview of how the decade in which the pregnancy occurred, affected the unplanned, and unwanted pregnancy ratio on the one hand (the former was significantly lower before 1970, but kept stable after that period), and the induced abortion ratio on the other (the latter was significantly lower before 1970, but did not increase after the legalization of induced abortion in 1990), we refer to Vandamme, Buysse, and T'Sjoen (2013).

First, we examined whether there were differences in mean unplanned pregnancy, unwanted pregnancy, and induced abortion rates between both groups. We did this by testing a multilevel logistic regression model without the first level predictors (age, parity and marital status) and without income or educational level (see below). Next, we assessed whether mean age, total number of biological children, and marital status at the time of pregnancy (averaged over pregnancies within the same respondent) differed between the Turkish and general population-based sample. We also examined differences in income and educational level between the two samples by making use of a chi²-analysis.

Subsequently, we assessed the within and between-subject effects of age, number of biological children, and marital status on (1) pregnancy planning, (2) desire for pregnancies, and (3) pregnancy outcome in three subsequent logistic regressions. We fitted a model with these first level predictors and a random intercept for each subject to capture the correlation within subjects. Within-subject effects of these first level predictors were assessed by using subject-mean centred values. We examined both linear and quadratic effects of age and number of biological children at the time of pregnancy. We simultaneously assessed the second level effects of educational level and ethnic descent on pregnancy intent and outcome, whilst controlling for current age and gender. To assess whether the socio-demographic (first level) and socio-economic (second level) effects differed between the Turkish group and the general population group, cross-level and within-level interactions were tested.

Results are presented as exponentiated coefficients from the two-level logistic regression models (odds ratio [*OR*] and 95% confidence intervals [*CI*]). Two-tailed alphas of $p < .05$ were considered significant. SAS version 9_4 was used to perform the two-level logistic regression analyses (GLIMMIX procedure).

RESULTS

Pregnancy Planning, Desire, and Outcome

The mean unplanned pregnancy probability was 22.1% in the general population sample and 29.6% in the Turkish minority sample (see Table 1). The prevalence was significantly higher in the Turkish minority sample ($p < .05$). The proportions of pregnancies indicated as unwanted were 13.9% against 20.8%. After controlling for unplanned pregnancy, this difference was not significant ($p = .21$) since in both samples, almost all initially unwanted pregnancies were also unplanned pregnancies

(91.9% and 93.6% of the unwanted pregnancies, respectively[3]). Furthermore, unplanned pregnancies were initially unwanted in more than half of the cases in both samples (58.3% and 65.7% of the unplanned pregnancies, respectively).

Induced abortion prevalence was 4.2% in the general population sample while only 1.3% of the pregnancies lead to an induced abortion in the Turkish minority sample. The induced abortion prevalence in the general population sample was significantly higher than in the Turkish minority sample after controlling for unplanned and unwanted pregnancy ($p < .001$). Induced abortion was the outcome of 28.7% and 6.4% of the unwanted pregnancies, respectively, and 18.7% and 4.5% of the unplanned pregnancies, respectively.

Socio-demographic Circumstances at the Time of Pregnancy and Overall Socio-Economic Position

As depicted in Table 1, although the majority of the pregnancies in both samples occurred during the participants' first marriage or cohabitation, a significant higher prevalence of pregnancies after legal commitment to a first partner was seen in Turkish respondents (89.3% vs. 74.9%; $p < .001$). Pregnancies in the Turkish minority sample were less likely to occur during phases of non-cohabitation or marriage (1.5% vs. 8.5% of the pregnancies; $p < .01$) and less in a time period before first legal cohabitation or marriage (4.4% vs. 9.9%; $p < .05$). Over half of the respondents in both samples were between 18 and 29 years of age at the time of their pregnancy (77.2% and 61.2% of the pregnancies, respectively, occurred within this time frame), but again there was as difference in age constellation between the two samples. Turkish respondents tended to be younger at the time of pregnancy than respondents from the general population sample (22.5 vs. 25.3 years; $p < .001$). Regarding the total number of pregnancies and childbirths, the two samples differed from each other as well: A higher 2.8 pregnancies per respondent was recorded from the Turkish group versus 2.4 pregnancies per respondent in the general population group ($p < .01$). The percentage of respondents who were nulliparous (no previous childbirths) at the time of pregnancy was significantly higher in the general population ($p < .001$), while the percentage of multiparous respondents was significantly lower in this group ($p < .001$).

[3] A small percentage of the planned pregnancies are yet unwanted. These are the initially planned pregnancies that became unwanted later on, due to for instance a rapidly discovered medical problem (e.g., contamination with the cytomegalovirus or toxoplasmosis) or due to personal or interpersonal factors which negatively affect the desire for the pregnancy (e.g., the pregnant woman who discovers the extramarital relationship of her partner).

Finally, a significant difference in educational attainment was also seen between the two samples ($\chi^2(3) = 127.6$, $p < .001$). While 43.2% of the respondents in the general population sample had a Bachelor or Master degree and only a small number of them had no education or had only finished primary school (11.0%), only a small percentage of the Turkish respondents had a Bachelor or Master degree (9.1%) in contrast to 33.8% of them having little or no formal education. A significant difference in subjective income level was also noted ($\chi^2(2) = 91.1$, $p < .001$) with 45.6% of the respondents in the general population sample reporting it being easy to live comfortably on their income in contrast to 16.7% amongst the Turkish respondents. Since degree of educational attainment and subjective income level showed a significant congruence ($\chi^2(6) = 101.3$, $p < .001$), and income levels are less stable than educational levels, we proceeded with educational level as the main indicator of socio-economic position of respondents in the two groups.

Predicting Pregnancy Planning, Desire and Outcome with First and Second Level Predictors

Results of the three Multilevel Logistic Regression analyses are presented in Table 2. Age at the time of pregnancy has a quadratic effect on the unplanned pregnancy odds ($F(1,987) = 14.20$, $p < .05$): being younger or older at the time of a specific pregnancy increases the probability of the pregnancy being unplanned as compared to that probability at the subject-specific average age over all his/her pregnancies. The left-hand panel of Figure 1 illustrates this U-shaped relationship for a woman with no education from the Turkish sample. For a woman with, for instance, five pregnancies and an average age at the time of pregnancy of 30, the probability of an unplanned pregnancy was higher both when she was 40 or when she was 20 as compared to when she was 30. Similarly, we find a quadratic effect of parity on the odds of a pregnancy being unplanned ($F(1,987) = 7.55$, $p < .05$). This is illustrated in the right-hand panel of Figure 1. Interestingly, the probability of unplanned pregnancy is especially high when the parity is high for a specific subject (i.e., when the number of previous childbirths is high for that person). It is also worth noting that although age at pregnancy and parity at pregnancy are highly correlated ($r = .80$), we still find an effect of parity over and beyond age. Marital status at the time of pregnancy is also associated with unplanned pregnancy: Pregnancies which occurred during first marriages or cohabitations, during later marriages or cohabitations, or during phases of non-marriage or cohabitation, had a smaller chance of being unplanned than those occurring before the first marriage or cohabitation to a partner.

In the prediction of unwanted pregnancy, controlling for pregnancy intent, we again found evidence for a U-shaped relationship with age ($F(1,982) = 6.39$, $p < .05$), but only a linear relationship with parity ($F(1,982) = 9.35$, $p < .05$) – indicating a higher probability of unwanted pregnancy with increasing parity. No association was found with marital status.

Finally, in the prediction of induced abortion, controlling for pregnancy intent and unwanted pregnancy, we found evidence for a U-shaped relationship with age ($F(1,980) = 6.51$, $p < .05$), and with parity ($F(1,980) = 6.09$, $p < .05$). Marital status at the time of pregnancy was also associated with abortion. Pregnancies which occurred after a first legal commitment to a partner, during later legal commitments, or during non-legal commitment phases, had a smaller chance of resulting in abortion than those occurring before the first legal commitment to a partner.

We examined whether the effects of circumstance reported above were different between the general population and Turkish minority samples, but found no evidence for any significant interaction, indicating similar situational effects on pregnancy intent and outcome in both groups.

Controlling for the aforementioned first level predictors, we went on to observe a significant association between education level and unplanned pregnancy ($p < .001$). On the contrary, the association between education level and unwanted pregnancy was not significant after controlling for the pregnancy having been unplanned ($p = .07$). We also found no association between education level and induced abortion after controlling for unplanned and unwanted pregnancy ($p = .06$). None of these associations were significantly different between the general population and the Turkish minority samples.

Finally, the odds of having an unplanned and unwanted pregnancy were not significantly different between the general population and the Turkish minority sample, controlling for the effects of educational level, age, parity, and marital status ($p = .25$ and $p = .44$). The odds of experiencing an induced abortion (after controlling for unplanned and unwanted pregnancy) were, however, significantly higher in the general population sample ($p = .01$).

Table 1

Descriptive Statistics Detailing Pregnancy Intent, Outcome, and Socio-Demographic Circumstances of Pregnancies in the General Population and the Turkish Minority Sample (n(%))

	General population sample (*n* = 1687)							Turkish minority sample (*n* = 453)						
Pregnancy	**Total**	First	Second	Third	Fourth	Fifth	Sixth	**Total**	First	Second	Third	Fourth	Fifth	Sixth
Outcome														
Pregnancy planning														
Unplanned	373	146	82	73	39	17	13	134	40	30	28	18	12	4
	(22.1)	(20.7)	(15.6)	(28.3)	(32.0)	(38.6)	(68.4)	**(29.6)**	(27.7)	(22.1)	(32.6)	(47.4)	(63.2)	(44.4)
Planned	1311	560	445	185	83	27	6	319	122	106	58	20	5	7
	(77.9)	(79.3)	(84.4)	(71.7)	(68.0)	(61.4)	(31.6)	(70.4)	(75.3)	(77.9)	(67.4)	(52.6)	(36.8)	(55.6)
Total	1684	706	527	258	122	44	19	453	162	136	86	38	19	9
Pregnancy desire														
Initially unwanted	234	92	45	46	28	13	10	94	24	21	20	12	11	4
	(13.9)	(13.1)	(8.5)	(17.9)	(23.1)	(28.9)	(52.6)	**(20.8)**	(14.8)	(15.6)	(23.3)	(31.6)	(61.1)	(44.4)
Initally wanted	1447	612	482	211	93	32	9	357	138	114	66	26	7	5
	(86.1)	(86.9)	(91.5)	(82.1)	(76.9)	(71.1)	(47.4)	(79.2)	(85.2)	(84.4)	(67.7)	(68.4)	(38.9)	(55.6)
Total	1681	704	527	257	121	45	19	451	162	135	86	38	18	9
Pregnancy outcome														
Induced abortion	71	34	9	13	9	2	4	6	1	2	1	0	2	0
	(4.2)	(4.9)	(1.7)	(5.1)	(7.4)	(4.7)	(21.1)	**(1.3)**	(0.6)	(1.5)	(1.2)	(0.0)	(10.5)	(0.0)
Other	1603	666	517	243	113	41	15	445	159	134	85	38	17	9
	95.8	(95.1)	(98.3)	(94.9)	(92.6)	(95.3)	(78.9)	98.7	(99.4)	(98.5)	(98.8)	(100.0)	(89.5)	(100.0)
Total	1674	700	526	256	122	43	19	451	160	136	86	38	19	9
Predictor														
Marital status														
Before 1st legal	143	98	31	11	3	0	0	15	12	3	0	0	0	0
commitment	(9.9)	(16.4)	(6.8)	(4.9)	(3.0)	(0.0)	(0.0)	(4.4)	(9.5)	(2.8)	(0.0)	(0.0)	(0.0)	(0.0)
After 1st legal	1080	415	371	183	73	23	10	302	107	96	57	26	8	6
commitment	**(74.9)**	(69.3)	(80.8)	(81.0)	(73.0)	(65.7)	(58.8)	**(89.3)**	(84.9)	(90.6)	(91.9)	(92.9)	(100.0)	(100.0)
During later legal	97	25	32	16	12	8	4	16	4	5	5	2	0	0
commitment	(6.7)	(4.2)	(7.0)	(7.1)	(12.0)	(22.9)	(23.5)	(4.7)	(3.2)	(4.7)	(8.1)	(7.1)	(0.0)	(0.0)
During non-legal	122	61	25	16	12	4	3	5	3	2	0	0	0	0
commitment	(8.5)	(10.2)	(5.4)	(7.1)	(12.0)	(11.4)	(17.6)	(1.5)	(2.4)	(1.9)	(0.0)	(0.0)	(0.0)	(0.0)
Total	1442	599	459	226	100	35	17	338	126	106	62	28	8	6

	General population sample (*n* = 1687)							Turkish minority sample (*n* = 453)						
Pregnancy	**Total**	First	Second	Third	Fourth	Fifth	Sixth	**Total**	First	Second	Third	Fourth	Fifth	Sixth
Age (in years)														
<18	16	14	2	0	0	0	0	12	10	2	0	0	0	0
	(1.0)	(2.0)	(0.4)	(0.0)	(0.0)	(0.0)	(0.0)	(3.1)	(7.1)	(1.7)	(0.0)	(0.0)	(0.0)	(0.0)
18-29	1019	528	314	123	38	12	2	296	121	91	51	23	7	3
	(61.2)	(75.5)	(60.0)	(48.0)	(32.2)	(29.3)	(10.5)	**(77.7)**	(85.8)	(77.8)	(71.8)	(74.2)	(63.6)	(37.5)
30-39	581	151	199	119	71	23	13	71	10	24	20	7	3	5
	(34.9)	(21.6)	(38.0)	(46.5)	(60.2)	(56.1)	(68.4)	(18.6)	(7.1)	(20.5)	(28.2)	(22.6)	(27.3)	(62.5)
>40	48	6	8	14	9	6	4	2	0	0	0	1	1	0
	(2.9)	(0.9)	(1.5)	(5.5)	(7.6)	(14.6)	(21.1)	(0.5)	(0.0)	(0.0)	(0.0)	(3.2)	(9.1)	(0.0)
Total	1664	699	523	256	118	41	19	381	141	117	71	31	11	8
Parity[#]														
Nulliparous	807	705	88	11	2	1	0	176	162	11	2	1	0	0
	(48.2)	(100.0)	(16.8)	(4.3)	(1.7)	(2.3)	(0.0)	**(39.1)**	(100.0)	(8.2)	(2.3)	(2.6)	(0.0)	(0.0)
Primiparous	553	0	436	93	18	5	1	147	0	123	20	3	1	0
	(33.2)	(0.0)	(83.2)	(36.3)	(14.9)	(11.6)	(5.6)	(32.7)	(0.0)	(91.8)	(23.3)	(7.9)	(5.6)	(0.0)
Multiparous	314	0	0	152	101	37	17	127	0	0	64	34	17	9
	(18.8)	(0.0)	(0.0)	(59.4)	(83.5)	(86.0)	(94.4)	(28.2)	(0.0)	(0.0)	(74.4)	(89.5)	(94.4)	(100.0)
Total	1674	705	524	256	121	43	18	450	162	134	86	38	18	9

Note. Sum of subsections differs from the total *N* because of missing data. Percentages are calculated on the valid number of cases. Data for seventh till tenth pregnancies are not presented.

[#]Although parity is theoretically defined as the number of times a woman has delivered a baby, we use it both for men and women here.

Table 2

Results of Multilevel Logistic Regression Analyses on Unplanned, Unwanted Pregnancy and Induced Abortion, Controlling for Gender[4], and Current Age (OR [95% CI])

	Unplanned Pregnancy	Unwanted Pregnancy	Induced Abortion
1. Planned pregnancy		0.01 ***	0.08 *
		[0.01, 0.02]	[0.01, 0.81]
2. Wanted pregnancy			0.01 ***
			[0.00, 0.01]
3. Age	0.97	0.94	0.92
	[0.91, 1.03]	[0.85, 1.04]	[0.81, 1.04]
4. Age*Age	1.01 ***	1.01 *	1.02 *
	[1.01, 1.02]	[1.00, 1.02]	[1.00, 1.03]
5. Marital status			
Ref.: Before first legal commitment			
After first legal commitment	0.14 ***	0.39	0.04 **
	[0.07, 0.31]	[0.12, 1.30]	[0.01, 0.34]
During later legal commitment	0.05 ***	0.35	0.04
	[0.11, 0.24]	[0.03, 3.65]	[0.00, 1.68]
During non-legal commitment	0.15 *	0.28	0.32 *
	[0.36, 0.64]	[0.04, 2.22]	[0.00, 0.85]

[4] Gender itself did not affect the unplanned or unwanted pregnancy ratio, nor did it affect the abortion ratio in case of an unintended pregnancy (for an overview, we refer to Vandamme et al., 2013).

	Unplanned	Unwanted	Abortion
6. Parity	1.78 ***	1.89 **	3.32 *
	[1.40, 2.28]	[1.26, 2.83]	[1.25, 8.83]
Parity*Parity	1.25 **	0.95	0.49 *
	[1.07, 1.46]	[0.75, 1.20]	[0.28, 0.87]
7. Educational level			
Ref.: No formal education / Primary education			
Junior High school (age 12-15)	0.69	1.42	0.18 *
	[0.43, 1.13]	[0.66, 3.05]	[0.05, 0.69]
Secondary High school (age 15-18)	0.46 **	0.63	0.23 *
	[0.27, 0.77]	[0.28, 1.44]	[0.06, 0.92]
Bachelor / Master degree	0.35 ***	0.57	0.45
	[0.21, 0.56]	[0.65, 2.68]	[0.13, 1.53]
8. Ethnic descent			
Ref.: Turkish minority sample			
General population Sample	1.30	1.32	10.92 **
	[0.83, 2.01]	[0.65, 2.68]	[2.03, 58.81]

Note. *p <.05, **p <.01, ***p <.001. *OR* = Odd's Ratio; *CI* = Confidence Interval.

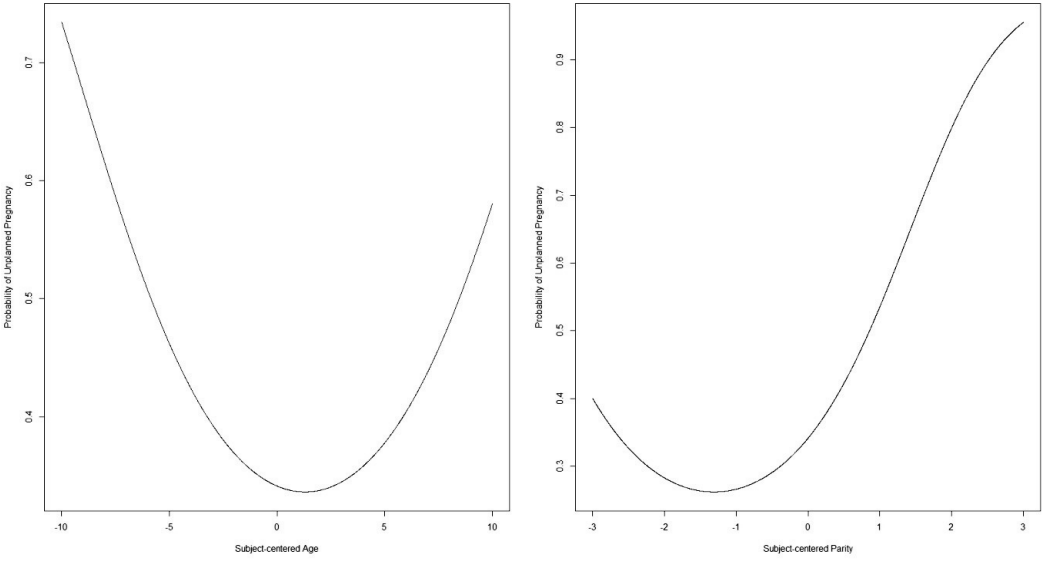

Figure 1. Within-subject quadratic effects of age and parity.

DISCUSSION

Findings, Interpretation, and Relevance for Policy Makers

The prevalence of unplanned pregnancy that was found in our general Flemish population sample, as well as in our Turkish minority sample, is comparable to the 20 to 30% ratios that have been found in neighbouring countries such as France and the Netherlands (Bajos et al., 2003; Bakker et al., 2009). It is, however, much lower than the prevalence of unintended pregnancy in the US, which is about 50% (Finer & Henshaw, 2006). This relatively low unplanned pregnancy level might be an effect of the huge efforts that have been made in Belgium since the 1960s to reduce the number of unintended childbirths. This has been achieved by making contraceptives widely available and by setting up various awareness campaigns for family planning and reproductive health.

At first sight, it would appear that despite equal use of effective contraceptives – as has been reported by Elaut et al. (2015) – unplanned pregnancies are more frequent amongst members of the Turkish minority population. However, when differences in educational level and socio-demographic circumstances at the time of pregnancy between the Turkish minority and general population group are taken into account, this increased prevalence disappears. Instead, educational level, which is markedly lower in the Turkish minority group (e.g., Wets, 2006), is a significant determinant for unplanned pregnancy with people with lower levels of educational attainment being at higher risk. This finding is consistent with numerous international studies on the role of socio-economic circumstances in ineffective contraceptive use, unprotected sexual intercourse, and resulting unplanned pregnancy risk (Bajos et al., 2003; Finer & Henshaw, 2006; Wellings et al., 2013). The mechanisms by which education and income have an impact on such family planning behaviours in Flanders might be at the individual level (knowledge mechanisms), the relational level (social pressure), or the societal level (barriers such as access or costs) (Ayoola, Nettleman, & Brewer, 2007). Family planning policies in Flanders should focus on these underlying mechanisms with the aim of further reducing the number of unplanned pregnancies in socio-economically vulnerable individuals, both within the native Flemish population and amongst people from Turkish minority groups.

Both groups also reported equal percentages of pregnancies as being unwanted after the socio-economic disparities in unplanned pregnancies were taken into account. It seems that an unplanned pregnancy is perceived as equally unwelcome by members of Turkish minority groups as by people from the general Flemish population. In addition, educational level did not affect the risk of unwanted pregnancy in the same way as it elicited an effect on pregnancy planning. These results highlight the known important difference between behavioral strategies to reduce unplanned pregnancies (e.g., by

promoting effective contraceptive use) and subjective ideographic and emotional experiences of an unwanted pregnancy (Fischer et al., 1999).

In contrast to the similarities in pregnancy intent between the two groups mentioned above, the main outcome of unintended pregnancies differed. While induced abortion was the outcome of almost 20% of the unplanned pregnancies in the general population, less than 5% were terminated by participants in the Turkish minority sample. These numbers are low compared to the percentage of unintended pregnancies that result in an abortion in the US or neighbouring countries like France (Bajos et al., 2003; Finer & Henshaw, 2006). An important comment, however, is that the induced abortion ratios that were reported by the two samples (4.2% and 1.3%, respectively) will probably be underestimations of the real number since the latest Flemish report on induced abortion estimates the total abortion rate to be 13.2% (SENSOA, 2011). This underreporting bias might be present, although several recommended steps were undertaken to reduce it (see below) (Smith, Adler, & Tschann, 1999). The lower induced abortion ratio in the Turkish minority group might be a side-effect of this underreporting bias, as in this group, the stigma on reporting an induced abortion might be higher because of the tendency to hold more traditional views of motherhood (Schoenmaeckers et al., 1999). The rather conservative Islamic norms and values (see below) in Turkish minority groups living in Flanders, sometimes conflicting with Western values of reproductive autonomy, might play a role in this underreporting effect (Gürsoy, 1996). Stigma around abortion and social norms related to parenthood might, however, also affect the decision itself to undergo an abortion. It might thus also be the case that people in the Turkish minority group decide to opt for abortion less frequently in case of an unintended pregnancy than people in the general population group. Future research should examine how abortion stigma and social norms about parenthood in Flanders affect induced abortion decisions or reports about it, especially in Turkish minority groups.

Our findings further demonstrate clear patterns of postponing and stopping behaviour in both the Turkish minority group and the native Flemish group. This is in line with an international review that looked at the most cited reasons for abortion worldwide (Bankole et al., 1998). In both samples, U-shaped results were present in the relationship between age and parity on the one hand, and unintended pregnancy and induced abortion on the other (Bankole et al., 1999; Rossier et al., 2007). These higher unintended pregnancy and induced abortion rates at the extremes of the age and parity continua indicate that policy makers and health care providers should pay more attention to effective contraceptive use and appropriate help with unintended pregnancies during later stages in life, in addition to the extensive focus on the prevention and help for teenage pregnancies. Our findings on the effects of marital status on pregnancy intent and outcome in both samples also correspond with the results of numerous qualitative studies showing that the quality and stability of a relationship is a

frequently-stated determinant for an abortion decision, independent of country of origin (Bankole et al., 1998).

The above-mentioned results highlight that despite the different norms around fertility and parenthood in Turkish minority groups–reflected in more childbirths, pregnancies at younger ages, and more frequently being married or cohabiting for the first time at the time of pregnancy–unintended pregnancies do occur at an equal frequency and pregnancies are unwelcome at the same stages of life as in native Flemish people.

Strengths, Weaknesses, and Future Research

This study dealt with the issue of ethnic descent and family planning in Flanders by making use of two large-scale population based surveys and a unique Multilevel methodology by which within-life patterns as well as between-group differences in unintended pregnancy and induced abortion could be examined. By asking our respondents to report on every pregnancy they had ever encountered, we avoided the stigma-inducing question ”Have you ever had an abortion or an unintended pregnancy?”. This lowered–but most likely did not rule out–the chance of underestimation and recall bias. Underestimation bias was also reduced by making use of a CASI set-up, which is a combination of a recommended face-to-face interview technique and the possibility for respondents to respond confidentially with the computer set-up (Smith et al., 1999). In addition, attempts were made to match interviewers to respondents in terms of age, gender, and ethnic descent.

One limitation, however, concerns the retrospective nature of the study. Answers to retrospective questions about pregnancy intent might be biased by factors that have altered feelings or memories before the time of the survey (Rosenzweig & Wolpin, 1993). Therefore, our study allowed respondents to indicate the possibility that the pregnancy was *initially unwanted, but later wanted*, although this category was eventually combined into the category *simply unwanted* in our study.

Secondly, although pregnancy intent was split into pregnancy planning versus desire, we did not probe contraceptive behavior at the time of pregnancy nor for timing of future pregnancy plans, unlike the measurement of unplanned pregnancy carried out in the London Measure of Unplanned Pregnancy (LMUP; Barrett, Smith, & Wellings, 2004). As a consequence, we were unable to pin down the ideographic meaning of *unplanned* or *unwanted* for our respondents, nor could we examine within- or between-group differences in contraceptive use before the pregnancy occurred.

Thirdly, the focus on the Turkish minority group was directed to people living in Flanders with at least one parent who was born in Turkey. As a consequence, the group mostly consisted of second generation migrants. Results could have been different for first generation Turkish migrants.

Fourthly, due to methodological reasons[5], we could not test the overall role of religion in the prevalence of unintended pregnancies and induced abortions.

Finally, despite several attempts to maximize the response rate in both studies (e.g., interviewers were trained in motivational techniques, interviewers returned two times when the eligible respondent was not at home the first time, and they left a contact card and contacted eligible respondents by telephone when the third visit had been unsuccessful), the response rate in the general population sample did not reach 50% (Buysse et al., 2013). Barriers for participation might have been the quite extensive length of the questionnaire as well as cultural factors related to participation in research in general. The final population based sample was however representative for the overall Flemish population in terms of gender, age, and educational level. The higher response rate in the Turkish minority population might have been due to the effective recruitment strategies of the interviewers in this study as well as to a difference in place of residence (men and women from Turkish descent more often live in less civilized regions where eligible respondents are easier to reach; see Newington & Metcalfe, 2014).

Since the results demonstrate a lower abortion rate in the Turkish minority group, future research should further investigate abortion stigma in this ethnic minority group. The decision-making process following discovery of an unintended pregnancy in Turkish couples should be examined more thoroughly, ideally making use of qualitative data.

In addition, scholars should further disentangle the factors that lead to unplanned pregnancies in individuals from socio-economically vulnerable groups, such as situational non- or misuse of contraceptives, especially in older people and those with large families. The focus should concentrate on these socio-economic disparities in order to reduce the number of unintended pregnancies in Turkish minority groups.

CONCLUSIONS

This study shed light on how socio-economic vulnerabilities of both Turkish and native Flemish people increase the risk of unplanned pregnancy while ethnic descent itself does not. Hence, family planning interventions in Flanders should focus on socio-economically vulnerable groups of men and

[5] The overall majority of the participants in the Turkish minority group (> 90%) reported to be Muslims and to attach quite to high importance to religion. In the general population group, different groups could be ascertained: *Catholics* (almost half of the participants), *unreligious people* (one in four participants), *Christians* (one in five participants), and *other* (one in ten participants). Importance of religion was also highly divided with half stating that it is very important and one third stating it is not important at all. Within the general population group, type and importance of religion were not associated with induced abortion odds in the event of an unintended pregnancy.

women. Moreover, the study revealed that Turkish minority people do resemble native Flemish people with regard to the issue of unintended pregnancy and induced abortion more than the groups differ from each other, as these events tend to occur at the same periods in life relative to the average timing of pregnancies for each group. The latter indeed differed between the two groups because of discrepant social norms on childbearing and fertility. Policies should then not overestimate the differences between native Flemish people and people from Turkish descent living in Flanders regarding these reproductive health issues. Since induced abortion ratios in Turkish minority people were, however, lower, future research should focus on how stigma affects the process of deciding to have an abortion or how it affects the reporting of induced abortion in this group.

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3 Partners' different ways of sharing the decision to have an abortion

Based on Vandamme, J., Buysse, A., Loeys, A., Vrancken, C., Vermeire, K., & T'Sjoen, G. Partners' different ways of sharing the decision to have an abortion.

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ABSTRACT

Objective. Despite unwanted pregnancies resulting from a sexual interaction between two people, research on the role of the male partner (MP) in the decision to opt for an abortion is rather scarce. In this study, we examine how the MP's share in the decision to have an abortion varies along the relational context, and we investigate both partners' satisfaction with the division of roles.

Methods. A sample of 176 Belgian adult abortion-seeking women and a subsample of involved MPs (*N* = 52) filled out an online questionnaire on both partners' shares in the process and outcome of the decision to have an abortion. Multinomial logistic regression analyses were performed to examine the link between relational type and quality and the MP's share in the process and outcome of the decision, respectively. Multivariate regression analyses were used to examine whether the satisfaction of the abortion-seeking women and the involved MPs with both their own role and their partner's role differed along the perceived MP's share in the decision process and outcome.

Results. From the women's perspective, MP's involvement in the decision-making process varied from being totally excluded (24.4%) to just being consulted by the woman (23.3%) to deciding jointly (44.3%) or even taking the lead (8%). According to the women, 62.5% of the decisions were a mutually shared decision to opt for an abortion. Women in non-romantic or short-term romantic relationships were less likely to involve the MP. Furthermore, a higher degree of commitment to the MP resulted in higher odds of having involved the MP in the decision process. A mutual decision for abortion was most prevalent in long- and short-term romantic relationships. Women's satisfaction with the role of their partner was high except in couples where the MP had a more prominent role in the decision process or outcome than the abortion-seeking woman herself. Similarly, MP's satisfaction with their own role was high, except when they had the dominant role in the outcome of the decision.

Conclusion. Male partners' roles in the decision to have an abortion vary along the type and depth of the relationship with the abortion-seeking woman. Both partners' satisfaction with the division of roles is generally high.

INTRODUCTION

Each year more than 40 million women worldwide opt for an induced abortion in cases of unwanted pregnancy (Sedgh, Singh, Henshaw, & Bankole, 2012). To date, women's pathways towards the decision to have an abortion have been well documented (Foster, Gould, Taylor, & Weitz, 2012; Rowlands, 2008; Törnbom, Ingelhammar, Lilja, Svanberg, & Möller, 1999). One of the most consistent, yet implicit, findings is that others are inherently involved, either directly or indirectly, in women's decisions for abortion.

The Relational Autonomy of Abortion-Seeking Women

Firstly, women very often refer to the existing societal norms on being a "good" parent (e.g., being the right age, with the right partner, in good finances) when making a decision to have an abortion (Ekstrand, Tydén, Darj, & Larsson, 2009; Kirkman, Rowe, Hardiman, & Rosenthal, 2011). Secondly, women's thoughts and feelings regarding abortion are often implicitly or explicitly influenced by the (expected) needs, goals, and feelings regarding pregnancy and childbirth of the people they are surrounded by (e.g., parents, peers, or their male partners) (Chibber, Biggs, Roberts, & Foster, 2014; Evans, 2001; Vandamme, Buysse, Loeys, Vrancken, & T'Sjoen, 2017). Finally, women might also receive direct advice or clear judgements about the decision, which sometimes leads to feelings of being pressured by others in their decisions about the unwanted pregnancy (Ekstrand et al., 2009; Tatum, Rueda, Bain, Clyde, & Carino, 2012; Törnbom et al., 1999). This direct and indirect involvement and influence of others in the decision to have an abortion can best be understood from the concept of "relational autonomy" in which interdependence from surrounding others is both seen as a component as well as a condition for decision autonomy (Nedelsky, 1989). The ideal of autonomy is, as such, separated from being independent of surrounding others (Vansteenkiste, Niemiec, & Soenens, 2010).

Role of the Male Partner?

Despite the extensive literature on the involvement and influence of others in the decision to have an abortion, however, research on the specific, real life role of the male partner involved in the pregnancy (further referred to as the MP) in the decision to have an abortion is rather scarce (Costescu & Lamont, 2013; Reich & Brindis, 2006; Vandamme et al., 2017). Although scholars are now paying increasing attention to the direct or indirect role of men in women's pregnancy related intentions, desires, and decisions (Kroelinger & Oths, 2000; Miller, Severy, & Pasta, 2004; Zabin, Huggins, Emerson, & Cullins, 2000), and their role in the subsequent use of contraceptives (e.g. Bankole & Singh, 1998; Bongaarts & Bruce, 1995), the desired or actual roles of male partners in induced abortion decisions

have been ignored (Lohan, Cruise, Halloran, Alderdice, & Hyde, 2010; Naziri, 2007; Reich & Brindis, 2006; Sharp, Richter, & Rutherford, 2015). This is unsurprising, given the societal and historical context of induced abortion in most Western countries where women, partly due the growing feminist movements, received the legal right and power to decide whether or not to have an abortion in cases of an unwanted pregnancy, no matter the opinions and wishes of the male partner (David, 1992; Dudgeon & Inhorn, 2004). The actual role of male partners in these decision processes is therefore quite sensitive and, perhaps as a consequence, an understudied topic despite unintended pregnancies and decisions on childbearing being inherently dyadic issues, eliciting change for both partners (Bankole & Singh, 1998; Lachance-Grzela & Bouchard, 2009; Miller et al., 2004; Salmela-Aro, Aunola, Saisto, Halmesmäki, & Nurmi, 2006).

In most of the studies that have been conducted on men who are involved in unwanted pregnancies that end up in induced abortion, male partners have been described as a possible source of positive instrumental or emotional support for women's distress. This distress can arise during various phases of the abortion procedure, from gaining access to the abortion center to having the abortion itself or the commencement of contraceptives post-abortion (Altshuler, Nguyen, Riley, Tinsley, & Tuncalp, 2016; Kero, Lalos, & Wulff, 2010; Veiga et al., 2011). Another form of support that has been suggested is the male partners' support for the outcome of the women's decision about the unintended pregnancy (Ekstrand et al., 2009; Jones, Moore, & Frohwirth, 2011). Some women indicate, however, that it is the absence of male support (for carrying the pregnancy to term) that has led them to decide to have an abortion, which can also be perceived as them having been abandoned with the sole responsibility for the decision (Chibber et al., 2014; Ekstrand et al., 2009; Kimport, Foster, & Weitz, 2011). Based on a stress and coping perspective on social support, it can be argued that the involvement of a supportive MP increases a woman's (belief in her) own coping abilities and as such, her individual emotional wellbeing (Major et al., 1990). Others have demonstrated that women benefit from men's presence and supportiveness because it increases the perception and reality of shared responsibility, resulting in both better reproductive and mental health outcomes (Altshuler et al., 2016; Becker, Bazant, & Meyers, 2008; Kapadia, Finer, & Klukas, 2011). Male partners are as such often involved in pre-abortion counseling sessions, during the treatment or in post-abortion services, as a means by which to improve women's reproductive and mental health (Altshuler et al., 2016; Becker et al., 2008; Beenhakker et al., 2014). Nevertheless, relational factors should be taken into account as not *all* women perceive the involved man as a significant and supportive figure in this process (Jones et al., 2011; Kapadia et al., 2011).

Despite the bulk of research describing men as being a source of support for the abortion-seeking women, very few studies have paid attention to the *actual* involvement of the MP in the decision to have an abortion, from both the women's as the MP's perspectives (Costescu & Lamont,

2013; Reich & Brindis, 2006; Vandamme et al., 2017). One of the problems scholars are confronted with is how to conceptualize the involvement of the male partner. As previous authors have already described, being aware of the pregnancy or the abortion does not necessarily mean that the MP also had a significant role in the decision-making process (Costescu & Lamont, 2013; Reich & Brindis, 2006). Furthermore, the MP agreeing on or supporting the final decision to have an abortion does not necessarily mean that he was able to contribute his opinions during the decision process (Reich & Brindis, 2006). In addition, the actual involvement of the MP has often been qualitatively and without theoretical base examined from either the woman's perspective alone (e.g., Ekstrand et al., 2009; Kimport et al., 2011; Skjeldestad, 1986) or the MP's perspective alone (Naziri, 2007; Reich & Brindis, 2006; Sharp et al., 2015), which does not allow for the possibility of examining whether this involvement is similarly evaluated by both female and male partners. Moreover, little is known about the relational contexts in which abortion-seeking women decide to opt for an abortion and how the actual involvement of the MP in this decision is embedded in this relational context (Reich & Brindis, 2006). A distinct relational-interactional perspective has nevertheless been demonstrated to be critical in understanding both the process and the outcome of couple's decisions, especially when it comes to reproductive decisions (Dudgeon & Inhorn, 2004, Miller et al., 2004; Vandamme et al., 2017). The definition and qualification of relational context has to date very often been reduced to either marital status or relationship length (e.g. Jones et al., 2011; Sharp et al., 2015), the presence of intimate partner violence (e.g. Jones et al., 2011) or a single question on relationship satisfaction (e.g. Kero, Högberg, Jacobsson, & Lalos, 2001), thereby losing detail with regard to the influence of relationship nature, quality, and context on pregnancy decisions (Kapadia et al., 2011).

Shared Decision-Making Processes, and Outcomes in a Contextual Perspective

This study is the first to explore how the type as well as the quality of the relationship between an abortion-seeking woman and her MP is linked with the MP's share in both the process and the outcome of the decision to have an abortion. This distinction between sharing the decision process and sharing the final outcome, and its link with relational context, is rooted in theoretical models and frameworks on shared decision-making within couples and families in general (Godwin & Scanzoni, 1989; Zeiler, 2007). Although (shared) decision-making is difficult to conceptualize, these models and frameworks generally distinguish the process of making decisions on a certain topic within a couple from the degree to which that decision process results in consensus or agreement (Godwin & Scanzoni, 1989; Zeiler, 2007). To qualify a decision process as shared, partners need to be able to communicate with each other and jointly deliberate on the decision (Zeiler, 2007). In this shared process, partners might be able to deal with different opinions and maybe come to a consensus as a result of compromises (Dekkers, 2009; Zeiler, 2007). In this process from decision-making to decision outcome,

direct or indirect, positive and negative, and unilateral or bilateral dyadic influences or power dynamics between partners might come into play (Godwin & Scanzoni, 1989; Miller et al., 2004; Simpson, Farrell, Oriña, & Rothman, 2015; Testa, Cavalli, & Rosina, 2012; Vandamme et al., 2016). As such, partner A might feel negative about the induced abortion option and communicate this to partner B (meaning that this partner has been involved to a certain extent in the decision-making process so there is a certain level of joint decision-making), even though they end up accepting the partner B's final decision for induced abortion as a result of accommodation to the needs of the other partner (Davis, 1976; Miller et al., 2004; Zeiler, 2007). This accommodation or negotiation occurs in a state of past and future interdependence from the corresponding partner, as suggested by Rusbult's Investment Model of Commitment in close relationships (Rusbult, Agnew, & Arriaga, 2011). It is therefore hypothesized that the higher a partner's level of (emotional, financial) dependence from the other partner is, the less decision-making power this partner possesses and vice versa (Lennon, Stewart, & Ledermann, 2012). This relational-affective dimension of decision-making makes decisions within families different from decisions in groups of unrelated people (Park, Tansuhaj, & Kolbe, 1991). The degree to which decision-making is then equally satisfying for both partners, might vary between relationships, between decisions within the same relationship, and even between the two partners in the relationship of a single couple, partially depending on cultural and relational norms regarding who should or can decide about what (Davis, 1976; Dekkers, 2009; Meier, Kirchler, & Hubert, 1999).

In this study, we aim to examine both partners' perceptions on the MP's share in the process of deciding what to do about an unintended pregnancy (i.e., the degree of joint decision-making) as well his share in the final decision to have an abortion (i.e., the degree of women's, MPs', versus the mutual ownership of the final outcome of the decision). This two-dimensional conceptualization of MP's involvement in the decision for abortion follows the literature on household decision-making in which partner's joint participation in decision-making processes (related to dependent versus independent decision-making, see also Dornbusch et al., 1985) is separated from the degree to which one of the partners dominates the final outcome of the decision (related to power as an outcome variable; see for example Meier et al., 1999; Simpson et al., 2015). We secondly examine the association with type and quality of the relationship on the one hand and level of satisfaction with the division of roles between the two partners on the other hand. Hence, based on previous studies, we aim to answer three research questions, and test three hypotheses:

Q1: What are the different relational types and the mean quality of the relationships between abortion-seeking women and their MPs?

Q2: Which role do MPs have in women's decision to have an abortion?

Q3. How satisfied are women and involved male partners (MPs who have been involved in the abortion process; further referred to as IMP's), with the division of roles and does satisfaction depend on their perceived share in the decision process and outcome?

H1. We expect that there will be no perfect overlap between MP's share in the decision process about an unintended pregnancy and MP's share in the final decision to have an abortion.

H2. We hypothesize that a more enduring and committed relationship to the MP will be positively associated with the MP's share in the process of the decision (a more joint decision process) and will be positively associated with a mutual decision for abortion (instead of one the partners mainly dominating the final decision for abortion).

H3. We hypothesize that women's satisfaction with the division of roles will be low in cases where the male partner has dominated the process or outcome of the decision to have an abortion.

METHOD

Procedure

This study was part of a larger longitudinal study concerning the experiences of deciding to have an abortion of women and their involved male partners (for an overview of the different study waves, see introduction section of the thesis). The involved male partners will be further referred to as IMPs, to differentiate them from the overall population of male partners (MPs) of abortion-seeking women. Hence, IMPs are the male partners who are aware of the unwanted pregnancy, and who are, in whatever way, involved in the planning of the induced abortion[1]. Adult (>18 years) abortion-seeking women were asked if they wanted to take part in the study when they entered one of the five mandated abortion centers in Flanders (the northern part of Belgium), prior to the mandatory pre-abortion counseling session. When a man accompanied an abortion-seeking woman, he was asked to participate too, after having confirmed he was the man involved in the pregnancy. When the male partner was absent, the abortion-seeking woman was asked to give him an information leaflet. Hence, only IMPs who accompanied the women to the abortion center of who were asked by the women to participate in the study were eligible to take part. Both partners could take part in the study independently and could withdraw from participation at each data wave. Non-responding involved male partners were asked to fill out a response card with demographical information. In the first data wave, women and IMPs filled out a paper-and-pencil questionnaire whilst in the waiting room of the

[1] The term *involved* does not refer to the share of the MP in the decisional process or the outcome of the decision, but refers to the MP being aware of, and hence involved in the planned abortion.

abortion center[2]. This questionnaire mostly included individual thoughts and feelings regarding the decision to have an abortion.

The current study was based on the second part of the longitudinal study, where both women and IMPs filled out an online home-based questionnaire about the relational context of their decision to opt for an abortion. This was completed in the waiting period between the first counseling session and the eventual treatment. The 6-days during waiting period is mandatory in Belgian abortion law. Participants were asked to fill out the questionnaire at home by the day after the counseling session. To minimize dropout, the healthcare provider who recruited the respondent in the first data wave sent a reminder e-mail, gave an information letter, and referred to an information video in which participants were motivated to fill out the second questionnaire. In the questionnaire, participants could indicate whether and how they wanted to proceed with the next data waves[3]. Those who took part in all waves of the study received an incentive to the value of 25 euro. Participants needed to sign an electronic informed consent and the study was approved by the Ethical Committee of the Ghent University Hospital, Belgium.

Measures

Demographic characteristics.

Participants' age, educational level, origin, living situation, and reproductive history were questioned in the first data wave (the paper-and-pencil questionnaire in the waiting room of the abortion center).

Relational characteristics.

The type, significance, duration, and quality of the relationship between the abortion-seeking woman and the MP was measured in the second data wave. Women could report whether the MP was her current romantic partner or not (i.e., defining the type of relationship). Subsequently, participants were asked to report on how significant the role of their partner was in their life at present, on a scale from 1 to 5. Additionally, for those where the male partner was defined as a romantic partner, relationship duration was probed. Type, significance and duration of the relationship were combined into one relational type variable with five categories: (1) *non-romantic and non-significant relationship*,

[2] Male partners who were absent during the first visit to the abortion center but who wanted to take part in the study, could fill out the first questionnaire online.

[3] They could choose between a further "light" or "full" participation. Full participation included taking part in a daily survey up until and 5 days after the abortion procedure, as well as filling out a post-abortion questionnaire two weeks after the pregnancy termination. Light participation only included taking part in a short survey on the day of the termination and filling out the short post-abortion questionnaire. These longitudinal data fall out of the scope of this paper.

(2) *non-romantic but significant relationship*, (3) r*omantic relationship with a duration of less than one year* (short-term relationship), (4) *romantic relationship for one to five years* (medium-term relationship), (5) *romantic relationship for more than five years* (long-term relationship).

Quality of the relationship was measured with the Dutch version of the Quality of Relationships Inventory (QRI), a measure than can be used for different types of family and peer relationships (Pierce, Sarason, & Sarason, 1991; Verhofstadt, Buysse, Rosseel, & Peene, 2006). The measure includes *perceived support* (7 items), *conflict* (12 items) and *depth* (6 items) in the relationship with a partner. Sample items are "To what extent could you count on this person for help with a problem?" (support scale), "How critical of you is this person?" (conflict scale), "How significant is this relationship in your life?" (depth scale). Cronbach's alphas were 0.87, 0.92 and 0.86 respectively. The QRI was not examined in situations where the MP was not a romantic partner and was of no significance to the woman's life.

Both partners' contributions to the decision to have an abortion.

Decision process. To measure the degree of MP's share in the decision-making process, the following question was asked to the women: "Regarding yourself and the male partner who was involved in the pregnancy…, in your opinion, who has decided about the outcome of this pregnancy up to this point?". Based on the Family Decision Making Scale, and similar to the dimension of "joint decision making" in Meier's study on household decisions in couples (Dornbusch et al., 1985; Meier et al., 1999), answers ranged from 0 (*only him*) to 10 (*only me*). The higher the score on this item, the more the woman was reporting to have decided independent of the MP, and the less jointly she perceived deciding with him about the unintended pregnancy. For the IMPs, answers could range from *only her* (0) to *only me* (10), so that higher scores meant more involvement of the participant himself in the decision to have an abortion. For women and the IMPs separately, those scores were recoded into four categories: (1) *the woman decided by herself*, (2) *the woman decided after consulting the MP*, (3) *they decided jointly*, or (4) *the MP decided after consulting the woman*.

***Decision outcome*.** The MP's share in the final decision to have an abortion was measured with an item based on the Global Measure of Equity in Relationships (Young & Hatfield, 2011). The item assessed the degree to which the decision to end this pregnancy with an abortion was either mutually shared by both of the partners or something more favored by one of the partners. Participants were asked to select the answer that best described the decision in their case with regard to their own and their MP's wishes on the outcome of the pregnancy. Scores could range from -3 through 0 to 3, with a negative score indicating that *the final* d*ecision to have an abortion had mostly been directed by the MP's wishes*, a positive score indicating that *the abortion decision had mostly been directed by the*

woman's wishes and a 0 score meaning that *the abortion had been equally in accordance with the woman's wishes as those of the MP*.

Satisfaction with division of roles in the decision to have an abortion.

Participant's satisfaction with the division of roles was measured with two items: one about the *satisfaction with the own role* and the other about the *satisfaction with the role of the involved partner*. Scores ranged from 1 to 5 with a higher score indicating a higher satisfaction.

Study Sample

From the total sample of women and involved male partners (IMPs) who agreed to participate in the first data wave (N = 436 and 123 respectively), 176 women (40.4%) and 52 IMPs (42.3%) progressed onto the second wave and fully filled out the online questionnaire about relational context of the decision. Women participating in the second part of the study tended to be slightly older than women in the non-responder group ($t(150) = 2.46$, $p < 0.05$). This was not the case for the IMPs ($t(41) = 1.38$, $p = .18$). Neither the women nor the IMPs in the study samples differed from the non-responders in terms of type of relationship (non-romantic relationships accounted for 15 vs 14.6%, $\chi^2(1) = 0.60$, $p = .44$; 5.8 vs. 7.4%; $\chi^2(1) = 0.06$, $p = .81$ respectively), civil status (single individuals accounted for 51.7 vs. 45.7%; $\chi^2(1) = 1.27$, $p = .26$; 46.5 vs 42.9%; $\chi^2(1) = 0.13$, $p = .73$ respectively) or nationality ($\chi^2(1) = 0.31$, $p = .58$; difference could not be calculated for the IMPs). Women and IMPs participating in the second part of the study also did not differ from the women and IMPs who only participated in the first data wave of the larger study design in terms of age ($t(403) = 1.89$, $p = .06$; $t(112) = -.81$, $p = .42$), civil status ($\chi^2(3) = 5.81$, $p = .12$; $\chi^2(3) = 1.53$, $p = .68$), living situation (living together with a partner or not; $\chi^2(1) = 2.23$, $p = .12$; $\chi^2(1) = 0.55$, $p = .46$) or ethnic descent ($\chi^2(2) = 2.53$, $p = .28$; difference could not be calculated for the IMPs) but they did differ with regard to educational level (49.3% and 47.5% having a Bachelor or Master degree compared to 30.9% and 32.5% respectively; $\chi^2(3) = 14.11$, $p < .01$ and $\chi^2(3) = 8.5$, $p < .05$).

Data Analysis

Data were analyzed separately for women and the IMPs. For both the sample of women and the sample of involved male partners (IMPs), descriptive analyses were performed to report on relational context, perceptions on both partner's shares in the process and outcome of the decision, and degree of satisfaction with the division of roles. To test the link between the two relational measures (type and quality of the relationship) and the MP's share in the decision process and outcome, Multinomial Logistic Regression Analyses were performed in a stepwise fashion. These were

only performed in the sample of women as the small number of participants in the male sample did not allow us to compute such regressions.

In the first multinomial logistic regression analysis, the MP's share in the process of the decision was used as a dependent variable. In the second analysis, MP's share in the outcome of the decision was used as a dependent variable, hereby controlling for the MP's share in the decision process. In both multinomial logistic regression analyses, two steps were included. In the first step, the association with relational type (five categories) was examined. In this analysis, the largest category (the group of women who were in a long-term relationship with their MP) was used as the reference category. To examine the effect of the MP's share in the process and outcome on degree of satisfaction with the division of roles between the abortion-seeking women and their partners, Multivariate Linear Regression analyses were used, therefore controlling for relational context. These analyses were performed separately for women and the male partners, thereby using the participants' own reports on the contribution of the MP to the decision process and outcome. Data were analyzed with *SPSS* 23.

RESULTS

Descriptive Statistics

Sample characteristics.

Characteristics of the participants in the samples of women and IMPs are depicted in Table 1. Mean age of the women was 30.7 (*SD* = 6.2) and almost half of them (49.3%) had a Bachelor or Master degree. At the time of the survey, most of the abortion-seeking women (84.7%) were in romantic relationships with the MP (see Table 1). Length of their romantic relationship ranged from three weeks (minimum) to 23 years (maximum), with a mean relationship duration of 5.7 years (*SD* = 5.8; not in table). When the scores on the QRI of the abortion-seeking women who had been in a romantic relationship with their MP for more than one year and were cohabiting with them (*n* = 82 in this sample) were compared with mean reference scores of women in committed relationships in Belgium (Verhofstadt et al., 2006; $M_{support}$ = 3.3 , $M_{conflict}$ = 1.9, M_{depth} = 3.4), it was remarkable that the perceived degree of support was significantly higher ($t(81) = 3.57$, $p < .01$), and the perceived degree of conflict was significantly lower than in the reference group ($t(81) = -2.95$, $p < .01$). Degree of relational depth was equal to the reference group ($t(81) = -1.65$, $p = .11$). Although these groups are hard to compare, the comparison at least indicates that the women under study who were in medium to long-term relationships with an MP reported on average rather supportive and low-conflict relationships. However, compared to a sample of Flemish pregnant women who were not seeking an induced

abortion[4], more women in our sample were in non-romantic or short-term relationships (34% compared to 10.1%) and more women had a civil status of single (52.3% compared to 21.4%).

In the sample of involved male partners, the overall majority (94.2%) were in a romantic relationship with the corresponding woman and 67.3% had been in a relationship with them for at least one year. Mean age was 33.0 (*SD* = 7.9) and 47.5% had a Bachelor or Master degree. Scores on the QRI for the IMPs who had been in a romantic relationship with the abortion-seeking woman for more than one year and were cohabiting (*n* = 23) on average resembled the scores of a reference group of Belgian men in committed relationships (Verhofstadt et al., 2006; $M_{support}$ = 3.4, $M_{conflict}$ = 2.0 , and M_{depth} = 3.4) with the support scores being somewhat higher ($t(22) = 3.38$, $p < .01$), and the conflict and depth scores being equal *(*$t(22) = -1.53$, $p = 14$; $t(22) = -0.38$, $p = .71$ respectively).

We tested whether there were differences between women who's MP also participated in the second data wave of the study (*n* = 39) and women for whom this was not the case (*n* = 137). The two groups did not differ in type of relationship with the MP ($\chi^2(4) = 6.60$, $p = .16$) or civil status ($\chi^2(3) = 0.70$, $p = .87$) nor did they differ in whether they lived together with a partner or not; $\chi^2(1) = 0.19$, $p = .67$). There was, however, a difference in the scores on relational depth with a higher relational depth being reported by women whose partner participated in the study as well ($F(1,161) = 7.7$, $p < .01$). As expected, also the reported level of involvement of the MP differed between these two groups of women. In the group of women where the MP participated as well, MPs had a higher share in both the decisional process and the outcome of the decision for abortion ($\chi^2(3) = 20.1$, $p < .001$; $\chi^2(2) = 7.74$, $p < .05$). While satisfaction with the own role was equal between these two groups of women ($F(1,174) = 3.1$, $p = .08$), satisfaction with the role of the MP was marginally higher when the MP participated in the second data wave as well ($F(1,174) = 3.1$, $p < .05$).

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[4] Unpublished preliminary data from a Flemish study of couples who opted for a child. Both the pregnant women (*N* = 53) and the involved male partners (*N* = 21) filled out an online questionnaire during the first trimester of the pregnancy. Participants were mainly recruited through social media. The sample is hence not a representative sample of pregnant couples. However, it is the best comparison group available since the same questions were probed as in the current study.

Table 1

Sample Characteristics (N = 176 women and 52 involved male partners)

	Women		IMP's [#]	
	n	*%*	*n*	*%*
Demographic characteristics				
Age				
< 20	2	1.3	2	4.8
20-29	65	43.0	14	33.3
30-39	71	47.0	18	42.9
≥ 40	13	8.6	8	19.0
Educational level				
No formal education/Primary education	5	3.4	3	7.5
Junior High School	13	8.9	0	0.0
Secondary High School	56	38.4	18	45.0
Bachelor/Master degree	72	49.3	19	47.5
Ethnic descent				
Native	124	83.2	41	93.2
Western immigrant	12	8.1	3	6.8
Non-Western immigrant	13	8.7	0	0.0
Civil Status				
Single	78	51.7	20	46.5
Cohabiting	27	17.9	7	16.3
Married	37	24.5	12	27.9
Divorced	9	6.0	4	9.3
Widowed	0	0.0	0	0.0
Living situation				
Cohabiting with a partner (and others)	89	58.6	25	56.8
Living alone (or with others), without a partner	63	41.4	19	43.2
Reproductive characteristics				
Gravidity				
No previous pregnancy	55	36.7	25	56.8
Previous pregnancy	95	63.3	19	43.2
Previous abortion				
No	108	74.0	37	84.1
Yes	38	26.0	7	15.9

	Women		IMP's [#]	
	n	%	*n*	%
Pregnancy gestation				
< 4 weeks	13	7.7	4	8.5
4-7 weeks	111	65.7	29	61.7
8-11 weeks	41	24.3	14	29.8
≥ 12 weeks	4	2.4	0	0.0
Relational characteristics				
Relationship with MP[5#]				
Non-significant relationship[6]	13	7.4	0	0.0
Non-romantic but significant relationship[7]	14	8.0	3	5.8
Short-term romantic relationship	34	19.3	14	26.9
Medium-term romantic relationship	53	30.1	13	25.0
Long-term romantic relationship	62	35.2	22	42.3
	M	*SD*	*M*	*SD*
QRI[8 †]				
Support	3.3	0.62	3.5	0.49
Conflict	1.9	0.61	1.9	0.54
Depth	3.1	0.66	3.3	0.54

Note. Sums of the subsections differ from the total *N* because of missing data.

[#] MP= male partner who was the man involved in the pregnancy; IMP= male partner who was involved in the abortion process and took part in the survey.

[†] The QRI (Quality of Relationships Inventory) was only applied in the 162 women with a significant relationship.

[5] Three women in our sample (1.7%) did not know for sure who was the male partner involved in the pregnancy.
[6] The MP's in this group were mostly one-night stands, ex-partners, or friends with benefits.
[7] The MP's in this group had diverse roles in the women's lives, including being an ex-partner, a good friend or a boyfriend.
[8] In the subsample of couples (when there was a link between the participating woman and the participating male partner), partner's reports on the three subscales of the QRI largely overlapped ($t(38) = -0.80$, $p = .43$ and $r = .43$, $p < .01$ for level of support; $t(38) = -0.08$, $p = .94$ and $r = .63$, $p < .001$ for level of conflict; $t(38) = 0.49$, $p = .63$ and $r = .49$, $p < .01$ for relational depth). Hence, relational context is looked upon as a concept at the level of the dyad.

Both partner's shares in the decision for abortion.

We first look from the perspective from the women. As table 2 demonstrates, only a minority of the abortion-seeking women (14.2%) reported the MP not being aware of the unintended pregnancy they were involved in. A larger proportion of women (24.4%), however, reported having decided alone, without consulting the MP. Women did not involve the MP in the decision process in 11.9% of the situations where he was nevertheless aware of the pregnancy at the time of the survey (18 out of 151, not in table). For three quarters of the women (75%), the MP was involved to a certain extent in the process of deciding about the outcome of the unintended pregnancy, which ranged from only being consulted by the woman (23.3%) to being an equal decision partner (44.3%) to having taken the lead in the decision (8%). The majority of the women (62.5%) reported the outcome of the decision process (i.e., the decision to have an abortion) as a mutually shared decision. When there was an imbalance in whose needs were mostly met by the decision for abortion, this imbalance was perceived by most of the women to be more on the woman's than on the MP's side (23.9% compared to 13.6%).

Table 3 demonstrates that there was a significant relationship between MP's involvement in the process of deciding what to do about the pregnancy and his share in the outcome of the decision ($\chi^2(6) = 119.1$, $p < .001$). However, about half of the women who reported a decision process in which the MP was not involved, still perceived the abortion as being a mutually shared decision with him (47.8%; see Table 3). Similarly, for 16.3% of the women who reported having decided jointly with the MP, the final outcome of that decision was not a mutually shared decision.

From the perspective of the IMPs, a joint decision process occurred in a small majority of the situations (63.5%) and the abortion was perceived to be an mutually shared decision by both of the partners in 75.0% of the decisions.

Table 2

Both Partner's Shares in the Decision to Have an Abortion

	Women		IMP's	
	n	*%*	*n*	*%*
MP aware of the pregnancy				
Yes[9]	151	85.8	52	100.0
No	25	14.2	0	0.0
I don't know	0	0.0	0	0.0
MP's share in the decision process[10]				
Woman decided alone	43	24.4	2	3.8
Woman decided after consulting the MP	41	23.3	13	25.0
Woman and MP decided jointly	78	44.3	33	63.5
MP decided after consulting the woman	14	8.0	4	7.7
MP's share in the decision outcome				
Abortion more the woman's decision	42	23.9	6	11.5
Abortion a shared decision	110	62.5	39	75.0
Abortion more the MP's decision	24	13.6	7	13.5

Note. MP= male partner who was the man involved in the pregnancy; IMP= male partner who was involved in the abortion process and took part in the survey.

Both partner's satisfaction with the division of roles in the decision to have an abortion.

Women's mean satisfaction with their own role in the decision about the outcome of the pregnancy was high, with a mean score of 4.1 (*SD* = 0.99) on a 5-point scale. Satisfaction with the role of the male partner was still high (*M* = 3.9, *SD* = 1.12), but significantly lower than their satisfaction with their own role ($t(180) = 2.7$, $p < .01$).

The IMPs were also more satisfied with the role of the abortion-seeking woman (*M* = 4.2, *SD* = 0.91) than with their own role (*M* = 3.9, *SD* = 1.11; $t(51) = 2.60$, $p < .05$).[11]

[9] In 69.5% of the situations where the MP was aware of the pregnancy, the woman told the MP about the pregnancy after *she* became aware of it, while in 29.1% of the situations, the MP accompanied the woman when the pregnancy was confirmed. According to the abortion-seeking women in this sample, only 1.3% of the male partners discovered the pregnancy themselves.

[10] In the subsample of participating couples, partners' reports on their shares in the decision process, largely overlapped ($\chi^2(9) = 47.6$, $p < .001$). The same overlap was seen in partners' reports of their shares in the decision outcome ($\chi^2(4) = 40.1$, $p < .001$). As a consequence, role division is looked upon as a concept at the level of the dyad.

[11] Satisfaction with the role of the woman and the role of the male partner was also found to be quite overlapping between partners within the same couple ($t(38) = 1.21$, $p = .23$ and $r = .27$, $p = .10$; $t(38) = 1.35$, $p = .19$ and $r = .40$, $p < .05$). However, as correlations are smaller here, satisfaction with role division is looked upon as a concept at the individual level.

Table 3

Both Partner's Shares in the Final Outcome of the Decision to Have an Abortion Along With Their Shares in the Process of the Decision, in the Sample of Abortion-Seeking Women (N = 176)

	Decision process							
	Woman decided alone		Woman decided after consulting the MP		Woman and MP decided jointly		MP decided after consulting the woman	
	n	%	*n*	%	*n*	%	*n*	%
Decision outcome	46	100	32	100	80	100	15	100
Abortion more the woman's decision	23	50.0	14	34.1	6	7.5	0	0.0
Abortion a mutually shared decision	22	47.8	24	58.5	67	83.8	1	6.7
Abortion more the MP's decision	1	2.2	3	7.3	7	8.8	14	93.3

Note. MP= male partner who was the man involved in the pregnancy; IMP= male partner who was involved in the abortion process and took part in the survey.

Division of Roles in the Decision-Making Process and Decision Outcome Depends on Relational Context[12]

To examine the link between the relational context of the abortion-seeking women and both partners' shares in the decision to have an abortion, four multinomial logistic regression analyses were performed in the sample of women[13]. The first analysis revealed that type of relationship was significantly associated with the level of involvement of the MP in the decision process ($\chi^2(12) = 70.12$, $p < .001$). As depicted in Figure 1, compared to women in a long-term relationship (>5 years), women who were in a non-romantic but significant relationship and those in short-term or middle-term romantic relationships were less likely to have an equally shared decision process with their MP about the unintended pregnancy ($\beta = -4.0$, $p < .001$; $\beta = -2.3$, $p < .01$; $\beta = -1.5$, $p < .05$ respectively).

In the second step of the multinomial logistic regression analyses, quality of the relationship (support, conflict, and depth) was added as a predictor for the division of roles in the decision process. The results revealed that only the degree of depth of the relationship was associated with the level of

[12] In addition to the role of relational features in MP's share in the decision, the role of socio-demographic characteristics was examined as well. Neither age, educational level, ethnic descent, or pregnancy gestation were associated with the level of involvement of the MP in the process or outcome of the decision.

[13] An explorative analysis on the male data revealed the same patterns as in the female data. Due to the large overlap between both partner's perceptions on the division of roles and due to the sample of IMPs being smaller (creating less power), and non-representative for all abortion-seeking couples, only the female data are presented for this analysis.

involvement of the MP ($\chi^2(3) = 16.3$, $p < .01$). More specifically, the more depth a woman attributed to her relationship with the MP (above and beyond type of the relationship), the higher the odds of them having decided jointly with the MP what should be done about the unintended pregnancy ($\beta = 1.6$, $p < .01$) or the higher the odds that the MP had played a more prominent role in the decision process than her ($\beta = 2.8$, $p < .01$).

A third multinomial regression analysis revealed a significant relationship between type of relationship and the MP's share in the final outcome (the decision for abortion), controlling for his share in the process of the decision ($\chi^2(8) = 18.6$, $p < .05$). As is depicted in Figure 2, for women who were in a significant non-romantic relationship with the MP or who were in a medium-term romantic relationship with the MP, the decision for abortion was less frequently a mutually shared and more frequently the MP's decision than for women who were in a long-term relationship with the MP ($\beta = -3.60$, $p < .05$; $\beta = -2.44$; $p < .05$). Quality of relationship, which was entered in the fourth step of the regression analysis, did not additionally contribute to the prediction of both partners' shares in the final decision to have an abortion ($\chi^2(2) = 4.7$, $p = .10$ for support; $\chi^2(2) = 5.3$, $p = .07$ for conflict; $\chi^2(2) = 3.8$, $p = .15$ for depth).

Satisfaction with Division of Roles Depends on Both Partner's Shares in the Decision Process and Outcome

In two multivariate linear regression models, degree of satisfaction with the own and the partner's role in the decision was looked at as a function of both partner's shares in the process and outcome of the decision for abortion, after controlling for the type of relationship. We did not control for relational depth in this analysis, as through this we would have excluded women who were in a non-significant relationship with their MP. Results revealed that women's degree of satisfaction with the role of the MP significantly differed depending on the role of the MP in both the process ($F(6,330) = 4.01$, $p < .01$) and the outcome of the decision ($F(4,332) = 2.87$, $p < .05$). Post-hoc comparisons revealed that when the MP was dominant in the decisional process instead of the woman, women's satisfaction was lower than average ($p < .001$). Women's satisfaction with the role of the MP was, on the other hand, higher than average when she took the decision after consulting the MP or when their decision on what to do about the pregnancy was fully joint ($p < .05$ and $p < .01$ respectively). Satisfaction was equal in case of the decision being made fully jointly compared to when the MP only had a side role ($p = .45$) or in case of the MP having a side role compared to when he had no role ($p = .60$). There was no association with women's satisfaction with their own role. This is illustrated in Figure 3. Similarly, when the final decision for abortion was more the MP's decision than the woman's decision, women were significantly less satisfied with the MP's role in the decision ($p < .01$). Satisfaction with the role of the MP was equal in case of the decision being mutually shared with the

MP compared to when the decision was mostly the woman's decision (p = .73). This is illustrated in Figure 4. However, the actual power of this post-hoc analysis was very low. When the IMP's level of satisfaction with the own and the women's role (after controlling for type of relationship) was examined in function of the IMP's perception on both partner's shares in the decision, results revealed a significant association with the MP's share in the final outcome of the decision to have an abortion (F(4,86) = 4.5, p < .01). Post-hoc analyses showed that when the abortion was more the MP's decision than his partner's decision, the levels of satisfaction with their own and the corresponding woman's roles, were significantly lower than the mean (p < .001, p < .01 respectively). Satisfaction with their own role was equal in case of the decision being mutually shared with the woman, compared to when the decision was mostly the woman's decision (p = .57, although the actual power of this post-hoc analysis was very low). This is also illustrated in Figure 4.

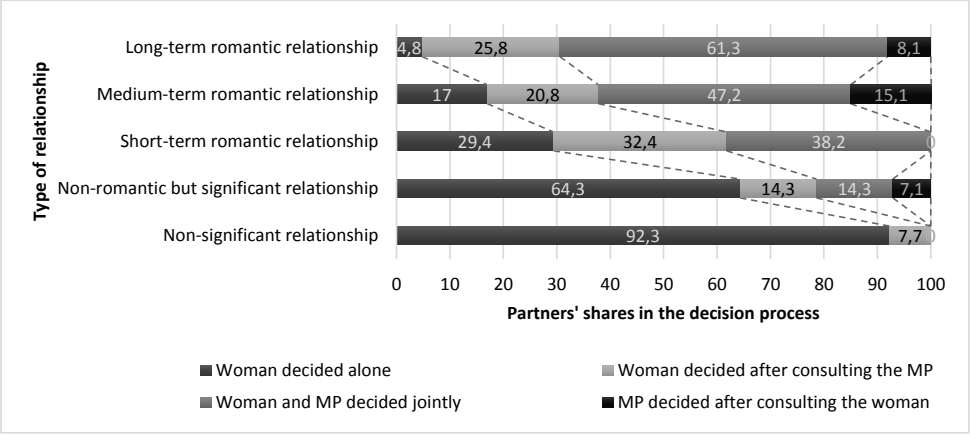

Figure 1. Both partners' shares in the decision process along type of relationship.

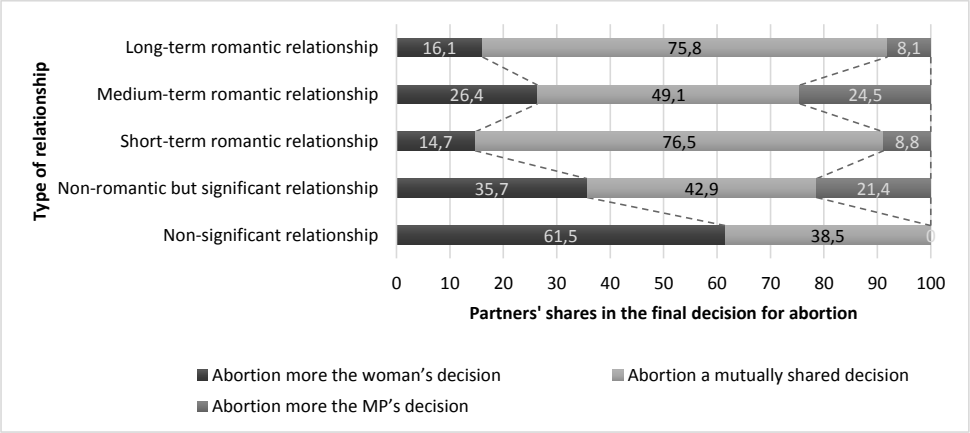

Figure 2. Both partners' shares in the final decision for abortion along type of relationship.

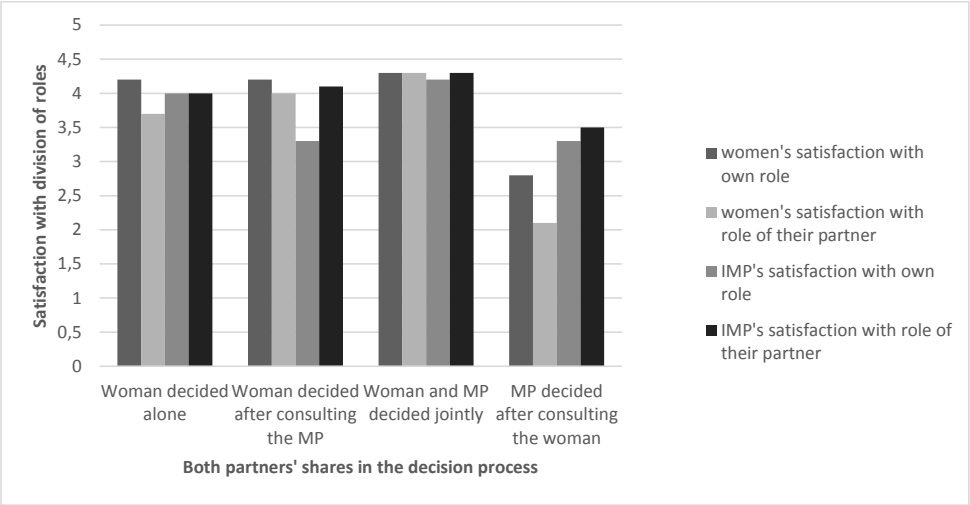

Figure 3. Women's and IMP's satisfaction with the division of roles along the MP's share in the decision process.

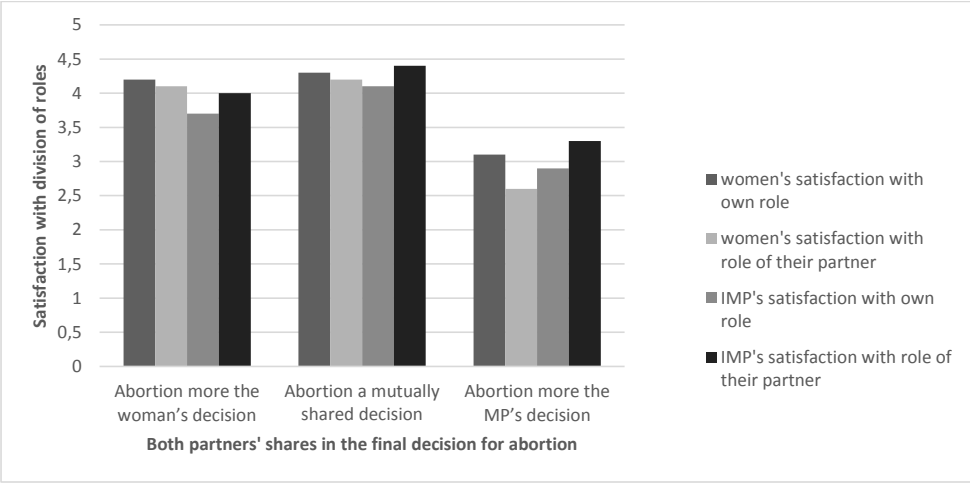

Figure 4. Women's and IMP's satisfaction with the division of roles along the MP's share in the final decision for abortion.

DISCUSSION

This study questioned a substantial group of abortion-seeking women and a subsample of male partners who are aware of the planned abortion, about their share in the process and outcome of the decision to have the induced abortion. First and foremost, the results reveal that for a great deal of abortion-seeking women, the male partner has a significant share in the process and/or the outcome of the decision although the degree of involvement might vary. In addition, most women and involved male partners seem to be very satisfied with their shares in the decision to have an abortion although both partners tend to be more positive about the role of the woman than the role of the male partner. Furthermore, the results show that there are different ways in which the male partner can be involved in the decision to have an abortion and that these scenarios are rooted in the relational background of the women. The situation in which the male partner dominated the process or outcome of the decision might either give rise to or result from dissatisfaction in both partners.

Main Findings

The MP's role varies from only being consulted by the abortion-seeking woman (which was the case for about one fourth of the MPs), to being an equal decision partner (which was the case for almost half of the MPs) to taking the lead in the decision (which was the case for a minority of the MPs). These results confirm the findings of Reich and Brindis (2006), who reported a continuum of involvement of the male partner in an induced abortion. In contrast to their study, however, where one third of the men who were confronted with an induced abortion were excluded from the decision process by the involved women, our results revealed that only one fourth of the abortion-seeking women did not involve their male partner in the decision process. The difference might be due to recruitment strategy: recruiting the male partners who have been involved in an abortion through advertisements might not yield the same sample as when women and male partners are recruited after entering an abortion clinic. This is reflected in our sample of involved male partners where there was quite a high percentage that stated that the decision process was an equal joint one and where the level of satisfaction with the division of roles was high. This might be different for male partners who are willing to talk about the abortion weeks or months after the procedure (i.e., their level of satisfaction with the division of roles might be lower; see Reich & Brindis, 2006).

Results regarding both partner's shares in the outcome of the decision also revealed different scenarios. For a significant proportion of the abortion-seeking women, the final decision to have an abortion was one that was mutually shared by both of the partners. In almost one fourth of the situations, however, the decision was more dominated by the woman's wishes, and, in a minority of the situations, the decision was dominated by the wishes of the male partner. These results confirm

the findings of Jones and colleagues (2011) that there is usually a high degree of male support for women's decision to have an abortion, and the findings of Costescu and Lamont (2013) where the majority of the interviewed couples stated that the abortion was a mutual decision. When the abortion is not an equally shared decision, the imbalance is mostly on the woman's side, as has already been postulated by other researchers (Costescu & Lamont, 2013; Vandamme et al., 2016).

Interestingly, a substantial group of women who did not involve the male partner in the decision process nevertheless perceived the abortion as a decision that equally represented the wishes of the male partner as well as herself. This brings to light the fact that women might take the expected needs, goals or desires of others–in this case the male partner–into account, even when these others are not actively or directly involved in the decision process (Ekstrand et al., 2009; Kirkman et al., 2011). This might be related to the difference between strategic enactments of power in couples (the direct or indirect *attempts* to influence the other partner's outcomes) and both partner's potential *sources* of influence (e.g., Simpson et al., 2015). On the other hand, a substantial group of women did involve their male partner in the decision process but perceived the decision to have an abortion as mostly dominated by what they wanted, and less by what their male partners wanted, demonstrating that a shared decision process (including the exchange of information related the decision to each other) does not necessarily mean a mutually shared outcome of that decision, a conclusion that is similar to those put forward by other authors looking at shared decision-making in couples (Meier, 1999; Zeiler, 2007). These results certainly bring to light the different dimensions and as such the complexity of the involvement of male partners in the decision to opt for an abortion.

The results also revealed the variety of relational contexts in which abortion-seeking women decide to have an abortion. Although a great number of abortion-seeking women were in medium- to long-term romantic relationships with the male partner who was involved in the pregnancy, almost one in six was in a non-romantic relationship and about one in five was in a short-term romantic relationship. Since pregnancies are evidently more likely in non-single women where sexual frequency and, as such, the odds of an unintended pregnancy are higher, it is not surprising that most abortion-seeking women are in romantic relationships with the MP (Bankole, Sing, & Haas, 1999). However, since women in less stable relationships are more likely to decide to have an abortion in the event of an unintended pregnancy, it is not surprising that there is a reasonable number of abortion-seeking women in non-romantic or short-term relationships as well. The quality of the established relationships between the abortion-seeking woman and the MP seemed to be quite high, as the degree of support in the established romantic relationships was even higher than in a reference group of Belgian couples. This high perception of relational quality might be due to the women in established relationships receiving a lot of support during the still ongoing process of the abortion, something that has already been shown by other authors (Jones et al., 2011). Alternatively, it might be a selection effect, indicating

that couples who stay together in a romantic relationship after having decided to undergo an abortion, are the couples where the degree of support was already high and the level of conflict was already low before the occurrence of the unintended pregnancy. Yet another hypothesis is that more women in high quality relationships are overrepresented in the study.

The variety of relational contexts is reflected in the variety in the involvement of the male partner, both in the process of deciding and in the outcome of deciding. The male partners of women who were in long-term romantic relationships were more likely to have an equal contribution to the decision process than male partners of women who were in non-romantic, short-term or middle-term relationships. This resembles the findings of Jones et al. (2011) on which women are more likely to disclose an abortion to the relevant male partner. In addition to the type of relationship, the depth of the relationship with the corresponding male partner also played a role in the chance that the male partner had an equal contribution to the decision or not. The level of received support from the male partner and the level of conflict in the relationship did not make a difference in whether or not he has been involved, however. Meier et al. found similar results including the absence of an association between general satisfaction with the relationship and couples' level of joint decision-making in household contexts (Meier et al., 1999). This indicates that it is mostly the degree to which an abortion-seeking woman perceives her male partner as a significant person in her future life (related to the degree to which she depends on him) that determines his involvement in the process, rather than the degree to which she perceives him as a person who is generally supportive of her or with whom she expects not to have conflict. This certainly brings to light the need to think about the involvement of the male partner in women's decisions to have abortions from a mutual future and interdependence-perspective, as is described by the Investment Model of Commitment in couples (Rusbult et al., 2011; Vandamme et al., 2016).

An interesting finding was the association between type of relationship and the degree to which the final decision to have an abortion was mutually shared by both of the partners versus more in favor of one of the partners. Our study revealed that the decision to have an abortion was more likely to be a decision more attributable to one of the partners in non-romantic or in middle-term romantic relationships in comparison to short-term or long-term relationships. The hypothesis here is that in short-term romantic relationships, the decision to have an abortion is a more evident one for both of the partners. This is reflected in research on the demographic profile of abortion-seeking couples: they are more likely to be in unstable relationships than those who decide to carry an unintended pregnancy to term (Bankole et al., 1999). Indeed, women and men both want to become parents at the right time, with the right partner, which probably motivates partners in developing relationships to opt for an abortion (Kero et al., 2001). The hypothesis for long-term romantic relationships, on the other hand, might be that these couples have already discussed the topic of being

confronted with an unintended pregnancy before, which makes it easier for them to mutually decide on having the abortion. In contrast to our hypothesis, relational quality (especially level of commitment), after controlling for relational type, did not predict a higher odds of the decision being mutually shared by both of the partners.

Finally, the results demonstrate that although women and involved male partners were in general highly satisfied with how the decision had been achieved between them, both are more satisfied with the role of the woman than the role of the male partner. This might be associated with what other authors have described as the male partners' feelings of helplessness and women's feelings of sometimes carrying sole responsibility during the abortion process (Halldén & Christensson, 2014; Kimport et al., 2011). Importantly, both partners were equally satisfied with the division of roles whether the decision to have an abortion was mutually shared or whether the power imbalance was more on the woman's side. This might contrast with studies hypothesizing that the support of a male partner might be important for *all* abortion-seeking women (Major et al., 1990). We might convince ourselves that women as well as male partners often have good reasons for a power imbalance between them during the decision to have an abortion. Indeed, other authors have demonstrated that male partners sometimes want to disengage themselves from the decision process (Reich & Brindis, 2006; Sharp, 2014). But a further interesting part of our results is that for those couples where the male partner took the lead in the decision process or where his wishes dominated in the final decision to have an abortion, both the women and the male partners were much more likely to express low satisfaction with the division of roles. Previous authors have indeed already brought to light that women do not want the decision to have an abortion to be to a decision in which the needs of other people are at the forefront (Kimport et al., 2011; Vandamme et al., 2016)[14]. For the male partners, however, it seems that they do not want to have the largest power in the final decision either. This might be associated with male partners wanting to behave as "responsible" men who respect women's legal rights and power in the decision to have an abortion, as stated by Sharp et al. (2014). Research has indeed shown that when the actual decision situation does not fit the ideal scenario[15] (of women being the primary decision-makers about reproductive health issues), satisfaction is low (Davis, 1976; Dekkers, 2009). As has been suggested by others, future research on the effect of social norms regarding gender and fertility, on power dynamics in the decision to have an abortion, is necessary to

[14] Participants were also asked to report on the *ideal* (instead of the *actual*) division of roles in the decision process (data not shown). These data revealed that only two women *wanted* the male partner to take the lead in the decision. None of the involved male partners *wanted* to take the lead themselves.

[15] The data on the ideal scenario of male involvement also showed that the actual division of roles largely followed the desired division of roles.

deepen our knowledge on the variety of men's roles in reproductive health issues worldwide (Dudgeon & Inhorn, 2004).

Implications for Practice

Health care providers and counselors working with women should acknowledge the male partner's often significant role in the process of deciding to have an abortion. They should however be vigilant to couples where the male partner has taken a lead in the decision to have an abortion since this distinction of roles has been evaluated negatively by both of the partners. These couples might be vulnerable to relational problems or individual feelings of anger (in the women) or guilt (in the male partners).

In addition, policy makers, and abortion health care providers should be aware of the absence of a one-size-fits all-approach regarding the involvement of male partners since different forms of role division between partners are found to be equally satisfying for both of the partners. Moreover, the relational future and current stability of the relationship with the male partner should always be taken into account.

Finally, health care providers could help to enhance both partners' satisfaction with the role of the MP in the decision for abortion by gaining insight into both partners' perspectives on the ideal way for him to be involved.

Strengths, Limitations and Future Research

This study asked a substantial number of women and a subsample of involved male partners about how they perceived their share in the decision to have an abortion. It differentiated the decision process in terms of women deciding jointly versus independently from their male partners what to do about the unintended pregnancy, from the decision outcome in terms of who's wishes dominated in the final decision to have an abortion. It also looked at the positive versus negative evaluations of that decision process, in line with existing frameworks on shared decision-making, power and equity in couples and families. Furthermore, it explored the variety of relational contexts in which abortion-seeking women reside when deciding to have an abortion, by making use of a validated relational measure.

One of the limitations of this study was that men who were not involved in the abortion process could not be questioned about how they evaluated the fact that they were excluded from the process. Other authors have, however, made serious attempts to reach these men (e.g., Naziri, 2007; Reich & Brindis).

Another limitation is that we did not uncover any of our participants' motivations for sharing their decision to have an abortion with their partner. By focusing on the purely dyadic process of power

and equity in the decision, we set aside the known influence of power dynamics as prescribed by cultural or societal norms such as the influence of gender roles (Dekkers, 2009). In addition, we did not probe the women's reasons for seeking an induced abortion. It might be the case that for women for whom the reason for having an abortion is the desire to stop childbearing because of having reached an ideal family size, the male partner might play a more important role than for women for whom relational problems are the main reason for having an abortion. As suggested by Jones et al. (2011), future research should gain further knowledge on women's (culturally-based or relational) motives for (not) involving the MP, as well as male partners' motives for not being actively involved.

Thirdly, participants were not a representative sample of the overall population of abortion-seeking women and involved male partners. Firstly, in line with what Kero and colleagues (1999) did, we asked the abortion-seeking women to motivate the male partners who were absent during the first visit to the abortion center, to participate in the study too. However, only eight of these absent men participated in the second part of the study. Although these absent men reported a similar degree of satisfaction with the division of roles, a similar level of involvement in the decision, and an equal relational quality as the male partners who were yet present during the first visit to the abortion center (results not shown), a selection bias towards male partners who were more involved in the decision to have an abortion and who are of higher importance to the abortion-seeking woman, certainly has occurred (see beneath). In addition, despite various attempts to minimize dropout, only a subsample of the women and men who participated in the first wave of the study, took part in the second wave. Logistic barriers (e.g., the necessity to have a computer with internet connection, and to log in with a personal code), loyalty issues (participants did not meet the main researcher in person) as well as the quite high burden on participants (filling out a lengthy questionnaire during a possibly distressing period) might have caused dropout. Women and men with a high educational level were also overrepresented in this sample. This is a recurrent issue in survey research on pregnancy decisions (see for instance Brenning, Soenens, & Vansteenkiste, 2015). In addition, although there were no differences in relational type between male participants and non-responding IMPs, IMPs in high quality relationships are most likely overrepresented in our sample. This is supported by the difference in relational depth, satisfaction with the role of the MP, and relational quality between women whose male partners participated in the study and those for whom this was not the case. This is in line with what Kero and colleagues found (1999). The male partners who participated in our study could hence be indicated as "double involved male partners" as they have been involved by the women in the abortion process (as they are all aware of the abortion) as well as did they participate in the study (which meant that he either accompanied the woman to the abortion center or that the according woman asked him to participate in the study). A sample of involved male partners as we recruited them could hence never be representative for the overall population of male partners of abortion-

seeking women. We also expect women and IMPs in conflicting relationships might be less willing to participate in a study on the relational context of the decision to have an abortion (see also Vandamme et al., 2016). In addition, this study was conducted in a liberal Western country where quite a lot of attention is given to gender equality, and where (romantic) partners are quite an evident decision partner in reproductive issues. Our findings on male partners' involvement are therefore incomparable with findings in, for instance, Eastern countries where the extended family (including parents, for instance) has a much more important role in these issues, or in African societies where men exercise a much more dominant position over women when it comes to childbearing decisions, and where abortion laws, access to abortion, and gender equality are totally different (Dudgeon & Inhorn, 2004; Simpson et al., 2015). In addition, women and men from non-Western origins, especially first generation immigrants, are probably underrepresented in our sample because of language or logistic barriers. Furthermore, as demonstrated by Dudgeon & Inhorn (2004), an increased focus has nowadays been placed on men as significant partners in contraception and fertility issues. Future studies on the role of the male partner in the decision to have an abortion should try to reach more socially disadvantaged couples and couples in lower quality relationships at the time of the abortion as well as seeking to deepen our knowledge on the effect of culturally-based social norms regarding gender and power in couples.

Furthermore, as this study was cross-sectional, we could not explore the direction of the associations that were found. It is therefore impossible to know whether the quality of the relationship influenced the level of involvement of the male partner or whether the involvement of the male partner in the decision increased the depth of the relationship. The latter is equally likely as the former. In addition, we do not have information on women's relationship statuses before the occurrence of the unintended pregnancy. It is possible that the relationship between the pregnant woman and the male partner changed in the time since the decision to have an abortion first arose (Jones et al., 2011). Future research should try to disentangle these mutual influences by doing longitudinal and qualitative research on the role of male partners in the decision for abortion.

Finally, we relied on self-reports to explore both partners' perceptions on the degree to which the decision was shared. Others have already suggested that multimethod designs in which qualitative observational methods are combined with survey methods give rise to better insights into the processes of influence and power by which couples reach consensus on these decisions (Dekkers, 2009; Simpson et al., 2015). Future research could use data from counseling sessions to expand our knowledge on couples' processes of deciding to opt for an abortion.

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4 The decision to have an abortion from both partners' perspectives

Based on Vandamme, J., Buysse, A., Loeys, T., Vrancken, C., & T'Sjoen. G. (2017). The decision to have an abortion from both partners' perspectives: A dyadic analysis. *The European Journal of Contraception and Reproductive Health Care, 22,* 30-37. doi:10.1080/13625187.2016.1255940

ABSTRACT

Objective. Male partners are often involved in induced abortion although they have no legal rights. It is however unknown how women's thoughts and feelings regarding the decision for abortion are associated with the decisional experiences of the involved male partners and vice versa.

Methods. Flemish women and their involved male partners (IMP) filled out a questionnaire on abortion motives and feelings of decisiveness in the abortion center waiting room (*N* = 106 couples). Actor Partner Interdependence Models investigated whether the decisiveness of one partner was associated with a subjective feeling of autonomy (high internal, low external abortion motivation) and decisiveness of the other partner, above and beyond the own feeling of autonomy and personal vulnerabilities for being uncertain.

Results. Partner congruence in motivation and decisiveness was substantial (*r* = .23 to .42), especially for cohabiting partners. The IMPs were less internally motivated for the abortion than the women but both partners reported more internal than external motives, and they both tended to feel certain. In contrast to the women, a higher subjective feeling of autonomy in the IMPs was not associated with feeling more certain. When accounting for partners' living situation, levels of uncertainty were not only associated with personal vulnerabilities for being uncertain, but were also related to the degree of uncertainty and subjective level of autonomy of the other partner.

Conclusion. Partners' thoughts and feelings regarding the decision for abortion partially have an interpersonal basis and mostly run parallel despite an inherent gender difference in level and importance of decision autonomy.

INTRODUCTION

Today, women in many Western countries have won the legal battle for induced abortion (Pinter et al., 2005). Since 1990, Belgian women have been permitted to terminate an unwanted pregnancy on their own request till 12 weeks of gestation, subject to legal constrictions such as a mandatory waiting period and attendance at a pre-abortion counseling session. To give women full ownership in the decision about continuing the pregnancy, men have no formal legal rights in induced abortion. Despite the absence of legal rights for them, men are very often involved in the decision to opt for abortion, either directly or indirectly (Jones, Moore, & Frohwirth, 2011; Kero, Lalos, Högberg, & Jacobsson, 1999; Naziri, 2007). Unfortunately, to date little attention has been paid to the decisional experiences of the involved male partners (further indicated as IMP) themselves (Kero et al., 1999; Naziri, 2007).

The reality of male partners' involvement in the decision for an abortion in the context of women's legal reproductive ownership points to the theoretically understood difference between autonomy and dependence in human decisions (Deci & Ryan, 2008). According to Self-Determination Theory (SDT), autonomy refers to the volitional aspect of decisions, i.e., the degree to which the decision-maker feels free from external pressure to make the decision while dependence refers to the inevitable involvement of others in a decision-making process (Deci & Ryan, 2008). In SDT, a subjective feeling of autonomy, conceptualized by being more internally than externally motivated, is set central in the adaptation to minor or key decisions in life (for instance the decision to become pregnant; Brenning, Soenens, & Vansteenkiste, 2015)[1]. Previous research on abortion looking to demonstrate a role for decisional autonomy, in which women can decide for an abortion for reasons they themselves value and as a function of other important goals in life has found to it be important for women's emotional adaptation post-abortion (Kimport, Foster, & Weitz, 2011). We might then question the degree to which the IMPs feel they themselves have autonomy in the decision for abortion and how important this feeling of autonomy is for their own adaptation to the decision. As is seen with abortion-seeking women, IMPs are often motivated to decide for an abortion by the desire to provide good parenting, which might represent a high internal motivation (Kero et al., 1999). But while most of the IMPs seem to experience the abortion as being a personal, and volitional choice too, other men feel overtly or silently pressured by the woman to decide for abortion, demonstrating a certain degree of external motivation for the abortion (Kero et al., 1999; Naziri, 2007).

[1] In this study, we refer to autonomy as "having a *sense* of autonomy". This psychological definition of autonomy differs from philosophical conceptualizations of autonomy.

In addition to the very little research on the IMPs in induced abortion, to date authors have mostly focused on women's intrapersonal experiences with the decision for abortion and the personal, relational or societal factors associated with it (Foster, Gould, Taylor, & Weitz, 2012; Major et al., 2009), set apart from the actual experiences of the involved male partner. According to interdependence theory, this within-person focus neglects the possible interdependence between partners' cognitions, motivations, and emotions (Rusbult & Van Lange, 2003). The theory then states that within relationships, intrapersonal phenomena such as motives or feelings towards a certain decision get additional meaning in an interpersonal framework where the actual experience of the other partner towards that decision is also taken into account (Rusbult & Van Lange, 2003).

Although it has, for instance, been shown that perceived responsiveness and support of relatives (including the IMP) decreases women's risk of abortion related difficulties (Foster et al., 2012; Kimport et al., 2011), the degree to which her potential decisional difficulties are related to the actual thoughts and feelings of the IMP towards the decision for abortion, has not been investigated yet. Flipping the issue on its head, there is also little known about whether and how the IMPs' adaptation to the decision is associated with the actual thoughts and feelings regarding the abortion of the abortion-seeking women.

In this study, we therefore aim to map the degree and structure of interdependence between both partners' feelings of autonomy in the decision for abortion on the one hand, and both partners' feelings of decisiveness regarding the abortion on the other hand. The latter has been shown to be a good indicator for the emotional adaptation to the decision for abortion (Foster et al., 2012; Kimport et al., 2011). Firstly, we explore the degree to which partners' internal and external motives for abortion and feelings of decisiveness resemble each other, both within the couple as at a gender based level. Secondly, we investigate whether partners' possible feelings of uncertainty are not only associated with intrapersonal vulnerabilities, i.e., personal difficulties in making decisions in general, as predicted by the co-occurring risk perspective on induced abortion (Foster et al., 2012; Major et al., 2009), on the one hand, or low subjective feelings of decisional autonomy, as predicted by SDT, on the other hand (Deci & Ryan, 2008; Kimport et al., 2011), but also depend on the actual subjective feelings of autonomy and decisiveness of the other partner, as predicted by Interdependence Theory (Rusbult & Van Lange, 2003). Finally, it is examined whether the structure of interdependence between both partners' experiences differs along the relational context of the involved partners.

METHOD

Study Design

From January to September 2015, every adult (age > 18) Dutch-speaking woman seeking an induced abortion in one of the five Flemish abortion centers (located in the northern part of Belgium) was invited to take part in a longitudinal study on the decision-making process underlying induced abortion. When a man accompanied the abortion-seeking woman, he was asked to participate too, after having confirmed he was the involved male partner (IMP). Both partners could participate independent of each other. Both were told about two options: participating in a full diary study or filling out a questionnaire at four fixed data collection points (before the counseling session, one or two days after the counseling session, the evening of the abortion procedure, and two weeks after the procedure). For the current analyses, only the data of the first data wave (before the counseling session) were used. When the woman or the partner declined to participate, we asked them to fill out a reply-card stating their age, nationality, civil status, and the reason for non-participation. One third of the non-responders agreed to give this information. A paper-and-pencil questionnaire was filled out by each woman and the corresponding partner (when present) in the waiting room of the abortion center, before entering the counseling session and before the start of the mandatory six-day waiting period. When the corresponding partner was absent, women were invited to ask them to fill out an electronic version of the first questionnaire, the day after the counseling session. This option was taken by ten partners (8.1% of the total number of male participants in our study). Both partners needed to sign an informed consent before they filled out the paper-and-pencil or electronic questionnaire and the study was approved by the Ethical Committee of the University Hospital Ghent.

Measurements

Subjective feeling of autonomy: Internal and external abortion motivation.

Two subscales of the Motives for Parenthood questionnaire, constructed by Brenning and colleagues (2015) are adapted for use in current study: the *identified regulation* (4 items) and *external regulation* (4 items) subscale. The scales are based on theory and previously developed operationalization of pregnancy motivation, making a distinction between internal (own) and external (other-related) motives for making a decision (Brenning et al., 2015). Items measuring the degree of internal abortion motivation include, for instance, "Terminating this pregnancy will help me to fulfill the most important goals in my life" or "Terminating this pregnancy seems the only way to be able to fully develop as a person in the future". Items measuring the degree of external abortion motivation include, for instance, "I would not feel accepted by the people around me if I were to have a child now"

or "Choosing to have a child now would give me the feeling that I have failed with regard to the expectations of the people around me". Both women and the involved male partners were asked to independently rate the items on a 5-point response scale (1 = *totally disagree*, 5 = *totally agree*). Scores for both subscales ranged from 4 to 20. Cronbach's alphas for the internal motives scale were 0.79 for the women and 0.88 for the male partners, while for the external motives scale they were 0.76 and 0.71, respectively. The higher the score on the internal motives scale, the more the abortion was experienced as an autonomous decision involving free choice. The higher the score on the external motives scale (in the absence of a high degree of internal motivation for having the abortion), the more the abortion was experienced as a non-autonomous decision influenced and controlled by external factors[2].

Adaptation to the decision for abortion: Satisfaction-uncertainty.

To measure both partners' feelings of decisiveness with regard to the decision for abortion, the *satisfaction-uncertainty* subscale of the Dutch Decision Evaluation Scale was used (Stalmeier et al., 2005). This scale comprises of five items with a 5-point response scale (1 = *totally disagree*, 5 = *totally agree*) and maps patients' satisfaction and uncertainty about medical decisions. Sample items are "I expect to stick with my decision" (an item where the score is reversed) and "I find am finding it hard to make this choice". Scores range from 5 to 25. The lower the score, the lower the level of uncertainty towards the decision for abortion and the higher the emotional adaptation to that decision. Cronbach's alpha was 0.82 for the female and 0.75 for the male sample.

Personal vulnerability for being uncertain: General ability for cognitive closure (AAC).

To control for the role of personal difficulties in making decisions in general, the Ability to Achieve Closure scale (AAC) was used (Roets & Soetens, 2010). The AAC measures the perceived ability to cognitively "close the mind" to alternative options when making a decision. Sample items of the AAC are "When faced with a problem I usually see the single best solution very quickly" or "I would describe myself as indecisive" (reversed item). The scale comprises 15 items on a response scale from 1 (*totally disagree*) to 5 (*totally agree*). Scores on the AAC were calculated by taking the mean of the scores on the 15 items and range from 1 to 5. The higher the score, the easier it is for the person to

[2] In contrast to the study of Brenning et al. (2015), we did not calculate an overall Relative Autonomy Index by subtracting the scores on the external motivation scale from the scores on the internal motivation scale. The theoretical argument for separating the internal and external motives scale is based on the assumption that *external* influences to decide for abortion (e.g., to please the mother) might as well be associated with a high *internal* motivation for having the abortion (e.g., because having a good relationship with the mother in the future is important for the abortion-seeking woman). This theoretical hypothesis was indeed confirmed by the absence of a negative correlation between these two scales, as outlined in Table 3.

make decisions in general, and the lower the level of uncertainty about a certain decision. Cronbach's alphas were .91 and .90.

Study Sample

From the total sample of women and men who agreed to participate in the first wave of data collection, a subset of couples was drawn (N = 106), for whom there was a link with the corresponding partner. The process of selection of participants is shown in Figure 1.

In total, 436 women and 123 partners agreed to participate in the first data wave. Response cards were returned by 704 female and 222 male non-responders. Both for women and their partners, no differences were found between participants and non-responders in age ($t(418) = 0.62$, $p = .53$; $t(112) = 0.71$, $p = .48$), or nationality ($\chi^2(1) = 0.83$, $p = .36$; it should be noted that for the partners, χ^2 could not be calculated because of the small percentage of participating men with a non-Belgian nationality). Marital status did differ, however, ($\chi^2(3) = 10.8$, $p < .05$ and $\chi^2(3) = 34.6$, $p < .001$) with a higher percentage of single women and men in the study sample than in the non-responder group (53.9% versus 45.7% for the women and 47.5% versus 44.0% for the partners).

From this first data wave, we gathered data for 106 couples (24.1% of the total female sample and 85.4% of the total male sample). For all further analyses, only this sample of complete couples was used.

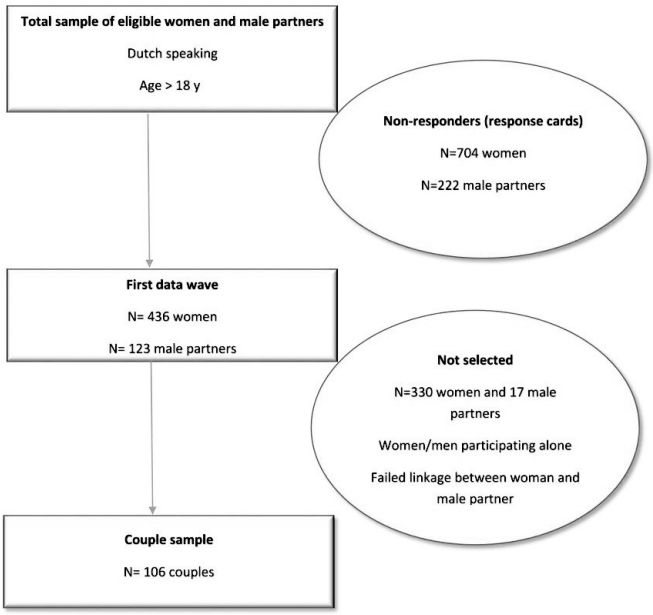

Figure 1. Overview of sample selection.

Analysis

First, paired t-tests were used to examine general woman-partner discrepancies in mean degree of internal, and external motivation, and level of uncertainty related to seeking an abortion. Correlation analyses were performed to investigate the degree of interdependence in both partners' scores. These analyses were performed in *SPSS*, version 20.

To explore the relationships between subjective feelings of autonomy (high internal and low external motives for the abortion) and decisiveness within and between partners, we relied on the *Actor-Partner Interdependence Model* (APIM; Cook & Kenny, 2005). This model offers an appealing framework to model interdependence in dyadic relationships by its definition of actor and partner effects. An actor effect indicates how much a person's outcome is predicted by his or her own characteristics (i.e., an intrapersonal association), whereas a partner effect indicates how much a person's outcome is affected by the corresponding partner's characteristics (i.e., an interpersonal association). In the APIM-model, the relationship between one's internal and external abortion

motivation and one's own and one's partner's degree of uncertainty about the decision was assessed, while accounting for interdependence between the woman's and the partner's uncertainty scores and examining the role of general ability for cognitive closure. We simultaneously examined different actor and partner associations between motivation and decisiveness in women and their partners.

The APIM was tested on a subsample of 96 couples for which complete data on the three main variables (internal, and external motivation and uncertainty) was available. Both APIMs were fitted using *Structural Equations Modeling* (SEM) in the R-package *Lavaan*.

RESULTS

Sample Characteristics

In Table 1, the socio-demographic features of the 212 women and men in the couple sample are depicted. More than half of the women had already been pregnant before and about one fourth had already experienced an induced abortion. More than half of the women (62.3%) were living together with a partner, while this was the case for 61.5% of the abortion-seeking male partners. Presumably for most of them, the partner who they were living with was also the partner who was participating in the study. We do not know, however, the exact number of abortion-seeking women for whom the participating partner in the study was not the partner who was involved in the pregnancy or who was not the woman's current partner. We estimate the percentage of couples for whom this was the case at 4-5% (based on information gathered in the second data wave).

Women and men in the couple sample did not differ significantly from the sample of women and men where the partner did not participate in the study, either in marital status ($\chi^2(3) = 0.81$, $p = .85$ and $\chi^2(3) = 3.83$, $p = .28$ respectively) or in living situation ($\chi^2(1) = 2.99$, $p = .08$ and $\chi^2(1) = 0.51$, $p = .48$). Their degree of uncertainty regarding the abortion was also equal ($t(426) = -1.6$, $p = .10$ for the women and $t(114) = .00$, $p = .99$ for the male partners). Internal and external motivation was found to be equal in both groups, both for women ($t(422) = -.65$, $p = .52$; $t(423) = .17$, $p = .86$) and for the male partners ($t(112) = .55$, $p = .58$; $t(11) = -.60$, $p = .55$).

Table 1

Sample Characteristics (N =106 couples)

	Women		Male partners	
	n	%	*n*	%
Age, in years, mean *(SD)*	104	*M* = 30.0 *(6.8)*	98	*M* = 32.2 *(7.7)*
Educational attainment	98		95	
No formal education/	5	5.1	4	4.2
Primary High School	12	12.2	9	9.5
Secondary High School	42	42.9	48	50.5
Bachelor/Master degree	39	39.8	34	35.8
Civil status	105		103	
Single	53	50.5	47	45.6
Cohabiting	24	22.9	24	23.3
Married	21	20.0	23	22.3
Divorced	7	6.7	9	8.7
Widowed	0	0.0	0	0.0
Living situation	106		104	
Cohabiting with a partner (and others)	66	62.3	64	61.5
Living alone (or with others), without a partner	40	37.7	40	38.5
Ethnic descent	103		103	
Native	90	87.4	89	86.4
Western immigrant	10	9.7	8	7.8
Non-Western immigrant	3	2.9	6	5.8
Gravidity[#]	102		101	
No previous pregnancy	35	34.3	40	39.6
Previous pregnancy	67	65.7	61	60.4
Previous abortion	102		100	
No previous abortion	74	72.5	78	78.0
Previous abortion	28	27.5	22	22.0

Note. Sum of subsections differs from the total *N* because of missing data.

[#]Although gravidity can theoretically only be used for defining the pregnancies in women, we use it here both for men and women.

Both Partners' Experiences of Subjective Decision Autonomy, and Uncertainty

In Table 2, the descriptive results on both partners' degree of internal and external motivation (representing the level of subjective decision autonomy) and uncertainty are shown. Both women and the male partners reported more internal than external motives for the decision to seek an abortion. Internal motivation for abortion was, however, higher in women, indicating that women generally feel more autonomous in the decision than their male partners do. The degree of external abortion motivation was, on the contrary, equal for both partners. Male partners and women reported an equal degree of uncertainty about the decision, which was moderately low for both partners (12 on a scale from minimum 5 to maximum 25, which is below the midpoint of 15).

In Table 3, the between-partners as well as within-person correlations between the scores on the three main variables are represented. From the significant between-partner correlations on the diagonal we find that feelings of autonomy and decisiveness of partners within a couple are interrelated with each other. The more uncertainty the woman encountered, the more the male partner was likely to be uncertain ($r = .42$, $p < .001$). The more internally motivated the woman was for having the abortion, the more the male partner felt that the decision is made for internal reasons too ($r = .30$, $p < .01$). However, it is worth noting that the degree of interdependence between partner's scores on internal abortion motivation was higher for partners who were cohabiting ($r = .40$, $p < .001$; not in table) than when the woman was living apart from the male partner ($r = 0.12$, $p = .441$; not in table)[3].

Interestingly, when male partners experienced more external pressure to have the abortion, they were also more internally motivated for the decision ($r = .31$, $p < .01$; see Table 3). For women this was not the case, however, as the association between external and internal abortion motivation was not significant.

[3] The mean level of internal motivation for having the abortion and the mean level of decision uncertainty did not differ between partners living together and those living apart (data not shown). The mean level of external motivation to opt for abortion was however somewhat higher in the group of non-cohabiting couples compared to the group of cohabiting couples, but only as reported by the involved male partners ($t(100) = 2.71$, $p < .05$).

Table 2

Descriptive Statistics

	Women		Partners		Paired t-test
	M	*SD*	*M*	*SD*	*t (df)*
Motives for abortion *[min. 4 – max.20]*					
Internal motivation	14.2	4.0	12.7	4.5	3.14 (99)**
External motivation	8.1	3.9	7.4	3.6	1.68 (101)
Uncertainty about the abortion[4]	12.0	4.8	11.8	4.3	0.56 (104)
[min. 5 – max. 25]					
General ability for cognitive closure	3.7	1.0	4.1	0.9	-3.27 (87)**

Note. ** *p*< .01.

Table 3

Correlations between Internal and External Motives for Abortion, and Levels of Uncertainty, Within and Between Partners

	1	2	3
1. Internal motivation	**0.30****	-0.11	-0.32**
2. External motivation	0.31**	**0.23***	0.37**
3. Uncertainty	-0.21*	0.00	**0.42****

Note. * $p < .05$, ** $p < .01$. Correlations for the women are presented above the diagonal and correlations for the male partners are presented below the diagonal. Correlations between women and male partners are presented on the diagonal.

Intrapersonal and Interpersonal Associations Between Subjective Decision Autonomy, and Uncertainty, Controlling for General Ability for Cognitive Closure

In Table 4, the results of the APIM analysis on the link between abortion motivation and uncertainty about the decision whilst controlling for ability for cognitive closure are shown. As predicted, women were in general more certain about the decision when they were more internally motivated to have the abortion. The woman's degree of uncertainty was independent of how the IMP motivated the decision for abortion (no partner effects), but was strongly associated with her general ability for cognitive closure. The level of uncertainty about the abortion experienced by the IMP was

[4] We compared the reported levels of uncertainty in our sample with the levels of uncertainty regarding having a child in a non-representative control group of early pregnant women ($N = 53$) and their involved male partners ($N = 21$). The mean level of uncertainty was found to be lower in this control group than in our sample of abortion-seeking women ($M = 7.7$, $SD = 3.5$; $t(51) = -8.80$, $p < .001$). A similar pattern was seen in the group of involved male partners ($M = 7.9$, $SD = 2.9$; $t(19) = -6.0$, $p < .001$).

also independent of what motives lay beneath the decision, both for themselves and for the women (meaning there were neither actor nor partner effects of feelings of autonomy on the IMPs' uncertainty scores). Levels of uncertainty still strongly depended on the IMPs' general abilities for cognitive closure in decision-making, however.

Table 4

APIM Analysis Assessing the Association between Level of Subjective Decision Autonomy (High Internal, Low External Motivation for Having the Abortion), and Level of Uncertainty, Controlling for General Ability for Cognitive Closure (N = 96) [#]

	Uncertainty Women *B* (*SE*)	Uncertainty Male partners *B* (*SE*)
Own internal motivation	-0.24** (0.11)	-0.13 (0.10)
Own external motivation	0.15 (0.11)	-0.02 (0.12)
Partner's internal motivation	0.02 (0.10)	-0.14 (0.11)
Partner's external motivation	0.06 (0.12)	0.15 (0.10)
General ability for cognitive closure	-0.48*** (0.42)	-0.46*** (0.43)

Note. ** $p < .01$, *** $p < .001$. Standardized coefficients; coefficients have to be interpreted on a linear scale.

[#] Number of couples in this analysis differs from the total number of couples in the study because of missing data.

When living situation of the abortion-seeking partners was taken into account (not in table), the results also showed significant partner effects. In Figure 2 it is illustrated that abortion-seeking women who were cohabiting, were more uncertain about the decision to have an abortion if the IMP pressed the decision by more external motives, whereas IMPs were more decisive about the abortion when their cohabiting female partners reported more personal, internal reasons for the decision (partner effects of feelings of subjective autonomy). For those not living together, a higher external abortion motivation (indicating a lower subjective feeling of autonomy) in the women was associated with a higher degree of uncertainty in the women themselves (actor effect) as well as in their IMPs (again a partner effect of feelings of subjective autonomy; see Figure 3). Interestingly, only in cohabiting couples, the association between both partners' levels of uncertainty remained significant after accounting for the role of both partners' subjective feelings of autonomy. Hence, a higher degree of internal motivation in the women was only significantly associated with a lower level of uncertainty in the IMPs in cohabiting couples, but not in those who live apart ($p < .01$). Similarly, only in cohabiting couples, a higher degree of external motivation in the IMPs was associated with a higher level of

uncertainty in the women ($p < .01$). In contrast, a higher degree of external motivation in the women was only associated with a higher level of uncertainty in the IMPs in couples who live apart ($p < .05$).

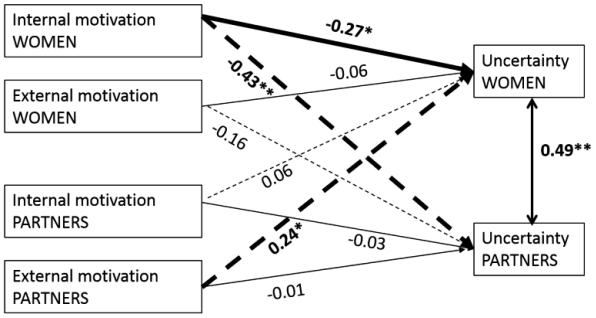

Figure 2. Visualization of the actor and partner associations between level of subjective decision autonomy (high internal, low external abortion motivation) and level of uncertainty, for cohabiting partners (standardized parameters). * $p < .05$, ** $p < .01$.

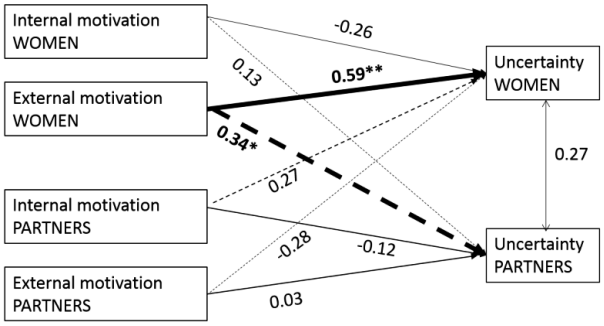

Figure 3. Visualization of the actor and partner associations between level of subjective decision autonomy (high internal, low external abortion motivation) and level of uncertainty, for partners living apart (standardized parameters). * $p < 0.05$, ** $p < 0.01$.

DISCUSSION

Findings and Interpretation

In this study, it is brought to light that, to some degree, partners' thoughts and feelings regarding the decision for abortion are associated with each other. First and foremost, the motives and feelings of decisiveness of both partners involved in the abortion corresponded fairly well, especially for couples who are cohabiting. The more the IMP felt decisive, the more the woman felt certain about the abortion too and vice versa. Similarly, the more the woman felt that the decision for abortion was

her own choice (high internal motivation), the more the IMP felt that the decision was under his own volition for him too. This correspondence between partners' experiences implies that in general, women who have involved their male partner in their abortion have co-constructed their ideas and feelings regarding the decision with him before they enter the abortion center. Both partners then define the motivations underlying their decision for an abortion more as a personal, volitional choice than as a compliance to external expectations and both are quite decisive, which demonstrates that both feel as if they co-own the decision. As previous authors have demonstrated, both of the involved partners often perceive an abortion as an inevitable and certain solution because of their own wishes to be responsible, good parents (Kero et al., 1999; Kero, Högberg, Jacobsson, & Lalos, 2001). Our findings implicitly demonstrate the various personal criteria used by men and women to define responsible parenthood, such as fully desiring the baby, being in a good relationship or having a good job. The absence of these necessary conditions for responsible parenthood leads to an internal motivation for having the abortion in both partners. Nevertheless, a certain degree of external pressure from family, friends or partner not to have a child now was often present in both partners' motives for abortion. This absence of complete independence from others, both for women and their male partners, has already been described in previous qualitative studies and follows the original feministic concept of relational autonomy (Ekstrand, Tydén, Darj, & Larsson 2009; Kjelsvik & Gjengedal, 2011; Nedelsky, 1989).

In this study, especially the interpersonal, in addition to the intrapersonal nature of women's and men's motives and feelings regarding the decision for abortion is demonstrated. It appears that in cohabiting couples, the uncertainty of one partner is not only associated with their own difficulties with making decisions in general but can partially be explained by the degree to which their partner is uncertain too and the degree to which he or she feels free to decide on having an abortion. Also for those not living together, the degree to which the woman felt externally pressured to have the abortion affected or was affected by the uncertainty of her non-cohabiting male partner. Since this study presents cross-sectional data, the process by which these associations occur is not revealed. It might be the case that the uncertainty of one partner affects whether the other partner feels free to make their own decision or vice versa – that feelings of choice or pressure in one partner affect the degree of uncertainty experienced by the other partner. Nevertheless, partners own thoughts and feelings regarding the abortion are inseparably linked with each other.

In addition to the results on congruence and interdependence, some general differences between women and the male partners were found as well. Women reported feeling as if they owned the decision the most since their internal motivations to seek an abortion were generally higher than those of the male partners. This might represent the actual legal and clinical situation in which she, as

a patient, needs to give her informed consent to the medical doctor and as such needs to be more able to justify the abortion decision. Our results demonstrated that women need this feeling of decisional autonomy to be sure that the decision is right for them at that moment in their lives, as has already been postulated by other authors (Broen, Moum, Bödtker, & Ekeberg, 2005; Kimport et al., 2011). The male partners, on the other hand, seem to be quite dependent for their decisiveness on the women's abortion motives, and not on their own abortion motives. This reflects the results of other studies on attitudes towards male involvement in the decision for abortion: according to the men, although there is a need and wish for involvement and having a voice, the ultimate decision should mainly rest with the women (Sharp, Richter, & Rutherford, 2015).

Finally, our results demonstrated that personal pre-abortion differences still play an important role in the adaptation of both partners to the decision for an abortion. These results confirm the stress and coping-perspective on women's wellbeing post-abortion (Foster et al., 2012; Major et al., 2009). The more difficulties a woman or man reported encountering in decision-making in general, the more uncertain he or she was about the decision to opt for an abortion, demonstrating the adaptive role of people's overall ability for cognitive closure (Roets & Soetens, 2010).

Differences in Results and Conclusions in Relation to Other Studies

Cases of disagreement of male partners with the abortion-seeking women–which have been described in other studies (Naziri, 2007; Reich & Brindis, 2006)–seem to be rather absent in our study, as the internal abortion motivation and decisiveness of both partners in our sample was quite high. This is likely due to a difference in recruitment strategy. In the studies by Naziri (2007) and Reich and Brindis (2006), a very selective group of men were questioned about their (mostly negative) experiences of the decision to opt for abortion during the post-abortion period after having recruited them via newspapers or abortion clinics. Indeed Naziri (2007) mentions that for the majority of their male participants, the decision to have an abortion led to a serious crisis in their relationship with the abortion-seeking woman. We hypothesize that the male partners in our study were quite engaged in their relationships with the abortion-seeking woman (see also the limitations of our study), which undoubtedly influenced the chance that they were willing to participate in the study and the degree to which they were likely to agree with the woman on having an abortion. Questioning male partners who only became aware of the abortion after the termination had taken place, could have yielded different results.

The results also contradict one of the central hypotheses of universal Self-Determination Theory which sets autonomy central in the adaptation to the decisions of all human beings (Deci & Ryan, 2008). More subjective decisional autonomy in the male partners was namely not related to less uncertainty for themselves, in contrast to the importance of a feeling of autonomy for the women's

level of decisiveness. This might represent the unique nature of reproductive decisions in which gender roles play a particular role. Reproductive decisions are probably also a very special issue with huge relational and societal complexity which a theory on individual decision-making is bound to partially fail to explain. As others have demonstrated, intrapersonal or even partner-related factors are only one of the determinants for good emotional adaptation in response to the abortion experience. Societal factors such as abortion-related stigma, support from relatives other than the male partner, delays in referral to the abortion clinic, or religion also play an important role (Kimport et al., 2011; Major et al., 2009; Rocca et al., 2015).

Relevance of the Findings: Implications for Clinicians and Policymakers

Pre-abortion counselors and health care providers involved in abortions should be aware of the interdependence between both partners' experiences of deciding for abortion, either when speaking with the woman or male partner alone or with both partners being present in the abortion center. Couple abortion counselling, as proposed by Becker, Bazant, and Meyers (2008), could then help partners who are both present in the abortion consultations–if they so desire–to discuss and review their mutual influences on each other's perceptions, opinions, and feelings regarding the abortion, in the presence of the other partner. In current Flemish abortion practice, the male partner is usually involved in the counselling session when he in fact accompanies the woman to the abortion center. Counselors do however acknowledge women's primary need for decisional autonomy meaning that women are never pushed towards actually involving the male partner. Offering the involved male partners who accompany abortion-seeking women to the abortion center an opportunity for either individual or couple counselling, can help them to formulate their possible own uncertainty and the intrapersonal or interpersonal origins of it. As such, even in the absence of the other partner, the interdependence between both partners could be reviewed and discussed. This could help both partners to understand the underlying relationship between one's own and the partners' thoughts and feelings regarding the abortion. Counselors could in addition help both partners to understand and normalize their possible feelings of uncertainty by framing these feelings in their own history of coping behaviors such as their general ability of making decisions.

Strengths and Weaknesses of the Study

Although a reasonably high number of couples were systematically and simultaneously questioned about their individual experiences of the decision to have an abortion, this study has some important limitations. First and foremost, the study sample is likely to have been subject to selection bias. In the study, only those men who either accompanied their female partners to the abortion center or who were asked by an abortion-seeking woman to participate and eventually agreed to, were

included in the analyses; for the bulk of this analysis we only focused on men whose female partners also participated in the study. Although we found no difference in mean levels of decisiveness, autonomy or living situation between the men in our couple sample and men who participated alone (without the female partner), we might hypothesize that the men in our sample might already be quite supportive of their partners' decisions for abortion, or were at least already quite dedicated to their relationships with them. This might have affected the high degree of partner congruence in autonomy, and decisiveness found in this study. Although we tried to reach out to male partners who did not accompany women to the abortion center (to limit this kind of selection bias), only 10% of the men in our study were recruited this way. This small group of men did not differ from the men who were present in the abortion center in mean degree of uncertainty about the abortion or mean degree of decisional autonomy but the degree of congruence between the partners in uncertainty and autonomy was found to differ (results not shown). This might indicate that the context of both partners being present in the abortion center when filling out the questionnaire has influenced the level of interdependence in scores on the main variables in a significant way. As Reich and Brindis (2006) suggest, we questioned men in their role as involved male partners of an abortion-seeking woman. This group of men is certainly not representative of all men who are confronted with an induced abortion.

Secondly, the women and male partners were questioned at one particular moment in the abortion process: in the waiting room of the abortion center (except for those men who filled out the questionnaire at home), before they spoke to a counselor. We could hypothesize that the location and the specific moment encouraged both partners to be congruent in their reported abortion motivation and decisiveness. Indeed, several studies have found women's decisiveness to be quite high before receiving pre-abortion counselling (Vandamme, Wyverkens, Buysse, Vrancken, & Brondeel, 2013). This might contrast with the results of random retrospective studies in which the small group of women or men who become doubtful about their decision post-abortion are probably overrepresented. As this study was not longitudinal, we also lack information about the direction of the partner influences uncovered.

Finally we did not ask participants whether they possibly also have motives for carrying the pregnancy to term. We assumed that most of the participants had already more or less decided before arriving at the abortion center and supposed it would be unethical to ask for their considerations regarding the opposite choice. We could, however, have provided insight into the societal and internal barriers for having an induced abortion affecting both partners, by questioning external pressure for deciding to carry the pregnancy to term, as has been illustrated by research on the effect of (internalized) abortion stigma (Rocca et al., 2015). In addition, when questioning for external abortion motivation, we did not ask about the sources of external pressure for deciding for abortion. It would

have been interesting to explore the degree to which this external pressure was derived from the according partner in comparison to other sources of pressure such as parents, friends or society in general.

Despite these limitations, both members of a sample of 106 couples were questioned about their motives and feelings regarding the decision for abortion. An intensive data recruitment strategy (women seeking an induced abortion and their involved male partners, whether present or absent during the first visit to the abortion center), a rigorous data analytical method (APIM analyses), theoretical and clinically-based research questions (Self-Determination Theory within the context of women's reproductive autonomy, Interdependence Theory) and the use of valid and reliable questionnaires enabled the researchers for the first time in abortion research, to systematically examine whether and how partners experiences with the decision for abortion are associated with each other.

Unanswered Questions and Future Research

Despite the focus on the interpersonal context in which abortion experiences occur, this study mostly dealt with the individual issues arising from the partners' decisional processes (the motivation and decisiveness towards the already planned abortion). Future research should further elaborate on the interactional mechanisms and processes by which partners influence each other during the decision for an abortion. Starting from the process by which male partners become involved in the decision, future research could examine how women and their IMPs move from becoming aware of the unintended pregnancy to their final decision for abortion. Future studies should therefore either seek to use longitudinal designs or attempt to ask both of the partners involved in an unintended pregnancy to report their feelings about the decision prior to their visit to the abortion center.

CONCLUSION

The motives and feelings of decisiveness of partners involved in the process of seeking an induced abortion mostly mirrored each other. The subjective feelings of autonomy in the decision for abortion of one partner were associated with the feelings of decisiveness of the other and vice versa. Both of the partners experienced a certain degree of autonomy although the decision was more motivated by the women's reasons for having an abortion. Only women needed this personal abortion motivation to be certain about the decision to opt for an abortion. For both partners, feelings of uncertainty largely followed a pattern of higher difficulties in making decisions in general.

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5 The presence of dialectical thoughts in the decision to have an abortion

Based on Vandamme, J., Buysse, A., Loeys, A., Vrancken, C., & T'Sjoen. G. Dialectical thoughts in the decision to have an abortion: A mixed-methods longitudinal study.

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ABSTRACT

Objective. Ambivalence is a frequently studied topic in the research on induced abortion, despite the lack of theoretical basis and corresponding methodologies to study it. Based on the theory of dialectics, we gain insight into the occurrence, determinants, and effects of dialectical thoughts in the decision to have an induced abortion.

Methods. Flemish abortion-seeking women and involved male partners reported on the occurrence and content of moments where they thought about carrying the pregnancy to term. Participants rated their emotional wellbeing both pre- and post-abortion. Content Analysis was used to categorize the dialectical thoughts. Mixed Logistic Regression analyses were performed to test the association between the occurrence of dialectical thoughts and a participant's general ability for cognitive closure, educational level, age, and gravidity (number of previous pregnancies). Linear Mixed Models were used to examine the association with emotional wellbeing pre- and post-abortion.

Results. In the pre-abortion questionnaire, 61.3% of the abortion-seeking women and 46.2% of the male partners reported having had dialectical thoughts. In the post-abortion questionnaire, this percentage was 53.1% and 34.8% respectively. Reporting of more than two moments of dialectical thinking was rare. Dialectical thoughts were grouped into six categories showing underlying cognitive processes of anticipation, reflection, evaluation, problem-solving, meaning-making, and relating. Both lower ability to achieve cognitive closure and higher educational level in the women were associated with higher odds of reporting dialectical thoughts both pre- and post-abortion. The occurrence of reported dialectical thoughts pre-abortion was not associated with emotional distress (either pre- or post-abortion). The occurrence of reported dialectical thoughts post-abortion was associated with emotional distress in the women however, even after controlling for general ability to achieve cognitive closure.

Conclusion. Among abortion-seeking women and the involved male partners, reflections on continuing with the unintended pregnancy are common but not standard. They are rooted in people's general cognitive capacities and part of a meaning-making process. They are only associated with emotional distress when they occur post-abortion.

INTRODUCTION

In Western Europe, proportions of unintended pregnancy range between 20% and 40% (Bajos et al., 2003; Font-Ribera, Pérez, Salvador, & Borrell, 2007; Vandamme, Buysse, & T'Sjoen, 2013). In 20% to 60% of these cases, women opt to have an induced abortion. Research on how women have experienced this decision has focused overwhelmingly on the occurrence of ambivalence (Aléx & Hammarström, 2004; Allanson & Astbury, 1995; Husfeldt, Hansen, Lyngberg, Nøddebo, & Petersson, 1995; Kero & Lalos, 2000; Rowlands, 2008; Törnbom, Ingelhammar, Lilja, Svanberg, & Möller, 1999). As will be argued here, however, the topic of ambivalence in the literature on induced abortion has received little theoretical attention. In addition, discordant findings regarding the occurrence and effects of feelings of ambivalence have led to different views on how ambivalence should be understood in this context.

Ambivalence in the Decision to Have an Abortion

Ambivalence has been operationalized by authors in the field of induced abortion as the simultaneous occurrence of positive as well as negative feelings and attitudes towards the pregnancy or the upcoming abortion (Kero, Högberg, Jacobsson, & Lalos, 2001; Törnbom et al., 1999). These contradictory feelings and attitudes might, according to these authors, be related to a conflict between pragmatic and emotional arguments, social and ethical values, the involved individual and others, and abstract and personal meanings (Aléx & Hammarström, 2004; Allanson & Astbury, 1995; Kero & Lalos, 2000; Kirkman, Rowe, Hardiman, & Rosenthal, 2011). These authors distinguish between the occurrence of ambivalence and having doubts about how right the decision to have an abortion is (Kero & Lalos, 2000; Kero et al., 2001). Indeed, the majority of abortion-seeking women are quite or even very certain about the necessity of having the abortion both before and after the treatment has taken place (Foster, Gould, Taylor, & Weitz, 2012a; Rocca et al., 2015; Vandamme, Wyverkens, Buysse, Vrancken, & Brondeel, 2013). Most of these scholars then highlight that ambivalent feelings regarding the unintended pregnancy or abortion are logical and therefore unproblematic (Kero & Lalos, 2000; Rowlands, 2008; Stotland, 1997). This hypothesis is supported by the high degree of ambivalence in decision-making about (avoiding) parenthood or during parenthood in general (Holmgren & Uddenberg, 1993; Jaccard, Dodge, & Dittus, 2003; Törnbom et al., 1999; Weille, 2011; Wikman, Jacobsson, Joelsson, & von Schoultz, 1993). Others, however, postulate that the presence of a state of ambivalence is a risk factor for poor post-abortion mental health and is, as such, a reason for offering counseling (Ashton, 1980; Lauzon, Roger-Achim, Achim, & Boyer, 2000). In these studies though, ambivalence is barely defined. Studies reporting the prevalence of ambivalence are also scarce, with some scholars only describing its occurrence without putting a figure on it (e.g., Aléx & Hammarstrom,

2004) while others estimate its prevalence at 10 to 30% (Husfeldt et al., 1995; Törnbom et al., 1999). These numbers, however, depend on when this ambivalence is assessed (Rowlands, 2008) and how it is defined (e.g., as the simultaneous occurrence of contradictory feelings or attitudes, or as actually being in doubt about going through with the induced abortion). In summary, ambivalence in the decision to have an induced abortion has to date mostly been considered as a possible result of the decision-making process, without an attempt at a profound understanding of its sources being made, let alone study of its underlying process or its possible effects.

Ambivalence and the Theory of Dialectics

As argued by Kuczynski & De Mol (2015) in the context of parent-child relationships, feelings of ambivalence (i.e., the simultaneous experience of positive and negative emotions, evaluations, or opposing directions for action; for example being angry as well as feeling proud about the unintended pregnancy at the same time) are one of the four driving forces behind change. Three other sources of change are conflicts (external contradictions, such as when a woman states a desire to terminate the pregnancy while her partner professes a desire to carry the pregnancy to term), expectation violations (if there is a discrepancy between expectations based on the past and current situation; such as when a woman expected to have a permanent home and to have changed jobs before starting to think about children but then suddenly finds out that she is pregnant), and finally, ambiguity (related to being uncertain about the future; such as when a woman is unable to predict whether she will ever have another opportunity to become a mother). It is argued that when people are confronted with a life-event in which a contradiction is felt between opposing feelings, expectancies, or goals, a certain degree of dialectical tension is created (identified as “crisis”), which eventually has to be resolved. In the dialectical metatheory proposed by the philosopher Hegel, is included that in every affirmation, an implicit contradiction is present (Overton, 2006). How individuals deal with this contradiction (solving the problem, engaging in new meaning making, disengaging from the contradiction and living with the tension, or ignoring the contradiction) will then determine which trajectory they will follow after being confronted with the contradiction (e.g., Abbey & Valsiner, 2004; Baxter, 1990). Hence, ambivalence from this point of view, ascertains a degree of functionality, as it might lead people to identify cues or signals that help them to make effective decisions based on the construction of new meaning (i.e., what does this decision mean in relation to my past experiences or my future goals?) (Abbey & Valsiner, 2004; Guarana & Hernandez, 2016). These new constructions of meaning might adopt the form of perceiving the decision to have an induced abortion in this case as an expression of the desire to be a responsible parent (Kero et al., 2001).

Differences in Coping With Contradictions

The theoretical perspectives described above already mentioned that individuals have different ways of dealing with contradictory emotions, expectancies, needs, and goals. The pathway through which new meanings or representations are constructed or in which the contradictions are being solved, requires a certain cognitive load as it includes the processing of information about the past, and the future. As has been argued by others, the limited information-processing capacity of human beings poses the necessity of making choices about what information is taken into account and what information is neglected (Kruglanski & Webster, 1996; Schwartz et al., 2002). According to the theory of Need for Cognitive Closure (Kruglanski & Webster, 1996)—a social cognition theory which has mostly been tested in experimental settings—the avoidance of seeking or actively recalling ambiguous, conflicting, or ambivalent information, is seen as an adaptive cognitive-motivational process when it concerns decisions in which uncertainty is inherent. This motivational process is influenced by contextual factors such as the degree to which the decision needs to be made quickly or is aversive, but is also influenced by individual factors such as a person's cognitive capacity to process different kinds of information. Individuals therefore seem to differ in their general need for cognitive closure across varying decisions (Roets & Van Hiel, 2007). In addition to variations in individual's needs for cognitive closure, individuals also differ in their ability to reach swift decisions and structure in life (Roets & Van Hiel, 2007). This ability seems to be positively associated with mental wellbeing (Roets & Soetens, 2010). A recent study indeed revealed that abortion-seeking women with a high ability to achieve cognitive closure, experienced less uncertainty whilst making a decision to have an abortion (Vandamme, Buysse, Loeys, Vrancken, & T'Sjoen, 2017). Hence, as has been demonstrated by others, personality differences might be associated with how ambivalence with regard to parenting decisions is dealt with and as such, whether ambivalence remains throughout the decision-making process or not (Pinquart, Stotzka, & Silbereisen, 2008). In the context of the decision to have an induced abortion, personality factors have been associated with ambivalence and ambiguity, as have other factors, including the existence of external pressure to have the abortion (Husfeldt et al., 1995; Vandamme et al., 2017), socio-demographic factors as age, religiosity, or education (Foster et al., 2012a), and the emotional experiences of the relevant male partner (Vandamme et al., 2017).

Contradictions in Male Partners of Abortion-Seeking Women

The few qualitative studies that have examined the experiences of male partners involved in the decision to have an induced abortion, have suggested that men experience an equal degree of ambivalent feelings as abortion-seeking women (Kero & Lalos, 2000; Törnbom et al., 1999). Hence, it is proposed that the underlying conflicts they encounter are similar to those of abortion-seeking

women. In addition, a previous study demonstrated that men and women experience an equal degree of uncertainty about having an induced abortion, and men are equally subject to the effect of general abilities to achieve cognitive closure (Vandamme et al., 2017). Studies in which both partners of a couple report on the process of dialectical thinking whilst making the decision to have an induced abortion are, however, currently lacking. In light of pre-abortion couple counseling as proposed by Becker et al. (Becker, Bazant, & Meyers, 2008), gaining insight into these male partners' cognitive dialectical experiences and their relationship with their own emotional wellbeing is nevertheless important.

Current Study

In this study, we aimed to examine women's and male partners' *processes* of deciding to have an induced abortion by investigating dialectical thoughts during that decision. We did this by making use of the turning points framework of Baxter & Montgomery (1996). Relational turning points are conceptualized by Baxter & Montgomery as moments to which a person retrospectively attributes a change in the decision to stay or leave the relationship. In the context of induced abortion, a negative turning point indicates a moment in which the decision to have the abortion is being cognitively reinforced while a positive turning point represents a dialectical moment in which an individual thinks about the other side of the coin, i.e. carrying the pregnancy to term. In this study, we investigated the prevalence of these dialectical thoughts in both abortion-seeking women and male partners, as reported pre- as well as post-abortion. We also explored the different categories of dialectical thoughts reported by the two partners. Thirdly, we examined whether the occurrence of these dialectical thoughts was associated with a personal ability to achieve closure, and with socio-demographic features as educational status, age, and gravidity (the number of previous pregnancies). Finally, we aimed to examine the association between the occurrence of these dialectical thoughts and emotional distress pre- and post-abortion. We hypothesized that:

H1. Abortion-seeking women and male partners who have general difficulties in closing their minds to ambivalent, ambiguous, or conflicting information would report more dialectical thoughts whilst making their decision to have an abortion, and would generally be more vulnerable to emotional distress pre- and post-abortion (Roets & Soetens, 2010; Vandamme et al., 2017)

H2. The occurrence of dialectical moments, in which thoughts about carrying the pregnancy to term emerge, does not result in higher emotional distress per se as it might give rise to a meaning-making process in which personal goals, needs, and values are considered, which can

help to make effective decisions (Abbey & Valsiner, 2004; Baxter, 1990; Guarana & Hernandez, 2016; Kuczynski & De Mol, 2015).

H3. Being able to report dialectical thoughts after the abortion has taken place would be associated with a higher level of emotional distress. This hypothesis was based on previous relationship research demonstrating that being able to retrospectively reflect on moments in which an individual would have liked to *end* the relationship, is related to less relationship satisfaction if the individual is still *in* the relationship (Baxter & Bullis, 1986) while being able to reflect on moments in which they wished to *stay* in the relationship is associated with less individual wellbeing if they are already *out* of the relationship (Humblet, unpublished).

By using a mixed-methods longitudinal design with a clear theoretical base, we aimed to deepen the knowledge on people's cognitive dialectical experiences of deciding to have an induced abortion. Hence, we aimed to provide theoretically-based inferences for pre- and post-abortion counseling practices.

METHOD

Procedure

This study was part of a larger longitudinal study on the experiences of women and involved male partners (IMPs) with the decision to have an abortion (Vandamme et al., 2017). The IMPs are male partners who are aware of the unwanted pregnancy and are actually involved by the abortion-seeking woman in the abortion process. Adult (> 18 years) abortion-seeking women were asked to take part in the study upon arrival at one of the five abortion centers in Flanders (the northern part of Belgium), prior to the mandatory pre-abortion counseling session. When a man accompanied an abortion-seeking woman, he was asked to participate too, after having confirmed that he was the male partner involved of the pregnancy. Both partners could take part in the study independently of each other and everyone was informed that they could stop at any time. In the first data wave, women and IMPs filled out a paper-and-pencil questionnaire in the waiting room of the abortion center (see Vandamme et al., 2017). In the second data wave, both women and IMPs filled out an online home-based questionnaire, at least one day after the mandatory counseling session. The third data wave consisted of a diary format in which participants filled out a short online questionnaire every evening. The diary started four days prior to the induced abortion and ended five days after the induced abortion. Participants also had the option of participating in a light version of this data wave, meaning they only filled out the short diary questionnaire the evening of the abortion procedure. In the fourth data wave, participants filled out a short post-abortion questionnaire 14 days after the abortion had

taken place. During the diary period and prior to the post-questionnaire, participants received text messages to remind them about the questionnaires, in an attempt to reduce dropout. All participants needed to sign an electronic informed consent form before filling out each questionnaire. The study was approved by the Ethical Committee of the Ghent University Hospital.

Study Sample

In this study, only the data of the pre-abortion questionnaires and the post-abortion questionnaire are used. For a detailed analysis of the men and women who chose not to participate, see Vandamme et al. (2017). In total, 183 abortion-seeking women and 52 IMPs filled out the turning points questionnaire at the second data wave. From this group of participants, we had data on emotional distress prior to the counseling session (first paper-and pencil questionnaire) for 171 of the women and 44 of the IMPs, respectively (missing data was due to lost paper-and-pencil questionnaires). From the group of participants who started to fill out the second questionnaire, 100 women and 25 IMPs filled out the turning points questionnaire in the post-abortion questionnaire. Dropout between the pre- and post-abortion questionnaire was 46% in the female sample and 52% in the sample of involved male partners. The analyses relied on the Missing at Random (MAR) assumption to deal with dropout (see the results section below).

Measures

Demographic characteristics.

Participants' age, educational level, ethnic origin, living situation, and reproductive history were ascertained in the first data wave (the paper-and-pencil questionnaire filled out in the waiting room of the abortion center).

Positive turning points: Dialectical thoughts on carrying the pregnancy to term.

Based on the *Retrospective Interviewing Technique* (RIT; Baxter & Montgomery, 1996), two questions were used to elicit respondents' dialectical thoughts in the decision to have the abortion. The question that aimed to elicit respondents' moments in which there was a thought on carrying the pregnancy to term (referred to as positive turning points in the RIT), was as follows: "People sometimes have moments of doubt in the process of deciding to have an abortion. Do you remember moments, since you became aware of the pregnancy or since you assumed yourself to be pregnant, at which you wanted to carry the pregnancy to term and you thought about not having the abortion? What were these turning points? Please describe these as extensively as possible, reporting as much as you can about the moments you remember at which you thought about carrying the pregnancy to term. Please

use sentences with a subject and a verb."[1] This question was asked twice: in the second data wave, prior to the induced abortion, and in the post-abortion questionnaire, 14 days after the induced abortion. It is important to note that the answer of the respondent to the turning points questionnaire is based on a *retrospective* construction of the respondent's cognitive process. As such, the absence of a report of these turning points only means that at the moment of the questionnaire, the participant does not remember moments in which they had a conscious thought about carrying the pregnancy to term. This does not mean that thoughts about carrying the pregnancy to term actually never entered the mind of the participant.

Emotional distress: Total mood disturbance.

Emotional distress pre- and post-abortion was measured with a Dutch 16-item shortened version of the Profile of Mood States (POMS; Van der Ark, Marburger, Mellenbergh, Vorst, & Wald, 1995). The shortened version has proven its validity in diary research measuring daily mood change (Cranford et al., 2006). Each item of the POMS is an adjective representing a mood state. Example items are "sad", "exhausted", "anxious", "angry", or "cheerful" (reversed item). For the current analyses, a Total Mood Disturbance (TMD) score was used (Mackenzie, 2001), which was calculated by summing up the means of the negative subscales (*depression* [4 items], *fatigue* [3 items], *tension* [3 items], and *anger* [3 items]) and subtracting the mean of the *vigor* scale (3 items). Scores can range from -4 to 13. The higher the score on the Total Mood Disturbance scale, the more negative the mood of the respondent. The pre-abortion POMS was included in the paper-and-pencil questionnaire that was filled out prior to the counseling session. Cronbach's alpha in the pre-abortion questionnaire was .89 for the women and .88 for the male partners. Internal consistency was .92 and .90, respectively, in the post-abortion questionnaire.

General ability for cognitive closure: AAC.

The *Ability to Achieve Closure* scale (ACC) was used to measure participant's general ability to achieve cognitive closure (Roets & Soetens, 2010). The AAC measures the perceived ability to cognitively "close the mind" to alternative options when making a decision. Sample items of the AAC are "When faced with a problem I usually see the single best solution very quickly" or "I would describe myself as indecisive" (reversed item). The scale comprises 15 items on a response scale from 1 (*totally disagree*) to 5 (*totally agree*). Scores on the AAC were calculated by taking the mean of the scores on

[1] This wording differs from the original turning points methodology used by Baxter & Montgomery in their Retrospective Interviewing Technique (1996). It enables participants to elicit volatile thoughts about carrying the pregnancy to term without these thoughts necessarily being a distinctive turning point in the decisional process.

the 15 items and therefore ranged from 1 to 5. The higher the score, the easier it is for the person to make decisions in general. The AAC scale was included in the paper-and-pencil questionnaire that was filled out prior to the counseling session. Cronbach's alpha was .92 for the women and .93 for the male partners.

Data Analysis

The qualitative data that were generated by the open-ended positive turning points questionnaire were analyzed with the conventional Content Analysis technique. This inductive qualitative technique enables researchers to analyze large amounts of text data by ordering the responses into non-predefined meaningful categories (Hsieh & Shannon, 2005). These categories are used to identify patterns in the content of the written text. We firstly read through the data several times to immerse ourselves. Subsequently, we identified key themes in the written answers (thoughts such as "Will I ever be able to get pregnant again?"). Next, we assigned codes to the different thoughts and re-ordered the data into different categories by making use of a back-and forward-system. Categories were adjusted each time a new dialectical thought could not be placed in one of the existing categories. In the first phase, the data of the women and the involved male partners were analyzed separately. In a second phase, the categories were brought together in order to come up with a categorical system that would fit for both of the partners.

The occurrence of dialectical thoughts was coded in a binary variable (0 = *no reports of such thoughts*; 1 = *at least one report of such thoughts*), both in the pre- and post-abortion questionnaire. Using Mixed Logistic Regression with a random intercept for each individual to account for the correlation between pre- and post-abortion measurements within each individual, the effect of educational level, age, and ability to achieve closure on the occurrence of positive turning points pre- and post-abortion was assessed in both samples. In a next step, the association between the degree of total mood disturbance (TMD) and the occurrence of dialectical thoughts was explored pre and post-abortion, relying on a Linear Mixed Model. Data were analyzed using *SPSS* version 23.

RESULTS

Sample Characteristics and Descriptive Statistics

In Table 1, the characteristics of participants are described. In Table 2, the scores on emotional wellbeing and general ability to achieve closure for both the women and the involved male partners are depicted. As can be seen in Table 2, both partners' levels of total mood disturbance (TMD) have decreased significantly fourteen days after the abortion in comparison to prior to the pre-abortion

counseling session[2]. When comparing the emotional distress of the women with the emotional distress of the male partners, paired *t*-tests reveal a significantly higher level in the women[3], both pre- and post-abortion ($t(39) = 5.62$, $p < .001$; $t(21) = 2.74$, $p < .05$; results not in table)[4].

Dropout Analysis

Participants who filled out the (start of the) post-abortion questionnaire, did not differ from those who did not take part in the post-abortion measurement in terms of pre-abortion emotional distress ($t(154) = 1.17$, $p = .24$ for the women; $t(41) = 1.83$, $p = .75$ for the male partners) or in their reports of dialectical moments (see below; $\chi^2(1) = 0.82$, $p = .37$; $\chi^2(1) = 2.79$, $p = .10$). They also did not differ in educational level ($\chi^2(3) = 6.85$, $p = .08$; $\chi^2(2) = 2.63$, $p = .27$). Withdrawal from the study did not relate to general ability to achieve closure for women ($t(150) = -.66$, $p = .51$), although it did for the male partners, with those who did not participate in the post-abortion measurement having a lower ability for cognitive closure than those who did ($t(40) = -2.55$, $p < .05$). None of the women with a pregnancy gestation that was higher than 12 weeks at the start of the pre-abortion online questionnaire ($n = 5$), took part in the post-abortion questionnaire (induced abortion beyond this gestational limit is not allowed in Belgium). Older women are also somewhat overrepresented in the post-abortion questionnaire, and foreign-born women are somewhat underrepresented ($t(156) = -2.6$, $p < .05$ and $\chi^2(2) = 9.18$, $p < .05$). Age and ethnic descent did not, however, differ between male partners who took part in the post-abortion questionnaire and those who did not ($t(44) = -1.93$, $p = .60$; $\chi^2(1) = 2.68$, $p = .10$).

[2] A decrease was found in the score on every negative subscale of the Profile Of Mood States (*depression*, *fatigue*, *tension*, and *anger*), both for women and the involved male partners. An increase in the score on the *vigor* subscale was found for women and the involved male partners as well.

[3] Again, there was a significant difference between women's and the involved male partners' score on every negative subscale of the POMS (*depression*, *fatigue*, *tension*, and *anger*) as well as on the *vigor* subscale (in the opposite direction).

[4] The correlation between partners' pre-abortion levels of distress was found to be insignificant ($r = .22$, $p = .17$). However, there was a significant correlation between partners' post-abortion levels of distress ($r = .47$, $p < .05$).

Table 1

Sample Characteristics (N = 183 women and 52 involved male partners)

	Women		Male partners	
	n	%	*n*	%
Demographic characteristics				
Age				
< 20	2	1.3	2	4.8
20-29	69	43.7	14	33.3
30-39	74	46.8	18	42.9
≥ 40	13	8.2	8	19.0
Education				
No formal education/Primary education	6	3.9	3	7.5
Junior High School	15	9.8	0	0.0
Secondary High School	59	38.6	18	45.0
Bachelor/Master degree	73	47.7	19	47.5
Ethnic descent				
Native	128	82.1	41	93.2
Western immigrant	12	7.7	3	6.8
Non-Western immigrant	16	10.3	0	0.0
Civil Status				
Single	82	51.9	20	46.5
Cohabiting	29	18.4	7	16.3
Married	38	24.1	12	27.9
Divorced	9	5.7	4	9.3
Widowed	0	0.0	0	0.0
Living situation				
Cohabiting with a partner (and others)	93	58.5	25	56.8
Living alone (or with others), without a partner	66	41.5	19	43.2
Reproductive characteristics				
Gravidity				
No previous pregnancy	57	36.5	25	56.8
Previous pregnancy	99	63.5	19	43.2
Previous abortion				
No	112	73.7	37	84.1
Yes	40	26.3	7	15.9

	Women		Male partners	
	n	%	*n*	%
Pregnancy gestation				
< 4 weeks	13	7.1	4	8.5
4-7 weeks	115	62.5	29	61.7
8-11 weeks	44	23.9	14	29.8
≥ 12 weeks	5	2.7	0	0.0
Relationship characteristics				
Relationship with MP[#]				
Non-significant relationship	14	7.7	0	0.0
Non-romantic but significant relationship	15	8.2	3	5.8
Short-term romantic relationship (< 1 y)	35	19.2	14	26.9
Medium-term romantic relationship (1-5 y)	54	29.7	13	25.0
Long-term romantic relationship (> 5 y)	64	35.2	22	42.3

Note. Sum of subsections differs from the total *N* because of missing data.

[#] MP= Male partner involved in the pregnancy

Table 2

Descriptive Statistics on Emotional Wellbeing (TMD)[5] and Ability for Cognitive Closure (AAC) in the Women and the Involved Male partners

	Pre-abortion			Post-abortion			Mean difference		
	n	*M*	*(SD)*	*n*	*M*	*(SD)*	*n*	*M*	*(SD)*
TMD									
Women	156	4.63	(3.49)	102	0.41	(3.06)	85	3.79***	(3.68)
Male partners	43	2.35	(2.56)	26	-0.66	(2.36)	20	2.10*	(3.78)
AAC									
Women	152	4.03	(1.05)		/			/	
Male partners	42	4.01	(1.04)		/			/	

Note. * $p < .05$, *** $p < .001$, TMD = Total Mood Disturbance; AAC = Ability for Cognitive Closure.

[5] Although hard to compare, the emotional distress of a control group of early pregnant women ($N = 53$; unpublished data) is definitely lower than the pre-abortion distress experienced by the women in our sample ($t(51) = -5.66$, $p < .001$). The opposite is true for the post-abortion emotional distress of the women in our study, which is mainly lower than the distress of the early pregnant women in the control group ($t(51) = 5.63$, $p < .001$). A higher level of pre-abortion distress is also seen in the male partners in our study when comparing them with the involved male partners in the control group ($t(20) = -4.79$, $p < .001$). However, post-abortion distress seems to be equal to the distress of the male partners in the control group ($t(20) = 1.19$, $p = .25$)

Presence and Content of Dialectical Thoughts on Continuing the Pregnancy

In the pre-abortion questionnaires, 61.3% of the abortion-seeking women and 46.2% of the involved male partners reported at least one moment of dialectical thinking (see Table 3)[6]. This percentage was 53.1% and 34.8%, respectively, in the post-abortion questionnaire. The drop in the percentage of women and male partners reporting dialectical moments in the post-abortion questionnaire compared to the pre-abortion questionnaire, was not found to be significant (p = .18 for the women and p = .90 for the male partners). Although it were mostly the same participants who reported having these moments in the post-abortion questionnaire as in the pre-abortion questionnaire ($\chi^2(1) = 19.1$, $p < .001$; $\chi^2(1) = 15.0$, $p < .001$), some women did report dialectical moments in the post-abortion questionnaire without reporting them in the pre-abortion questionnaire (11.6%), and vice versa (15.8%).

There was also no significant difference in the percentage of women reporting dialectical moments and the percentage of involved male partners reporting these moments, pre- or post-abortion (p = .06 and p = 0.12, respectively).

A closer look at the frequency of these moments (data not presented in the table) revealed that 27.5% of the women and 30.8% of the male partners reported only one dialectical moment in the pre-abortion questionnaire while 18.7% and 9.6%, respectively, reported two, 7.7% and 1.9% reported three, and 7.1% and 3.8% reported four or more moments of dialectical thinking. A similar frequency distribution was seen in the post-abortion questionnaire for the women, whereas for the male partners, no one reported more than one dialectical moment in the post-abortion questionnaire.

In Table 3, the different categories of dialectical thoughts about carrying the pregnancy to term that emerged from the data are depicted, together with their prevalence in the responses to the pre- and post-abortion questionnaires. In the following section, each of these categories of dialectical reflection is described in detail as well as being clarified by examples from both the female and the male sample.

[6] Although hard to compare, an equal prevalence of dialectical thoughts was found in a control group of couples who decided to have a child. Preliminary findings in this group (unpublished) demonstrate that since they found out to expect a baby, 59% of the women (N = 53) and 37.5% of the involved male partners at least had one moment in which they thought about *not* wanting to have the child.

Table 3

Prevalence of Categories of Dialectical Thoughts, as Reported Pre- and Post-Abortion by Women and Male Partners

		Pre-abortion		Post-abortion	
		Women (*N* = 184)	Male partners (*N* = 52)	Women (*N* = 103)	Male partners (*N* = 25)
Prevalence		%	%	%	%
Presence of dialectical thoughts		61.3	46.2	53.1	34.8
Absence of dialectical thoughts		38.7	43.8	46.9	65.2
Category	Codes	*n*	*n*	*n*	*n*
1. Projection of the self in the future		64	6	37	3
	Weighing up the desire for children in the future	30	1	17	0
	Anticipating difficulties during and post-abortion	18	2	7	1
	Imagining having the child or carrying it to term	16	3	13	2
2. The exploration of other horizons		47	6	17	0
	Convincing oneself “you/we can do it (with their help)”	20	4	10	0
	Searching for and finding out other possibilities	12	1	1	0
	Counterfactual thoughts – “what if it were different”	10	1	3	0
	Confrontation with positive examples	5	0	3	0
3. The provision of meaning to having children or being pregnant		45	7	18	1
	Thinking about children as symbols of love, joy, laughter, and womanhood	16	3	8	0
	Existential thoughts and beliefs about the “wonder of life”	29	4	10	1

		Pre-abortion		Post-abortion	
		Women (N = 184)	Male partners (N = 52)	Women (N = 103)	Male partners (N = 25)
		n	*n*	*n*	*n*
4. Matching the decision to the desires and decisions of others		27	8	14	3
	Confrontation with others who wanted or decided to have a child	21	2	7	0
	Taking the desire of loved ones for having the child into account	6	3	7	1
	Thinking about the burden for the female partner	0	3	0	2
5. Considering social norms and ethics about parenthood, abortion, and decision-making		19	2	5	0
	Reflecting on the ethical considerations of induced abortion	13	1	4	0
	Reflecting on social norms about decision-making	3	0	1	0
	Reflecting on social norms about parenthood	3	1	0	0
6. (Consciously) considering the pros of having the child		13	2	0	0

Projection of the self in the future.

Participants frequently described moments in which they imagined themselves with or without the pregnancy or the child in the future. As such, they thought about how the child or their family would look like if they were to carry the pregnancy to term.

"From the moment I started to imagine what our baby would look like, how it would be (his/her character), I was pushed in the direction of keeping it."
(woman, pre-abortion)

Sometimes participants reflected on their current or future desire to have children and considered the odds of fulfilling this wish in the future.

"The thoughts about a happy family and that, if I chose for abortion right now, this will probably no longer be an option."
(woman, post-abortion)

Women and male partners also reflected on the possibility of emotional, physical, and relational difficulties after having had the induced abortion. These trains of thought concerned thoughts about anticipated regret but also the fear of not being (emotionally) capable of going through with the abortion. Some women also expressed a fear of not being able to have children anymore. Others expressed thoughts about what the abortion would mean for their future relationship.

"I was afraid that the emotions associated with the abortion would damage our relationship. Therefore, I began to think about what it would mean to keep the child despite everything."
(man, post-abortion)

The exploration of other horizons.

Women and male partners sometimes reflected on the possibility of removing the various barriers to carrying the pregnancy to term. As a result of conversations with others (such as their partner, parents, or friends), or as a result of individual reflection, participants sometimes convinced themselves, or were convinced, that carrying the pregnancy to term would present no problem. This happened, for instance, when they were told by others that they would be supported in their decision to have a(nother) child or when they thought about the practical possibilities of having a(nother) child.

"There was doubt because basically, we both have a job and a stable income."
(man, pre-abortion)

For other participants, it happened when others or they themselves convinced them that they were (or would make) a good mother or father (in the future).

> *"When I told the news to my friend, she said I am a strong woman because I already have two kids who I have raised mainly by myself."*
> (woman, pre-abortion)

Sometimes the participants also actively searched for solutions to the practical barriers preventing them from having the baby.

> *"I tried to organize everything: The car, the bedroom, names, you name it. I also asked my partner to pretend for a few days that we would keep it. So we reviewed the organizational issues, searched for solutions for the financial, practical aspects of the story (and found them)."*
> (woman, pre-abortion)

An exploration of new horizons also occurred when participants had counterfactual thoughts. They thought about what would happen if the barriers for not having the baby right now were to disappear. They reflected on what the outcome of the decision would look like if they were able to remove these barriers.

> *"But if I allowed myself to think: 'Maybe it is his child, what if it is his child?' And then I would be talking about the person who I love the most, and who could have been the father of the child. Then it was more difficult for me. I realized that if I knew it was his child, even it had not been planned at all, it would have resulted in a lot of difficulties, it would have been much more difficult for me to let it go."*
> (woman, post-abortion)

Finally, some participants also explored the possibility of carrying the pregnancy to term when they were confronted with positive examples of women or couples who had decided to have another child. This included, for instance, when popular magazines shared the story of a mother who raised four children on her own or when friends told them about positive experiences about having another baby.

> *"If I sometimes read or see messages on television about families with three or more children, I sometimes ask myself 'they succeeded despite everything, no?' "*
> (woman, pre-abortion)

The provision of meaning to having children or being pregnant.

Another category of dialectical moments was moments of reflection about the emotional, relational, philosophical, or religious meaning of having children or being pregnant. It concerned moments in which participants had thought about children as being symbols of love (for their partner), joy, and laughter in life, or being a woman. This happened, for instance, when they enjoyed being a parent for their current children, when they saw other people enjoying their children, or when they were confronted with the meaning of having children for their relationship with their partner.

> *"Yesterday, my mother in law showed me pictures of N. (my partner) when he was young… A beautiful, cute little boy of 3 years old. At that moment, I realized how much I want to have children with him in the future; mix our genes into one. (…) I suddenly felt guilty for a moment because at this time, I have this in me, our baby…"*
> (woman, pre-abortion)

Apart from reflections on children being symbols for what people desire in life (love, joy, …), participants also described moments in which they thought about the pregnancy and the fetus as being a natural wonder, a spiritual confrontation with "life". Very frequently, these moments of reflection occurred when they were confronted with the ultrasound, when experiencing pregnancy-related symptoms or when others described pregnancies or children as being a wonderful experience. Sometimes it made the participants feel shameful or guilty.

> *"I am a very religious person and I thought about the fact that being pregnant is a gift that I was/we were able to receive from God."*
> (woman, pre-abortion)

Matching the decision to the desires and decisions of others.

Participants sometimes had dialectical thoughts about carrying the pregnancy to term when they were confronted with other people who wanted or had decided to have children at a certain point in their life. This happened, for instance, when participants thought about others not being able to have children when they would like to. More frequently, however, it happened when the participants saw friends, colleagues, or strangers who were pregnant or accompanied by children, when they saw pictures of babies, or were confronted with children in real life.

> *"After the abortion, my friend gave birth to a child. I visited her in the hospital and then it was very hard for me. If I had been pregnant at that moment, I would have been very doubtful about keeping the pregnancy."*
> (woman, post-abortion)

For some participants, reflections on carrying the pregnancy to term were also apparent at moments in which the (hypothesized) desire of others around them for having the child was taken into account.

"My mother would be so happy with a grandchild."
(woman, pre-abortion)

One category of reflections on carrying the pregnancy to term was only prevalent in the sample of involved male partners. These were the thoughts the male partners had about the emotional burden of the abortion for their female partners.

"When the mother started to talk earlier about the fact that she saw our child on the ultrasound, and she could not avoid crying at that moment, I doubted myself for a second."
(man, pre-abortion)

Considering social norms and ethics about parenthood, abortion, and decision-making.

Participants sometimes had thoughts about carrying the pregnancy to term when they reflected on the ethics of having an induced abortion. They thought, for instance, about not having the right to terminate a pregnancy or occasions when others had talked or written about abortion being murder.

"Certain 'judgements' about abortion played tricks with me. I know that a lot of people hold negative perceptions about it."
(woman, pre-abortion)

Participants also described moments in which they reflected on the social norms regarding parenthood, often concerning the age at which having children is "socially acceptable" and "normal". A desire to belong to the group of people who decides to have children at that age was also reported as a reason to consider the option of carrying the pregnancy to term.

"On the day of the pregnancy test I had thoughts about wanting to belong; a lot of friends and relatives have children now."
(woman, pre-abortion)

For a small number of participants, thoughts about carrying the pregnancy to term came up when they reflected on the social norms about decision-making. This happened, for instance, when others asked them to think about the decision for a longer period of time or suggested they thought carefully, or when they were confronted by others describing decision-making processes.

"When I read an op-ed piece in the newspaper about our materialistic urge and how this influences the decisions we make in our lives."
(woman, pre-abortion)

(Consciously) considering the pros of having the child.

For a few participants, thoughts about continuing the pregnancy were consciously evoked by a (rational) consideration of the pros of having the child. Most of the participants described this in terms of a subtle pressure to undergo the theoretical exercise of weighing up the pros and cons.

"After we knew for sure (from the pregnancy test) that we were pregnant, we discussed this together and, although from the onset I thought about not keeping it, we nevertheless still needed to weigh up the pros and cons."
(woman, pre-abortion)

The Report of Dialectical Thoughts in Association with General Ability to Achieve closure, Educational Level, Age, and Gravidity

In a first step, we fitted a Mixed Logistic Regression model with a random intercept for each individual, and fixed effects for general ability for cognitive closure, educational level (3 categories), age (3 categories), gravidity (2 categories), and their interaction with time (pre- or post-abortion). As there was no evidence of any differential effects between pre- or post-abortion, the interactions of these terms with time were dropped in a second step. Table 4 presents the estimated ratios (with their 95% confidence intervals). An odds ratio larger than one implies higher probabilities of the reporting of dialectical moments. In females, we thus find that at both time periods, higher ability to achieve cognitive closure was associated with lower odds of reporting dialectical moments, and higher educational level was associated with higher odds. In males, no significant associations were found (results not shown). This might be due to the smaller sample size.

Next, we explored the effect of the report of dialectical moments on emotional distress. We fitted a Linear Mixed Model with a random intercept for each individual and fixed effects for pre- and post-abortion reports of dialectical moments, general ability to achieve closure and educational level on pre-abortion and post-abortion total mood disturbance. The results are outlined in Table 5. In females, there was no evidence for the effect of pre-abortion reporting of dialectical moments on pre-abortion emotional distress. However, there was an effect of post-abortion reporting (but not of pre-

abortion reporting) of dialectical moments on post-abortion total mood disturbance[7]. In males, no significant associations were found (results not shown).

Table 4

The Report of Dialectical Moments Pre- versus Post-Abortion in Association with Age, Educational Level, Gravidity, and General Ability for Cognitive Closure (AAC) (NB: only the female data is shown)

	OR	95% *CI*
Period		
Ref.: Pre-abortion		
Post-abortion	0.53	[0.26, 1.08]
Age		
Ref.: <30		
30-39	1.33	[0.52, 3.37]
≥40	1.23	[0.25, 6.06]
Educational level		
Ref.: <Junior High School		
Secondary High School	3.65	[0.99, 13.43]
Bachelor/Master	4.94	[1.26, 19.32]*
Gravidity		
Ref.: No previous pregnancy		
Previous pregnancy	0.91	[0.37, 2.28]
AAC	0.45	[0.30, 0.70]***

Note. * $p < .05$; *** $p < .001$. *OR* = odds ratio of the report of dialectical moments; *CI* = confidence interval.

[7] No additional effect of the number of dialectical thoughts (one versus more than one) was found (results not shown).

Table 5

Emotional Distress (TMD) of the Women in Relation to the Report of Dialectical Thoughts

	Pre-abortion TMD		Post-abortion TMD	
	Estimate	95% *CI*	Estimate	95% *CI*
AAC	-1.34	[-1.87, -0.82]***	-0.58	[-1.34, 0.17]
Educational level				
Ref.: <Junior High School				
Secondary High School	0.52	[-1.15, 2.19]	0.53	[-2.35, 3.42]
Bachelor/Master	-0.66	[-2.31, 0.98]	-0.20	[-2.98, 2.59]
Pre-abortion report of dialectical moments	0.23	[-0.94, 1.40]	-0.26	[-1.98, 1.46]
Post-abortion report of dialectical moments			1.96	[0.31, 3.61]*[8]

Note. * $p < .05$; *** $p < .001$. *CI* = confidence interval.

DISCUSSION

In this study, a mixed methods longitudinal design was used to expand the knowledge on the occurrence, content, determinants, and effects of dialectical thoughts about carrying the pregnancy to term during the decision to have an induced abortion.

Prevalence of Dialectical Thoughts

While about one half of the abortion-seeking women and male partners reported having had at least one moment in which thoughts about continuing the pregnancy came to their mind in the pre-abortion questionnaire, the other half stated that they did not have any of these moments. Women and male partners were equally likely to report the occurrence of such moments. For those who did have such moments, only a minority reported having had more than two. In addition, these dialectical moments seemed to be rather limited in time (e.g., "I suddenly felt guilty for a moment"). This finding is comparable to the results of a British study from 1985 in which it was shown that while some women never thought about carrying the pregnancy to term, some only thought about it once or twice, and

[8] The post-abortion report of dialectical thoughts was positively associated with the score on every negative subscale of the POMS.

others (a minority) thought about it on multiple occasions, from time to time (as reported by Rowlands, 2008). Degree of ambivalence during decision-making, might indeed vary in intensity (Abbey & Valsiner, 2004; Rowlands, 2008). It might also be the case that even for those who did not report these moments, a short reflection on continuing the pregnancy has actually taken place (for instance when the unintended pregnancy was confirmed), but without this being remembered as a moment of dialectical contradiction. Indeed, others have reported that a substantial proportion of women have already decided that they would have an induced abortion before they have an unintended pregnancy or decide on it very quickly after the pregnancy is confirmed (Rowlands, 2008). This quick "crystallization" of the decision might be due to a process of seizing (i.e., an immediate desire for closure), as proposed by cognitive closure theory (Kruglanski & Webster, 1996). In addition, women or male partners might have ignored ambivalent, ambiguous, or contradicting information as a way of motivated self-protection, as predicted by the freezing tendency (an attempt to preserve current "knowledge") in cognitive closure theory (Kruglanski & Webster, 1996). Anyhow, although the occurrence of dialectical moments when deciding to have an abortion is common, it is not standard, and rather limited in frequency and time.

Six Categories of Dialectical Thoughts

Our first, highly prevalent category of dialectical thoughts concerned moments in which women or male partners thought about future negative effects of having the induced abortion, or in which they imagined how their future might be with the child *(Projection of the self in the future).* This category of thoughts resembles the anticipation and reflection strategies of parents who struggle with contradictory feelings or attitudes towards their parenting tactics, defined by Kuczynski & De Mol (2015) as "meta-parenting". Those who opt to have an induced abortion seem to use their imaginative capacities to reflect on the option of carrying the pregnancy to term, in addition to a rational weighing up of the pros and cons of having the child, as reported by others (Allanson & Astbury, 1995). Indeed, it was found that moments of logical reasoning about the other side of the coin were reported by only a small proportion of our participants (the sixth category of dialectical thoughts: *Consciously considering the pros of having the child*). Reflections by women on the odds of having a child in the future were also amongst the most prevalent dialectical moments. This is in line with the results of Allanson (2007), who found that abortion-seeking women's most prevailing reason for choosing to continue with their pregnancy instead, is the desire to have children in the future. Also moments in which women and men anticipated possible emotional or relational difficulties following the induced abortion were quite prevalent. Although most abortion-seeking women expected to cope well with the induced abortion, a certain group of women expected to feel guilty or sad after the abortion (Foster, Gould, & Kimport, 2012b). Other researchers have indicated that these negative anticipatory

thoughts might give rise to emotional distress, both in women and in involved male partners (Lauzon et al., 2000).

A second highly prevalent category included moments in which abortion-seeking women or male partners cognitively or actively explored or were confronted with possibilities other than terminating the unintended pregnancy (*The exploration of other horizons*). These moments included counterfactual thoughts ("what if this or that were different") on the one hand (a known phenomenon in social psychology with varying adaptive and maladaptive functions; e.g., Roese & Olson, 1995) and the active search for solutions to practical barriers preventing them from having the child on the other. These counterfactual thoughts and corresponding search for practical solutions can best be understood from the finding that most abortion-seeking women and male partners refer to the induced abortion as a pragmatic decision necessitated by timing and situational lifestyle issues that make responsible parenting impossible (current age, education, finances, relationship, or family size; Bankole, Singh, & Haas, 1998; Biggs, Gould, & Foster, 2013; Kero & Lalos, 2000). Sometimes, however, participants were confronted, usually by others, with the possibility of raising a child despite these practical barriers. The aforementioned moments seem to have made participants think about the most necessary elements of good parenting. This resembles the meta-parenting processes of problem-solving and assessing strategies (reflecting on what makes a good reason for certain decisions; Kuczynski & De Mol, 2015). In this oscillating process of reflecting, anticipating, assessing, problem-solving, and imagining, the women and men in our study constructed thoughts about the emotional, ethical, relational, and religious meanings of having children or being pregnant (the third category of dialectical moments: *The provision of meaning to having children or being pregnant*). During this meaning-making process, women might make connection with important goals in their lives such as a wish not to continue their relationship with the involved male partner (e.g., Jones, Moore, & Frohwirth, 2011), the importance of their existing children or their desire to become a mother ever again. Hence, this demonstrates the moral agency of abortion-seeking women and male partners (see Furedi, 2016).

The fourth and fifth categories of dialectical thoughts (*Matching the decision to the desires and decisions of others,* and *Considering social norms and ethics about parenthood, abortion, and decision-making)* revealed that, as others are also involved in the reasons that underpin having an induced abortion (e.g., Vandamme et al., 2017), interactions with loved ones and other people in society (e.g., when reading messages on the internet) also indirectly or directly feed into thoughts about carrying the pregnancy to term. Women and male partners match their own preferences to the desire for children of people close to them (both with regard to their own hypothesized child and the general desire for children of other people). Male partners have been reported elsewhere to be especially concerned with the needs and desires of their pregnant female partners (Halldén & Christensson,

2010). This results in participants reflecting on the importance of these loved ones in their future lives, which ties in to the known relational dialectic tension between inclusion and separation (Baxter & Erbert, 1999). They also match these preferences and ways of deciding to the prevailing social norms on parenthood, induced abortion and decision-making in society. This phenomenon is studied in the literature on abortion stigma in which individuals, especially women, sometimes feel a discrepancy between what they would be expected to do in their role as nurturing mother and what they are currently doing (Kumar, Hessini, & Mitchell, 2009).

In summary, the analysis of these dialectical moments brought to light that in every reflection on continuing a pregnancy, there is another side where the validity of the reasons for having the abortion are considered. This dialectical, oscillating process is inherent to human decision-making and helps men and women to create meaning in order to overcome contradictory needs, attitudes, emotions, or future goals (Abbey & Valsiner, 2004; Baxter, 1990; Guarana & Hernandez, 2016; Kuczynski & De Mol, 2015). A moment of thinking about continuing the pregnancy may then arise as either a reaction to external influences–such as a conversation with a family member, watching other children playing, hearing the heartbeat on the ultrasound or reading a message on the internet–or as a reaction to an inner reflection process. Very often, these two processes, defined by others as internal, and external dialectics (Baxter & Erbert, 1999; Kuczynski & De Mol, 2015), are interrelated. These results additionally seem to suggest that if a woman were to decide to change her mind and carry the unwanted pregnancy to term, adaptive outcomes would only be present in the case that this is preceded by a process in which internal, autonomous reasons for having the child are given weight rather than external reasons such as “because my mother would like to have a granddaughter”. This is supported by previous research showing that external pressures to continue a pregnancy are generally larger than the external pressure to have an induced abortion in cases of unwanted pregnancy (Skjeldestad, 1986).

The Occurrence of Dialectical Thoughts Depends on Personality and Educational Level

Our findings suggest that general cognitive abilities and capacities (general ability for cognitive closure, educational level) should be taken into account when studying women’s contradictory feelings, attitudes, needs, or goals during the decision to have an induced abortion. Indeed, being able to assess, reflect, anticipate or imagine demands a certain cognitive load and individuals might differ in how they manage this cognitive burden (Roets & Van Hiel, 2007). This is line with findings of Foster et al. (2012a) and Vandamme et al. (2017) regarding the influence of general difficulties in making decisions on women’s and male partner’s feelings of confidence or uncertainty in these situations. In contrast to Foster et al. (2012a), however, who demonstrated a positive relationship between educational level and being certain about having the induced abortion, we found that those with a

higher educational level reported more dialectical moments in which they thought about carrying the pregnancy to term. This might be explained by the difference between *being certain or having confidence* in the decision to opt for induced abortion (an outcome variable, measured at the moment women enter the abortion clinic) and retrospectively reporting *moments in which there were thoughts about the other side of the coin* (a process variable). Based on our results, we hypothesize that those with a higher educational level have a higher capacity to cope with the cognitive overload *during* the decision-making process.

A Time-Dependent Relationship Between the Occurrence of Dialectical Thoughts and Emotional Distress

As expected, and predicted by previous research, women with a lower ability to achieve cognitive closure were generally more prone to experiencing emotional distress prior to having an abortion (Roets & Soetens, 2010). It might be the case that an underlying personality factor such as neuroticism might explain this relationship (e.g., Pinquart et al., 2008) or that this relationship is due to frustrations about other (more minor) decisions in life besides the abortion. The level of distress experienced by abortion-seeking women prior to the abortion is evidently higher than for the involved male partners. For both of the partners, however, emotional distress post-abortion tended to return to population based levels, something that has also been shown by others (Rocca et al., 2015). As expected, based on previous qualitative research, no association was found between reporting having had dialectical moments pre-abortion and emotional distress pre- or post-abortion. This suggests that women who enter the abortion clinic who are able to recall moments in which they have thought about continuing the pregnancy should not be seen as problematic (Kero & Lalos, 2000; Rowlands, 2008). Similarly, those who do not report thoughts about carrying on with the pregnancy should also not be seen as problematic as their levels of distress post-abortion are comparable to those who did report these dialectical moments. Hence, no evidence has been found for the idea that women who put in a larger amount of effort in order to consider all the factors influencing their decision (including the contradictory factors) protect themselves from post-abortion distress (Rowlands, 2008). Despite this, an interesting point revealed by the longitudinal setup of our study is the results showing a positive association between report of these reflections post-abortion and post-abortion emotional distress, even after controlling for general ability to achieve cognitive closure. This suggests that being able to recall specific moments in which the decision leaned towards carrying the pregnancy to term once the decision is irreversible, might be associated with emotional difficulties. This phenomenon can best be understood from the freezing tendency outlined in cognitive closure theory, which states that preserving previously-acquired attitudes or stories such as “the abortion was the best solution for me,

my partner and the unborn child" has an adaptive function post-decision-making (Kruglanski & Webster, 1996). This finding therefore highlights the need to look upon the value and effect of ambivalent thoughts on decisions around induced abortion from a time-dependent perspective.

Implications for Practice

The results of this study suggest that in pre-abortion counseling, women and male partners' needs and whether or not they want to reflect on the decision process should definitely be taken into account. This already occurs in the counseling sessions offered in Flanders (Belgium) (Vandamme et al., 2013). It might be the case that for those who have general difficulties with closing their minds to contradictory information or those with a higher level of education, having a conversation in which cognitive reflection is introduced will make thoughts about carrying the pregnancy to term more likely to pop up. The presence of these thoughts pre-abortion should not, however, be interpreted as feelings of doubt likely to give rise to emotional difficulties, but should instead be perceived as rooted in that individual's general cognitive capacities, and therefore part of a possibility for constructing meaning and making more effective decisions. Scharwächter (2008) demonstrated that the therapeutic technique of focusing (i.e., paying attention to bodily senses in order to construct new perspectives on the experienced contradictions regarding the unintended pregnancy) might be helpful in cases of enduring contradictory feelings or attitudes regarding the decision to opt for an induced abortion.

Health care providers working in abortion clinics should, however, be vigilant to women or male partners who have clear memories of moments in which they thought about continuing the pregnancy *after* the induced abortion has taken place since these people might be vulnerable to a higher level of emotional distress post-abortion. Hence, post-abortion counseling services might help these women and men to cope with persistent contradictory feelings, needs, goals or attitudes.

Strengths, Limitations, and Future research

This was the first study to ask both women and their male partners to retrospectively report on their own qualitative process of deciding to have an induced abortion. Involving men in research in induced abortion is quite new, and has been demonstrated to be valuable as we know women's experiences of the (decision about the) unintended pregnancy are influenced by the experiences of their male partners and vice versa (Kroelinger & Oths, 2000; Vandamme et al., 2017). In this study, we looked at dialectical thoughts in the decision to have an abortion and the effects of these thoughts on emotional distress separately for women and male partners. By focusing on the moments in which participants thought about *not* having the abortion, we add to the broad body of literature on women and male partner's reasons for having an induced abortion (e.g., Allanson, 2007; Vandamme et al.,

2017). As such, a "both-and" perspective is taken, instead of forcing participants to "rationalize" and "justify" their decision when they are being asked to state why they decided to opt for an abortion. The advantage of our study design is that we used a pre-post longitudinal design, which contrasts with previous studies in which male partners were mostly recruited post-abortion or where samples were confined to those in need of professional help (e.g., Holmberg & Wahlberg, 2000; Naziri, 2007). In addition, we used a combined qualitative and quantitative analysis technique. This enabled us to explore the content of both partners' dialectical moments, with the aim of increasing understanding of how couples make a decision to have an induced abortion, as well as testing the hypothesized effects of these moments based on existing theories.

This study has been subject to a few limitations, however. First and foremost, the dropout rate was quite high despite the use of text message reminders. Dropout is likely to be due to three different causes. One group of women probably did not have the induced abortion[9]. These might be the women who eventually changed their mind (although this is hypothesized to be a small group based on clinical data an based on previous studies; see Rowlands, 2008), women who were denied the abortion because of time limits (n = 5 in our sample), women who had a miscarriage in the post-counseling period or women for whom no pregnancy could be detected on the ultrasound (although the latter group is hypothesized to be small as these women probably would not have participated in the second data wave of the study). Another group of women probably dropped out because of motivational issues. These are for instance the high emotional and practical burden on participants of filling out a questionnaire post-abortion (e.g., male partners who dropped out had a lower ability to achieve cognitive closure), or an initially external motivation for participation (i.e., participating to please the health care providers working in the abortion centers), which might disappear in the post-abortion period. Based on the dropout analysis, we hypothesize that dropout was not completely random but was nonetheless independent of the scores on the main variables in our analysis (the occurrence of dialectical moments and emotional distress). As has already been put forward by others, future research should aim to further follow-up abortion-seeking couples who eventually decided to carry the unintended pregnancy to term, as this group of women might be vulnerable to higher degrees of external pressure in the decision process (Skjeldestad, as cited in Rowlands, 2008). In addition, the post-abortion questionnaire took place 14 days after the abortion. As reported by others (Rocca et al., 2015), emotional distress post-abortion further decreases as the weeks and months go by. Hence, the

[9] In 2015, 16% of the women who had a pre-abortion counseling session at one of the five LUNA abortion centers, did not return for the abortion procedure (unpublished internal data). These women might have had their abortion elsewhere (for instance in the Netherlands), might not have been pregnant, might have been confronted with a miscarriage, might have changed their mind, etc.

effect of the occurrence of dialectical thoughts we found in the post-abortion questionnaire might have been different if we had measured emotional distress six months or a year post-abortion. Furthermore, the turning points questionnaire was presented twice, which might have led to recall effects in participants.

Secondly, pre-abortion emotional distress was measured prior to the counseling session even though it has been demonstrated by others (Vandamme et al., 2013) that emotional distress tends decrease after the counseling has been received. Hence, it might be hypothesized that variation in levels of post-counseling distress might be more informative than levels of pre-counseling distress. However, we tested the association between the report of dialectical thoughts and other measurements of emotional wellbeing (post-counseling, but still pre-abortion) and these yielded the same results.

Thirdly, in the mixed methods analysis, we only looked at the effect of an absence or presence of dialectical thoughts, and did not directly focus on the number of these moments. Others have suggested that a higher prevalence of these dialectical thoughts is associated with higher decision complexity, and might directly give rise to decreased emotional wellbeing (Allanson, 2007; Baxter & Bullis, 1986). We did not, however, find evidence for this hypothesis. Finally, we did not explicitly investigate how participants actually coped with the contradictions they experienced during the moments in which they thought about carrying the pregnancy to term (whether they ignored it, communicated about it with others, or reflected on it on their own). As shown by Baxter & Bullis (1986), gaining insight into these situational ways of dealing with ambivalence or ambiguity could be a useful strategy for future research.

CONCLUSION

About half of the abortion-seeking women and male partners who enter an abortion clinic reported having had at least one moment in which they thought about carrying the pregnancy to term. During these moments, they reflected on past experiences, considered and assessed different possibilities, anticipated future difficulties, created meaning around having children, and thought about the roles of significant others. The recall of these moments should not be seen as problematic as there is no association with pre- or post-abortion emotional distress. The presence of these moments is rooted in people's general cognitive capacities, needs, and abilities. However, those who are able to recall specific moments post-abortion are vulnerable to increased emotional distress.

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6 The value of pre-abortion counseling

Based on Vandamme, J., Wyverkens, E., Buysse, A., Vrancken, A., & Brondeel, R. (2013). Pre-abortion counseling from women's point of view. *The European Journal of Contraception and Reproductive Health Care, 18*, 309-318. doi:10.1080/13625187.2016.1255940

ABSTRACT

Objective. The value of mandatory pre-abortion counseling for women seeking abortions has been repeatedly questioned. The aim of this study was to explore the perspectives and feelings of almost 1000 women regarding pre-abortion counseling in Flanders.

Methods. Participating women (*N* = 971)—all requesting an abortion at one of the five Flemish abortion centers—were offered a questionnaire prior to the counseling session and immediately afterwards. Both questionnaires measured their emotional and cognitive state as well as aspects of the content and the perceived value of the counseling session.

Results. Prior to the counseling, women are hesitant regarding the value of the sessions, feel distressed, yet decisive about their abortion. After the counseling session, women assign an increased value to the counseling, are very satisfied, and experience less distress and greater decisiveness. During counseling the abortion procedure (89%), the use of contraceptives (83%), and the individual decision-making process (81%) are nearly always addressed. The sessions are tailored to each woman and to the needs they expressed with regard to the content of the counseling.

Conclusions. Pre-abortion counseling in Flanders is standardized as well as personalized. The women in this study positively valued it.

INTRODUCTION

Abortion has been performed at all times, in all societies, and continues to play an important role in fertility control (Timpson, 1996). Despite its importance in family planning, it remains a complex and controversial issue that challenges the legal, political, moral, religious, and economical structures in society. For example, the long-term mental and physical effects following abortion have been extensively studied (Charles, Polis, Sridhara, & Blum, 2008; Thorp, Hartmann, & Shadigian, 2002; Major et al., 2009). Results from these studies have been interpreted by several Pro-Choice and Anti-Choice movements, flaring up the ideological and contentious debate on induced abortion (Løkeland, 2004). This debate is reflected in the legality, availability, and accessibility of abortion services, which differ all over the world. Even in Europe, there is an enormous variability, ranging from liberal abortion laws and easily accessible services to complete prohibition or inaccessibility (Pinter et al., 2005). Some countries have given priority to the prevention of women's mortality by providing safe abortions while others have well-established abortion care services with health insurance systems covering all the costs. An important difference regarding these services, concerns the existence of a mandatory pre-abortion counseling session, on the one hand, and a mandatory waiting period, on the other. Both legal requirements apply in Belgium.

Since 3 April 1990, abortion has been legal in Belgium, which permits women in a state of distress to terminate their pregnancy until 12 completed weeks of gestation. These states of distress are not further specified by law, since they are perceived and their impact is judged autonomously by the women themselves (SENSOA, 2011). The law states that every abortion must be performed in a multidisciplinary institution which provides information and counseling services. The law also imposes a mandatory reflection period, of at least six days between the pre-abortion counseling session and the termination itself. Both of these services have to take place in the same institution.

In Flanders (the Northern part of Belgium), five abortion centers (part of the "LUNA" association) have been established within the primary health care system in addition to certain hospitals where abortions are also performed. In practice, the multidisciplinary care which is imposed by law embodies a non-directive counseling session with a psychosocial worker and a medical consultation with a doctor (which includes performing an ultrasound), both taking place during the woman's first visit. The pre-abortion counseling session in these centers is conceived as an opportunity for all the women to talk. It aims at supporting women and providing them with the information they need in order to facilitate or consolidate their decision-making process. Therefore, the psychosocial workers in the LUNA abortion centers are trained to adopt a non-judgmental and non-directive attitude. This training is inspired by a client-centered approach, which emphasizes the importance of empathy and brings the specific needs of each client into focus (Rogers, 1956). Previous studies concerning abortion health

care have shown the importance of the provision of information by supportive and non-judgmental staff, addressing the needs and interests of the individual client (Beja & Leal, 2010; Harden & Ogden, 1999; Kumar, Baraitser, Morton, & Massil, 2004; Lie, Robson, & May, 2008; Slade, Heke, Fletcher, & Stewart, 2001; Surman, 2001).

The usefulness of mandatory pre-abortion counseling is a hotly debated subject. Opponents postulate that counseling is superfluous and intrusive since the majority of women already have made their decision when consulting abortion services (Brown, 2013; Foster, Gould, Taylor, & Weitz, 2012; Kumar et al., 2004; Rowlands, 2008; Törnbom, Ingelhammar, Lilja, Svanberg, & Möller, 1999). They argue that counseling should only be targeted at those in need, namely, women who find it hard to make a decision or are at risk of post-abortion problems (Brown, 2013; Törnbom et al., 1999). In contrast, literature has indicated women's high satisfaction with the abortion counseling (Zapka, Lemon, Peterson, Palmer, & Goldman, 2001), and the possible benefits of the latter on women's mental health post-abortion (Steinberg, 1989).

However, research has rarely examined pre-abortion counseling. Specific literature on abortion care is scarce, and differs in many respects. The existing studies have focused on women's general experiences with the abortion care, ranging from the first appointment with a doctor, to the final abortion in a specific clinic (Harden & Ogden, 1999; Kumar et al., 2004; Slade et al., 2001; Zapka et al., 2001). Moreover, these studies have been conducted in countries and areas with completely different legal and cultural climates, making it very difficult to come to general conclusions about the role of pre-abortion counseling.

The present study aims to complement the literature on pre-abortion counseling, both theoretically and methodologically. Theoretically, our study explored the perceived value and preferred content of pre-abortion counseling as indicated by the women themselves. Methodological advancements of the study included (i) the use of a pre- and post-measurement design, and (ii) assessment right before and immediately after the counseling session. This contrasts with how data were gathered in other studies, which took place approximately one month after the abortion procedure (Kumar et al., 2004; Slade et al., 2001; Zapka et al., 2001). Therefore, our study was the first to compare women's pre-counseling needs with their post-counseling evaluations. To our knowledge, there is only one other study—which analyzed perceptions regarding couples' counseling—that used this methodology (Becker, Bazant, & Meyers, 2008).

The purpose of our explorative study was to examine pre-abortion counseling in a specific context (i.e., Flanders, where every abortion-seeking woman goes through this counseling session), from a specific point of view (i.e., the women themselves), and at a specific point in time (i.e., during the first visit to the abortion center). We wished to discover (i) what women want to discuss and to what extent this is reflected in the actual counseling session, (ii) the emotional and cognitive state of

women when entering and leaving the abortion center, and (iii) how women experience the counseling session and to what extent they perceive it as useful. By taking the pre-abortion counseling in Flanders as a specific study case, we wanted to provide new insights into the debate about pre-abortion counseling.

METHOD

Procedure

This cross-sectional study involved women requesting an abortion between March 2010 and June 2010 in the LUNA abortion centers. The staff in the five abortion centers was invited to systematically recruit every abortion-seeking woman who attended the center. There were no exclusion criteria, except for women who did not speak Dutch, French or English, due to translation difficulties of the questionnaire. The recruitment technique consisted of an oral explanation of the purpose of the study, and an information letter. Of all women who refused to participate, their nationality, date of birth, and reason for non-participation were noted. Women who agreed to take part needed to sign the informed consent form which mentioned the strict confidentiality of data-gathering, the voluntary participation, and the impossibility for the abortion centers to have access to the completed questionnaires since each was sealed in an envelope and placed in a closed box. This study was approved by the Ethical Committee of the Faculty of Psychology and Educational Sciences at the University of Ghent.

Measures

Two questionnaires were presented to the participating women: one immediately before, and one immediately after the counseling session. Most questions were purposely constructed in accordance with the current abortion counseling practice in Flanders and the international literature on pre-abortion counseling. In addition, questions were reviewed and adapted together with experts in the field. After having pilot-tested the questionnaire with six (female) volunteers, questions continued to be revised until comprehensibility and an appropriate length were guaranteed. When parts of the questionnaire were not available in English or French, they were translated by professionals.

Background information.

Five background questions were asked in order to know more about the participants, the counsellors, and the sessions. Information was collected on participants' age, nationality, and

experience with previous induced abortions. Further, information was gathered about the counsellor's education level, and about the persons attending the session (women's companionship).

Counseling content.

Two multiple-choice questions dealt with the content of the counseling session, asking which themes women wanted to discuss during the session (pre-counseling), and which themes they eventually discussed (post-counseling). Based on participants' observations concerning the counseling sessions and discussion with experts, a list was made with 11 themes that covered the content of the counseling. Three themes concerned the exchange of information (*contraceptive use*, *information about the abortion procedure*, and *information about the consequences of the abortion*). Five themes dealt with aspects of the decision-making process (*the abortion-decision and possible doubts*, *reasons for the abortion request*, *alternatives to the abortion*, *emotions*, and *feelings of guilt*). Third-party involvement made up the final denominator, with *experiences of others*, *role of significant others*, and *religious aspects* as specific themes. A remaining category *other themes* was added in order to give women the opportunity to bring up issues that were important to them but were not on the formulated list. In addition, women were asked post-counseling whether some themes were not discussed even though they wanted to, and vice versa.

Emotional and cognitive state.

The questionnaire contained the Profile Of Mood States - Short Form (POMS-SF), which measures momentary mood states (Curran, Andrykowski, & Studts, 1995; McNair, Lorr, & Droppleman, 1992). This shortened version of the POMS, consisting of five subscales, showed an internal consistency of between .77 and .92 in this sample (Cronbach's α). Besides its reliability, the POMS-SF was shown to be both convergent and discriminately valid in clinical populations (Baker, Denniston, Zabora, Polland, & Dudland, 2002; Wyrwich & Yu, 2011). Using a 32-item inventory, five mood dimensions were assessed, including *depression* (eight items: minimum score 0; maximum score 32), *fatigue* (six items: minimum score 0; maximum score 24), *tension* (six items: minimum score 0; maximum score 24), *anger* (seven items: minimum score 0; maximum score 28), and *vigor* (five items: minimum score 0; maximum score 20). Each item was rated on a scale ranging from zero to four, with higher scores indicating a more negative mood, except for the *vigor* scale, which is positively formulated.

Eventually a *Total Mood Disturbance* (TMD) score was calculated by taking the mean of the scores on the negative subscales (*depression*, *fatigue*, *tension*, and *anger*) and the reversed score on

the *vigor* subscale [1] (Mackenzie, 2001). TMD scores ranged from 0 to 24. Mood states of the participants were measured prior to the counseling session (Time 1) and immediately after the counseling session (Time 2). The resulting scores were compared to the scores of a norm group consisting of 1127 female students of the University of Amsterdam (Van der Ark, Marburger, Mellenbergh, Wald, & Vorst, 2005). Despite differences in age, culture, and country of origin, it is the best Dutch-speaking comparison group available.

In addition, participants were asked to rate their decisiveness regarding the abortion decision at two points in time. Decisiveness was measured by asking: "How sure are you about your decision to terminate your pregnancy at this moment?" The degree of decisiveness was marked by the respondents on a *Visual Analogue Scale* (VAS) of 100 mm with a minimum score of zero (indicating that they were *not sure at all*) and a maximum score of ten (indicating that *their decision was definitely made*). The use of VAS in the area of mood states has shown high validity and high reliability (Steiner, Streiner, & Pham, 2005).

Perceived value.

One question concerned the usefulness of the counseling session to women, as perceived right before and right after the session. The answers were scored on a VAS, comparable to the one described above. Finally, participants rated on a VAS how satisfied they were with the conversation and to what extent they were satisfied with the topics they discussed (*content evaluation*) on the one hand, and the way they were treated (*process evaluation*), on the other hand.

All questions were offered prior to the counseling session and repeated immediately afterwards, except for background information (only pre-counseling) and satisfaction (only post-counseling). By asking identical questions before and after the session, we were able to observe possible changes in the women's emotional and cognitive state and their perceived value of the counseling. In this way, we improved our cross-sectional study for certain variables by taking into consideration the baseline measurements.

[1] In this chapter, a slightly different formula was used for the calculation of the Total Mood Disturbance score than in Chapter 5 (where a shortened version of the POMS was used). Here, TMD scores could not be negative (as we first reversed the scores on the vigor subscale and calculated the overall mean of the five subscales) in contrast to the TMD scores used in Chapter 5 (where we subtracted the scores on the vigor subscale from the sum of the scores on the negative subscales).

Data Analysis

To determine whether the content of the counseling session was in accordance with the women's needs, logistic regressions were performed. Logistic regression models were also used to analyze other factors related to the presence of each theme during the session. To identify significant changes in women's emotional and cognitive state and the perceived usefulness, before and after counseling, *t*-tests for dependent samples were used.

As values related to important variables were missing in approximately 10% of the cases, a *Multiple Imputation Analysis* was conducted. We assume that the missing values can be related to certain research variables (e.g., mood states), therefore the *Missing Completely At Random Assumption* (MCAR) was replaced by a *Missing At Random Assumption* (MAR). All variables described within the scope of this research were put into the Imputation Analysis (background information, counseling content, pre- and post- emotional and cognitive states, and perceived value scores). Participants' age and the city where the abortion center was situated were only used as predictors since these variables had no missing values. All analyses were done using the statistical program *SPSS* (Version 19.0, SPSS Inc).

RESULTS

Sample

Of all 2,087 women requesting an abortion in the Flemish abortion centers during the three months of our study, 971 (47%) agreed to participate. The response rate was highest at the abortion center in Ostend (58%) and lowest at the abortion center in Brussels (34%). The main reasons for non-participation were *lack of interest* (34%), *language barriers* (26%), *lack of time* (16%), and *being under too much stress* (10%). Some women (8%) filled out the first questionnaire but not the second one. However, after Imputation Analysis, 971 complete cases remained. Most participants (94%) completed the questionnaire in Dutch, while 4% completed it in French, and 2% in English. The sample mainly consisted of women from Belgian origin (86%). Most of them were between 20 and 40 years old, with a mean age of 27.8 years (*SD* = 7.5). About 13% of the respondents were younger than 20, and about 8% of them were more than 40 years old. A comparison of the participating (*N* = 971) and non-participating women (*N* = 1116) revealed no differences in age (*t* = 1.77, *ns*), but they did differ with regard to nationality ($\chi^2(2) = 1.73$; $p < .001$). In fact, almost half (46%) of the non-participating women were non-Belgian, compared to 14% in our sample.

Over a quarter (27%) of the participants had already had an induced abortion in the past. More than half (54%) entered the sessions accompanied by at least one person, most often their partner (58%). In general, the counseling sessions were carried out by healthcare providers trained in *Social*

*Science*s or *Sexology* such as psychologists (30%), sexologists (12%), and social workers (8%). Healthcare providers with a purely medical background (i.e., general nurses), were present in 10% of the sessions.

Counseling Content

As shown in Table 1, some of the themes were discussed very often during the counseling session, while others were not. For example, nearly all sessions dealt with *Information about the procedure* (89%), *Contraceptive use* (83%), and *Decision and doubts* (81%), while few women indicated having discussed topics such as *Religious aspects* or *Feelings of guilt* (8% and 13%, respectively). The six remaining themes (*Information about the consequences*, *Reasons for the abortion request*, *Alternatives to the abortion*, *Emotions*, *Experiences of others*, and *Role of significant others*)–for further purposes referred to as 'varying themes' –were discussed in between 20% and 80% of the cases. After the session, four women reported having talked about other themes, such as financial or relational issues. Women's needs seemed to be greatest for the themes *Information about the procedure* and *Information about the consequences*, and smallest for *Feelings of guilt* and *Religious aspects*. As shown in Table 1 as well, for certain themes (e.g., *Information about the procedure*), there was a good congruence between the number of women who felt they wanted to discuss a theme and the number who eventually did. However, certain other topics (e.g., *Contraceptive use* or *Emotions*) were discussed more than the women felt they needed. Post-counseling, 1% of the women wished to discuss a topic that was not dealt with in the current session; in most cases this concerned information about the costs of the intervention. In 4% of the cases, themes were taken up that women did not want to discuss, such as the private family situation, contraception, and emotions.

Logistic regressions were used to analyze whether the themes that were taken up were significantly related to women's needs. As shown in Table 2, this hypothesis was confirmed for all themes. For example, 77% of the women who wished to talk about the role of significant others eventually had the opportunity to do so, while only 40% of the women who preferred not to address this, talked about it during the session. Hence, when a woman had indicated a certain theme as a prior need, the chance that this topic was broached was two to ten times higher. However, it was also very common that a topic which women had not indicated as an initial need was discussed as well. To have a clear understanding of this phenomenon, new logistic regression models were tested. Within these models, independent variables about women's characteristics were added to predict the discussion or absence of six varying themes (those dealt with in between 20% and 80% of the sessions).

Table 1

Discussion of- and Client's Wish to Discuss Themes During Pre-Abortion Counseling Sessions in Flemish Abortion Centers

Themes	Discussed	Wanted
1. Information about the procedure	89%	82%
2. Contraceptive use	83%	34%
3. Decision and doubts	81%	40%
4. Emotions	76%	31%
5. Reasons for the abortion request	75%	36%
6. Information about the consequences	69%	73%
7. Role of significant others	46%	16%
8. Alternatives to the abortion	35%	31%
9. Experiences of others	29%	18%
10. Feelings of guilt	13%	8%
11. Religious aspects	8%	7%

Table 2

Discussion of the Themes During the Pre-Abortion Counseling Sessions, by the Initial Wish to Discuss These Themes

Themes	Not wanted	Wanted	*OR*	[*CI*]
1. Information about the procedure	62%	95%	10.35*	[6.49, 16.52]
2. Contraceptive use	77%	93%	4.17*	[2.51, 6.92]
3. Decision and doubts	74%	92%	4.07*	[2.47, 6.70]
4. Emotions	69%	92%	4.83*	[3.02, 7.73]
5. Reasons for the abortion request	70%	83%	2.07*	[1.42, 3.02]
6. Information about the consequences	44%	79%	4.77*	[3.34, 6.83]
7. Role of significant others	40%	77%	5.05*	[3.26, 7.81]
8. Alternatives to the abortion	26%	57%	3.82*	[2.81, 5.18]
9. Experiences of others	24%	47%	2.78*	[1.90, 4.08]
10. Feelings of guilt	10%	43%	6.73*	[3.76, 12.02]
11. Religious aspects	6%	37%	8.49*	[4.00, 18.03]

Note. * $p < .001$. *OR* = odds ratio of discussion of a theme that the woman wished to be taken up; *CI* = confidence interval.

Independent variables in these regressions were the initial wish ("need") to discuss the theme as well as baseline scores for TMD and decisiveness, women's age, experience with previously induced abortion, and women's companionship.

Results are outlined in Table 3. As expected, women's needs had a significant effect on whether or not the corresponding themes were discussed, even after controlling for all the other variables. Moreover, small but significant negative effects of age were found for the themes *Alternatives to the abortion* (Odds ratio [*OR*] = 0.97, $p < .01$), *Experiences of others* (*OR* = 0.96, $p < .001$), and *Role of significant others* (*OR* = 0.96, $p < .001$), indicating that these themes were discussed less with older women. Furthermore, the more decisive a women was, the more she talked about *Information about the consequences* (*OR* = 1.13, $p < .001$), *Reasons for the abortion request* (*OR* = 1.08, $p < .01$), and *Experiences of others* (*OR* = 1.10, $p < .001$). The experience of a previous induced abortion meant it was less likely that the theme *Information about the consequences* (*OR* = 0.62, $p < .01$) was mentioned. If someone accompanied the woman the themes *Information about the consequences* (*OR* = 1.51, $p < .05$), *Alternatives to the abortion* (*OR* = 1.42, $p < .05$), and *Experiences of others* (*OR* = 1.49, $p < .01$) were more likely to be touched upon. Mention of emotions was more common during sessions where women were in a more negative mood (*OR* = 1.04, $p < .05$). In sum, although certain themes were almost always discussed, counseling themes seemed to vary along with the clients' needs and the characteristics of the women attending the session (e.g., age, decisiveness).

Emotional and Cognitive State

In general, women reported rather negative feelings before entering the counseling session. One sample *t*-tests revealed that scores on three negative POMS subscales were significantly higher than those from the comparison group of female Dutch students (8.89 vs. 6.63 for *depression*, $t = 7.86$, $p < .01$; 10.14 vs. 7.79 for *tension*, $t = 11.65$, $p < .01$; and 8.65 vs. 7.98 for *fatigue*, $t = 2.88$, $p < .01$). The mean score on the Total Mood Disturbance Scale was 9.49 (*SE* = 0.16). By contrast, VAS scores for decisiveness were quite high, with a mean score of 7.86 out of 10 (*SE* = 0.10). To explore whether significant changes had occurred in these scores on TMD and decisiveness after the session, paired sample *t*-tests were used. As depicted in Table 4, results showed significant positive changes between pre-counseling and post-counseling scores. Post-test TMD scores were significantly lower ($t = -20.50$, $p < .001$) while scores for decisiveness had significantly increased ($t = 7.22$, $p < .001$). As a result, women were in a less negative[2] and more decisive mood compared with the start of the counseling session.

[2] A decrease was found in the score on every negative subscale of the Profile Of Mood States (*depression*, *fatigue*, *tension*, and *anger*). No increase in the score on the *vigor* subscale was found.

Table 3

Logistic Regression Analyses Indicating Characteristics of Women that are Associated with the Discussion of Six Varying Themes During the Pre-Abortion Counseling Session (OR [CI])

Characteristics of women	Discussion of the varying themes					
	Information about the consequences	Reasons for the abortion request	Alternatives to the abortion	Emotions	Experiences of others	Role of significant others
1. Need	4.78 *** [3.27, 6.99]	2.22 *** [1.52, 3.25]	3.80 *** [2.77, 5.22]	4.52 *** [2.79, 7.31]	2.81 *** [1.88, 4.19]	5.11 *** [3.29, 7.95]
2. Total Mood Disturbance	1.02 [0.98, 1.05]	1.01 [0.98, 1.04]	0.99 [0.96, 1.02]	1.04 * [1.00, 1.08]	1.00 [0.97, 1.04]	0.99 [0.96, 1.02]
3. Decisiveness	1.13 *** [1.06, 1.19]	1.08 ** [1.02, 1.14]	1.02 [0.97, 1.08]	1.01 [0.94, 1.07]	1.10 *** [1.04, 1.17]	1.02 [0.97, 1.07]
4. Age	0.99 [0.97, 1.02]	0.99 [0.97, 1.01]	0.97 ** [0.95, 0.99]	0.99 [0.97, 1.01]	0.96 *** [0.94, 0.98]	0.96 *** [0.94, 0.98]
5. Previous induced abortion	0.62 ** [0.43, 0.89]	0.99 [0.70, 1.41]	1.26 [0.90, 1.76]	1.24 [0.83, 1.85]	1.11 [0.76, 1.63]	0.92 [0.67, 1.28]
6. Companionship	1.51 * [1.06, 2.14]	1.00 [0.72, 1.39]	1.42 * [1.04, 1.93]	0.88 [0.62, 1.26]	1.49 ** [1.09, 2.05]	0.93 [0.69, 1.25]

Note. * $p < .05$, ** $p < .01$, *** $p < .001$. *OR* = odds ratio of discussion of a theme related to women's characteristics; *CI* = confidence interval.

Table 4

Mean Differences Between Pre-counseling and Post-counseling Scores for Emotional States (TMD) and Cognitive States (decisiveness)

	Pre-counseling		Post-counseling		Mean difference	
Emotional and cognitive states	*M*	*(SE)*	*M*	*(SE)*	*M*	*(SE)*
TMD	9.49	(0.16)	7.24	(0.14)	-2.25 ***	(.11)
Decisiveness	7.86	(0.10)	8.40	(0.08)	.53 ***	(.07)

Note. *** $p < .001$. TMD = Total Mood Disturbance; *SE* = standard error. Standard errors instead of standard deviations are presented because of the imputation technique that was used.

Perceived Value

The women's mean score for perceived usefulness of the counseling session was 6.36 out of a maximum of 10 (*SE* = 0.10), indicating a moderately positive perception. This perceived usefulness significantly rose up to a mean score of 8.44 out of 10 (*SE* = 0.07) after the counseling session ($t = 18.75$, $p < .001$). In addition, high satisfaction with the counseling session was reported. In fact, mean VAS score for satisfaction with the conversation was 8.68 out of a maximum of 10 (*SE* = 0.05). Further analyses showed a significant difference between scores concerning process evaluation ($M_{process} = 9.04$, *SE* = 0.04) and those related to content evaluation ($M_{content} = 8.67$, *SE* = 0.05), although the difference was small ($t = 9.81$, $p < .001$).

DISCUSSION

Findings and Interpretation in Relation to Other Studies

This study aimed at clarifying the value of pre-abortion counseling in Flanders, as perceived by a large sample of abortion-seeking women. Results showed that although women are in a rather negative mood and feel somewhat hesitant towards the counseling session when they enter the abortion center, they highly appreciate the standardized as well as tailored sessions, and feel better afterwards.

As observed by other authors, women seem to be afraid of being judged by the healthcare providers prior to the counseling session (Harden & Ogden, 1999). However, at the same time, they are quite decisive about their abortion request; this is in line with results from previous studies (Brown, 2013; Holmgren, 1988; Husfeldt, Hansen, Lyngberg, Nøddebo, & Petersson, 1995; Kumar et al., 2004; Törnbom et al., 1999). The emotional and cognitive state of abortion-seeking women can thus be described as ambivalent, since they feel both negative and quite resolute about their decision to terminate their pregnancy. This ambivalence has been brought to light in several studies. When

confronting their upcoming abortion, women feel sad as well as relieved (Aléx & Hammarström, 2004; Allanson & Astbury, 1995; Kero, Högberg, Jacobsson, & Lalos, 2001; Kjelsvik & Gjengedal, 2011; Törnbom et al., 1999).

The counseling sessions in Flemish abortion centers combine a predefined content and themes that vary along clients' needs and characteristics. Patients are always informed about the abortion procedure, their decision-making process is reviewed, and future contraceptive options are discussed. Portuguese healthcare providers also rated these themes as the most useful aspects of abortion counseling (Beja & Leal, 2010). The provision of information is considered to be an important aspect of counseling by the women themselves, as previously reported by other investigators (Harden & Ogden, 1999; Slade et al., 2001; Zapka et al., 2001), while the use of contraception and the decision-making process are often not a desired topic. Nevertheless, counselors do talk about prevention of future unwanted pregnancies, and they review the abortion decision.

Beside the standard content, dealing with all themes is related to the women's needs. As stated by Surman (2001) and Rogers (1956), it is important to keep in mind the varying needs and the uniqueness of every woman. When younger women seek counseling, sessions deal to a greater extent with alternatives to the abortion, the role of significant others, and the experiences of other women. We hypothesize that younger women, compared to those who are older, consider more elements when they make an abortion decision. A negative correlation between confidence in the decision, and being a teenager, has been reported in previous studies (Foster et al., 2012). Furthermore, it was shown that the more decisive the woman, the more the conversation will focus on the decision to abort itself since reasons for the abortion, information about the consequences, and experiences of others are discussed to a greater extent. When another person is attending the session, information about the consequences, experiences of others, and alternatives, are discussed to a greater extent, which suggests possible influences of third parties on the content of the sessions. Counselors also adapt the content of the exchange to women's personal experiences since information about the consequences is less often provided to women who already had an abortion in the past.

Women evaluate the offered counseling as extremely positive. This finding is in line with those of other studies that have indicated women's positive feelings towards the general abortion healthcare (Harden & Ogden, 1999; Slade et al., 2001; Zapka et al., 2001). The women we assessed were highly satisfied with the counseling session, felt less negative, were even more decisive, and perceived the session as more useful than they thought it would be before.

Strengths and Weaknesses

This was the first large study–with almost 1 000 women participating–to question abortion-seeking women "in the heat of the moment" (i.e., in the clinical setting, when waiting for their

counseling session), and at specific points in time (right before and right after the session with the counsellor). With the provision of a pre-counseling measurement, our study was able to explore changes in women's feelings, their thoughts about the decision, and their perceptions regarding the counseling session.

Yet some aspects limit the generalization of our findings. First and foremost, the study design was explorative, and we had no control group. As a result, it is impossible to determine whether the observed differences between pre- and post-counseling scores are entirely due to the sessions. For example, as time goes by, and the moment of their abortion comes closer, women may feel better, even without the counseling session. Be that as it may, we gathered information about the useful aspects of the sessions by asking all participants: "What was helpful in the session?" Their answers indicated that the non-directive attitude of the counselor was particularly helpful (e.g., "She said I have the right to make this decision"). A second limitation concerns the considerable number of women who did not participate because of language issues, not being in the mood, and other reasons. Mostly because of these language problems, non-Belgian women are less represented in our study sample. As emotional distress may have been another barrier to participation, our respondents may have been in a more positive mood than the average woman who seeks abortion. These selective dropouts, together with the moderate uptake rate, limit the representativeness of our sample. Thirdly, it is possible that the healthcare providers were influenced by the research involving their service. This could have resulted in an improved awareness or a sense that they were being "evaluated", which may have improved the care provided. Also the use of the pre-counseling questionnaire could have resulted in a clearer image of women's profiles and needs, which in turn might have improved the client-centeredness during these sessions. Finally, this study was limited to women seeking an abortion in the specialized LUNA abortion centers. Hence, no generalization to all pre-abortion counseling sessions in Flanders can be made as a small percentage of the induced abortions are performed in clinics as well.

Future Research

In view of the limitations to the representativeness of our sample, there is need for more research that will include a greater proportion of non-Belgian women, and women feeling distressed or anxious. Furthermore, as our study design was explorative and did not involve a control group, we were unable to answer questions about the effectiveness of the counseling sessions which are current practice in Flemish abortion centers. More research, with different designs (e.g., randomized controlled trials), must be undertaken. It should also elaborate on how the aforementioned tailoring processes develop and identify those which contribute to effective counseling.

CONCLUSION

The 971 women in our sample highly appreciated the counseling sessions, although they initially felt a certain restraint and had already a well-thought-out plan about their unintended pregnancy. Women's needs and profiles modified the content of the counseling and add to the standard part of the pre-abortion counseling sessions in Flanders.

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7 General Discussion

"Any single-level approach will fail

to explain the multilevel complexity

of the decision to have an induced abortion."

7.1 Main findings

In this dissertation, we aimed to add to the literature on induced abortion by examining the complex and interacting contexts in which the decision to have an abortion occurs. As outlined in Chapter 1, we focused on the gaps in current research at the three different levels in Hinde's contextual model of social complexity (Hinde, 1997): the between-group level (Chapter 2), the interpersonal level (Chapters 3 and 4), and the intrapersonal level (Chapters 5 and 6). In **Chapter 2**, the focus was on the sociocultural and sociodemographic context of the decision to have an induced abortion in Flanders, with special attention to the occurrence of unintended pregnancies and induced abortions in the Turkish minority group. In **Chapters 3 and 4**, we focused in on the interactional and relational context of the decision to have an induced abortion, with special attention paid to the role and experiences of involved male partners[1]. In **Chapters 5 and 6**, the focus was on the context of intrapersonal differences in the decision to have an abortion and variations in experiences over time, with special attention to the role of counseling. A summary of the findings of this dissertation is outlined below. In the following sections, each of these findings will be discussed in more detail.

1) The decision to have an abortion occurs in a specific sociodemographic and sociocultural context

a. Despite the fact that effective contraceptives have been highly accessible for many decades in Flanders, unplanned pregnancies (of all pregnancies that occurred between 1966 and 2012) were found to be quite prevalent. More than one in four pregnancies were reported to have been unplanned, which is comparable to the occurrence of unplanned pregnancies in other Western European countries.

b. Unplanned pregnancies, but not induced abortions in the event of an unplanned pregnancy, were found to be more prevalent among people with a lower level of formal education.

c. For less than one in five unplanned pregnancies, induced abortion was reported as the outcome of that pregnancy. This is a relatively low prevalence compared to the reports in other Western European countries.

d. Although the decision to have an abortion occurs within a specific cultural group, with specific social norms about the ideal number of children and timing of having them, the socio-demographic situations associated with the decision to have an abortion (age, marital status, parity) are quite similar across cultural groups.

[1] The term *involved male partners* refers to male partners who were aware of the unintended pregnancy and the planned abortion, and who had the opportunity to take part in the study.

e. Unplanned pregnancies are equally as likely to be unwanted in native Flemish men and women as in men and women from Turkish descent.
f. Social norms regarding the importance of parenthood, and associated stigma about induced abortion, might prevent couples in Flanders, as well as couples in more traditional cultures, from either opting for an abortion in the event of an unintended pregnancy, or reporting it.

2) The decision to have an abortion occurs in a specific relationship with a specific male partner

a. The type and quality of the relationships in which abortion-seeking women exist, vary enormously.
b. The male partners of abortion-seeking women often have a certain role in the decision to have an abortion, either in the process of deciding, in the outcome of the decision, or in both. However, the relational context affects his degree of involvement.
c. Women and involved male partners' experiences of the decision to have an abortion partially depend on the experiences of their partner.

3) The decision to have an abortion takes place in the personal context of a specific person with specific needs and abilities

a. Women and involved male partners' experiences of the decision to opt for an abortion (in terms of feeling uncertain or thinking about carrying the pregnancy to term), partially depend on general decision-making capacities and abilities.
b. Abortion-seeking women differ in what they need and what they desire from the available abortion services (e.g., only wanting information about the abortion, receiving the chance to state their motivation for the decision, thinking about future use of contraceptives).
c. Pre-abortion counselors take into account the individual differences outlined above. Women appreciate and benefit from this tailored abortion care.

4) Experiences with the decision to have an abortion might vary over time

a. Although women and involved male partners' decisiveness regarding having an abortion is very high when they enter the abortion center, moments of thinking about carrying the pregnancy to term might have occurred along the way.
b. While in the pre-abortion period, levels of distress are elevated, this distress returns to basic levels in the post-abortion period.
c. Levels of distress decrease and levels of decisiveness increase from pre- to post-counseling.

5) There are both similarities and differences in the experiences of women and involved male partners

a. An unplanned pregnancy is equally likely to be perceived as unwanted by men as by women.
b. Both women and involved male partners tend to be highly satisfied with the division of roles in the decision to have an abortion.

c. The decision to have an abortion is mostly driven by internal instead of external reasons for both women and involved male partners.
d. The decision is associated with an equal degree of uncertainty in women as that reported by the involved male partners.
e. Both women and involved male partners might have had moments in which they thought about continuing with the pregnancy.
f. However, abortion-seeking women feel somewhat more autonomous in their decision than their involved male counterparts.
g. Abortion-seeking women experience a higher level of emotional distress than involved male partners.

6) Experiences of autonomy versus independence, experiences of autonomy versus power and power versus sense of agency in the decision to have the abortion

a. The experience of autonomy of the abortion-seeking woman (i.e., the degree to which the abortion is perceived as an internal, personal decision for her) is critical for both the women's and the involved male partners' satisfaction with the decision-making process.
b. Women who have involved their male partner in the decision process are directly affected by the thoughts and feelings of this involved male partner (indicating their interdependency).
c. Even when the male partner is not a decision partner (i.e., he does not have a say in the decision), the woman's decision to opt for an abortion might reflect his decision as well (demonstrating interdependency through indirect influence).
d. Despite the male partner not having any legal power to decide on whether or not to have the abortion, most of the involved male partners reported feeling autonomous in the decision to have the abortion.
e. In reflections on carrying the unwanted pregnancy to term, both women and involved male partners seemed to anticipate, solve problems, evaluate, relate to others, and make meaning of the unintended pregnancy and their subsequent decision. Both also use strategies to close their mind to contradictory information regarding the abortion. Both findings show women's and men's capacities as cognitive agents who make sense of the decision to have an abortion.

7) Different decisional pathways, same result

a. Abortion-seeking women's satisfaction with the decision process is independent of their male partner's share in the final decision for abortion (except when he would have a larger share than she has).
b. Women and involved male partners' degree of distress is independent of the occurrence of thoughts about carrying the pregnancy to term.

7.1.1 The sociocultural and sociodemographic context of induced abortion in Flanders

In the population based survey described in **Chapter 2,** we investigated associations between factors at the between-group level (educational level, ethnic descent, age, parity and relational status), and ratios of induced abortion in people living in Flanders. In our analysis, we took into account three considerations made by other authors in the field.

The first is the necessity to include the proximal steps prior to having an induced abortion when analysing induced abortion rates: experiencing the pregnancy as unwanted, and prior to that, unintentionally being pregnant as a result of ineffective or non-use of contraceptives[2] (Bajos et al., 2014; Rossier, Michelot, Bajos, & the COCON group, 2007). Our results indeed confirmed that the effect of factors as ethnicity or educational level (between-group factors) in each of these steps might be different. On the one hand, we found the known socio-economically disparities in unintended pregnancy, with people from lower educational status being more prone to experience unplanned pregnancies (e.g., Bajos et al., 2014; Finer & Henshaw, 2006; Font-Ribera, Pérez, Salvador, & Borrell, 2007; Wellings et al., 2013). On the other hand, educational level was not associated with unwanted pregnancy in the event of an unplanned pregnancy or induced abortion in the event of an unwanted pregnancy. The latter contrasts the findings of previous studies (Font-Ribera et al., 2007; Rossier et al., 2007; Zavodny, 2011) showing a positive association between educational level and the decision to have an abortion. It might however be the case that, as suggested by others, the specific situation in which the man or woman found him- or herself at the moment of the pregnancy (in terms of future educational goals or current job demands) would have yielded significant effects though (Jones, Frohwirth, & Moore, 2013; Sihvo, Bajos, Ducot, Kaminski, & the COCON Group, 2003). In general, while the unintended pregnancy ratios found in our study are lower than the ones reported in the US or certain south-European countries as Spain, and are quite comparable to the ones reported by our immediate neighbouring countries France and the Netherlands (which is mostly due to the widespread use of effective contraceptives in our country, e.g., Elaut et al., 2015), the induced abortion ratio in the event of an unintended pregnancy, is somewhat lower than the one reported in other Western studies (Bajos et al., 2003; Bakker et al., 2009; Finer & Henshaw, 2006; Font-Ribera et al., 2007).

[2] Although some pregnancies, which end up in induced abortion, might have been planned in the first place. An intended pregnancy might then evolve in the direction of an unwanted pregnancy because of, for instance, a breakup with the involved male partner.

We might think of different reasons for this lower abortion ratio (including methodological issues[3]) but one of them might also be the possible stigma associated with reporting an induced abortion, which might be larger in Flanders. This hypothesis on the role of stigma in the report of induced abortion is strengthened by the observation that the total abortion ratio as reported in our study, quite largely differed from the abortion ratio calculated by the National Evaluation Commission (SENSOA, 2011). We did not measure the level of internalized abortion stigma, so we could not test this hypothesis.

A second caution which we have taken into account is the necessity to acknowledge the socio-economic vulnerable position of ethnic minority groups when examining the prevalence of induced abortion in men and women from Turkish descent (Eskild, Nesheim, Busund, Vatten, & Vangen, 2007; Wets, 2006). Our findings demonstrated that, at first sight, more unplanned pregnancies were present in the Turkish minority group than in the general Flemish population sample. However, this difference disappeared after having taken into account the mean difference between these groups in level of formal education. This is in line with the findings of Elaut et al. (2015) showing that a lower educational level is associated with a lower *knowledge* on emergency contraceptives, both in native Flemish, and Turkish minority groups. As she also demonstrated that both groups nevertheless hold comparable rates of *actual* contraceptive use, it might be the case that Turkish minority groups are less often *aware* of the correct or possible means to avoid unwanted childbearing, albeit they actually *use* the existing means. This hypothesis is supported by our finding that the odds of induced abortion in the event of an unwanted pregnancy were lower in the Turkish minority group than in the general population group. Besides the hypothesis that this is due to a higher level of social disapproval of induced abortion because of the more traditional views on motherhood in Turkish culture, it might also be the case that these couples less often find their way to the abortion center (for an extensive overview of problems of accessibility to SRH services and knowledge on SRH topics in non-EU migrants, see Keygnaert et al., 2014). We were unable to examine the specific role of religiosity in this (e.g., Marsiglio & Shehan, 1993), but as the overall majority of participants in the Turkish minority group reported to be Muslims, we might think of the impact of Islamic inspired ideas about the ensoulment of the foetus in the decision about an unwanted pregnancy as well (Hessini, 2008).

A third and final recommendation which was taken into account is that we respected the previous literature on induced abortion showing that every decision for abortion occurs in a specific

[3] Including the fact that we calculated this ratio on a quite extended time range, from pregnancies in the 70's to more recent pregnancies. However, in another study on these data, it was argued that the abortion ratios did not differ between the pre- and post-legalization period (before versus after 1990; Vandamme, Buysse, & T'Sjoen, 2013). Another methodological issue is the measurement of unintended pregnancy. While unintended pregnancy is sometimes referred to as *either* an unwanted *or* a mistimed pregnancy, we defined it (as others did), as the absence of a pregnancy "plan".

situation in a couple's life, and is not confined to a certain *group* of men or women (Kero, Högberg, Jacobsson & Lalos, 2001). We thus examined for each pregnancy separately, whether it was a planned or wanted pregnancy, and what the outcome of the pregnancy was. We hence found that despite Turkish people differing from native Flemish people in the general timing and number of pregnancies, the situations in which pregnancies are experienced as unwanted, or are terminated by induced abortion, are roughly the same. These are: 1) being in an unstable relational phase; 2) being too old or too young; or 3) having an extended family already. Hence, in both of these groups, and both in men and women, the motivation underlying the decision to opt for abortion might be the desire to provide the best possible parenting for existing or future children, with the right partner, at the right time (e.g., Jones, Frohwirth & Moore, 2008; Kero, Lalos, Högberg, & Jacobsson, 1999; Kero et al., 2001). The findings in Chapter 2 give rise to a critical analysis of studies comparing induced abortion rates between groups of women, and postulate the need for a contextual approach to the study of induced abortion figures.

7.1.2 The relational context of induced abortion: The role of the male partner

In Chapters 3 and 4, we started from the observation that although male partners do not have legal rights in induced abortion, they are often to a certain extent involved in the abortion (e.g., Chibber, Biggs, Roberts & Foster, 2014; Evans, 2001; Jones, Moore & Frohwirth, 2010). We argued that the actual role of the male partner in women's process of *deciding* to have the induced abortion is however currently understudied, leaving an enormous gap in induced abortion research in particular and, more broadly, in fertility related research in general. Unlike previous scholars attempting to reveal men or women's attitudes towards the *hypothesized* role of male partners in the decision-making process (e.g., Coleman & Nelson, 1999; Marsiglio & Shehan, 1993), we examined the *actual* role of the male partner in the decision to have an abortion from a *relationship specific* perspective. The findings outlined in **Chapter 3** demonstrated that the relationships in which abortion-seeking women exist at the moment of the abortion vary from long-term romantic relationships (> 5 years) on the one end of the continuum, to non-significant, non-romantic relationships on the other end. Also, the quality of these relationships varies in terms of levels of support, conflict, and commitment. This variety actually reveals the myriad of reasons women or couples have for opting for induced abortion. For some women, an unstable, developing, unsupportive, extramarital, insignificant or violent relationship with the male partner is the main reason (e.g., Chibber et al., 2014), while for others in more stable relationships, the reason might be related to current work-life-balance, and the associated care for the existing children (Biggs, Gould, & Foster, 2013).

As expected based on relational theories, we found that both type and level of commitment to the relationship with the male partner—but not levels of conflict or support, in contrast to what

Coleman and Nelson (1999) suggested—were associated with the degree to which the male partner is involved in the *process* of deciding about the unintended pregnancy. This is in line with qualitative research demonstrating the important role of length of the relationship (closely related to feelings of relational commitment) in attitudes towards male partner involvement in reproductive decisions (Brown, 2015; Daugherty, 2011; Sharp, Richter, & Rutherford, 2015). In most of the situations, male partners of abortion-seeking women have, to a certain extent, been involved in the decision. However, as what Reich and Brindis (2006) put forward, their roles range from being consulted by the woman (in one in four of the situations) to being an equal decision partner (in almost half of the situations) to being the main decision-maker (only in a few situations). Type of relationship was also related to the degree to which the abortion was either mostly desired by one of the partners or mutually desired by both of the partners. Long-term and short-term relationships held the highest levels of *mutually shared* decisions to opt for abortion. The majority of women and involved male partners then stated that the abortion was equally desired by the male partner, in line with the findings of Costescu and Lamont (2013).

The results of the study outlined in **Chapter 3** demonstrated that involvement of the male partner in the decision to have an induced abortion is multidimensional and complex. Women who did not involve the male partner in the process of deciding about the unwanted pregnancy sometimes did report that the abortion was a mutually shared decision with the male partner. Similarly, in couples where the male partner was an equal decision partner, the final decision to opt for abortion was sometimes more the woman's than it was the male partner's decision. This corresponds to the literature on the difference between a shared decision-making process (in which communication between the two partners about the pregnancy is included) and a shared decision outcome (Godwin & Scanzoni, 1989; Meier, Kirchler, & Hubert, 1999; Simpson, Farrell, Oriña, & Rothman, 2015; Zeiler, 2007). It is also in line with the literature on process versus outcome power, and the literature on being agentic and having influence even in the absence of decisional power (Kuczynski & De Mol, 2015). Although a shared decision process thus enhances a mutually shared decision to have the abortion, the former is not a necessary precursor for the latter and vice versa.

Our findings certainly strengthen the request of other scholars to take into account the level of commitment between partners in the study of fertility decision-making in couples (Godwin & Scanzoni, 1989; Goldscheider & Kaufman, 1996; Simpson et al., 2015). Relational Interdependence Theory indeed suggests that partners' decision-making strategies are closely related to the degree to which partners depend on each other for their current and future wellbeing (Rusbult & Van Lange, 2003).

As previous studies have demonstrated that the abortion-seeking women and the involved male partners might differ in how they perceive the decision-making process (e.g., Costescu & Lamont, 2013; Sharp et al., 2015), we asked both partners to report on the male partners' role in the decision to have

the abortion. In line with the findings of the only couple level study on induced abortion of Costescu and Lamont (2013), we found that both partners were generally highly satisfied with the division of roles. However, satisfaction with the role of the male partner was somewhat lower than satisfaction with the role of the abortion-seeking woman, as reported by both of the partners. We argued that this might indicate the sometimes difficult position occupied by the male partner in induced abortion decisions. From the male partners' perspective, there is the desire to be heard and to be involved on the one hand, but there is the other side of not wanting and not being able to disturb women's rights (Coleman & Nelson, 1999; Ekstrand, Tydén, Darj, & Larsson, 2007; Sharp et al., 2015). From the perspective of the women, there might be a similar dilemma: wanting the support of the male partner for the decision on the one hand, but desiring own decision-making without his influence on the other (Kjelsvik & Gjengedal, 2011). Sometimes this leads to unintentional effects such as a woman feeling left alone when the male partner defers decision-making to her as a way of demonstrating respect and responsibility (Kjelsvik & Gjengedal, 2011; Reich & Brindis, 2006). Similarly, a woman might feel pressured by the male partner in her decision when he says he would try to be a responsible and competent father if she would eventually carry the pregnancy to term (Kjelsvik & Gjengedal, 2011; Reich & Brindis, 2006). It might also evoke feelings of powerlessness or helplessness in the male partners, even if they are to a certain extent involved in the decision-process (Halldén & Christensson, 2014; Reich & Brindis, 2006). Nevertheless, satisfaction with the role of the male partner was still high in both of the partners, despite the above mentioned dilemmas and difficulties. Partners' satisfaction with the division of roles was not dependent upon whether the male partner only had a side role or whether he had an equal role in the decision about the unintended pregnancy. Their satisfaction was also not dependent upon whether the abortion was more her than his decision or whether it was a mutually shared decision. The aforementioned findings suggest that couples might have a myriad of good reasons to divide their power in the way they did, based on their current relational situation. A woman might decide not to involve the male partner because she, for instance, expects never to meet the man again (e.g., in the event of a one-night-stand), because she is in a difficult relational situation (e.g., an extra-marital relationship), because she fears the end of the developing relationship, because she does not want to hurt the male partner or in turn because she does not want to be hurt by the male partner by opting for abortion. Similarly, a man might defer the right to decide to the woman because he feels he is not entitled to state his opinion about the unintended pregnancy in their current relationship (e.g., Reich & Brindis, 2006). This illustrates the theoretical difference between the male partner's reproductive *power*, as the *potential* or *ability* to influence the decision on the one hand (which can happen when he becomes aware of the pregnancy *before* the induced abortion), and his reproductive *control*, as the actual *exercise* of that power or influence on the other hand (Simpson et

al., 2015; Zeiler, 2004). Relational dynamics are then partly responsible for how decisional power is divided between two partners, and whether power is acted upon (Simpson et al., 2015).

Both partners' satisfaction with the role division was, despite generally high levels, particularly low in the event of the male partner being the primary decision-maker or when the final decision to have the abortion mainly fulfilled his instead of her needs. This finding corresponds with previous studies on women's important need to feel that the decision is theirs (having a feeling of autonomy; e.g., Kimport, Foster, & Weitz, 2011), and the need to preserve control over the decision process (holding the power to decide; e.g., Kjelsvik & Gjengedal, 2011). The necessity of women as being the key decision-makers in the end has also been reported in studies investigating men's attitudes towards male partner involvement in induced abortion. In line with our own findings, men mainly do not want to force women to have an abortion as they often already feel guilty about the larger burden of the unintended pregnancy on the woman (Halldén & Christensson, 2014; Sharp et al., 2015). When the decision for the abortion then turns out to be mostly his decision, although it might be given in by the desire to be a responsible father in the future, he also seems to be dissatisfied with how the decision occurred between them. Social norms regarding who should decide to have an induced abortion seem to play a distinct role in this (Halldén & Christensson, 2014).

As most of the male partners are aware of the unintended pregnancy of the abortion-seeking women, and as most of them are also involved in the decision process (demonstrated in Chapter 3), we examined in **Chapter 4** the degree to which these involved male partners perceive themselves as autonomous decision-makers, and how decisive they feel about having the abortion. In this chapter, we took a couple perspective as we examined dyadic relationships between how autonomous and decisive the women felt and how autonomous and decisive the male partner felt. The results demonstrated that the involved male partners are, similar to the women (e.g., Foster, Gould, Taylor, & Weitz, 2012 or **Chapter 6**), quite certain about having the abortion. They also experience a relatively high degree of internal motivation for the abortion (demonstrated in items as "Terminating this pregnancy would help me to fulfil the most important goals in my life"). They experience an equal level of external pressure towards having the abortion (measured with items as "I would not feel accepted by the people around me if I were to have a child now") as the abortion-seeking women, which was relatively low for both of them. These results are in line with previous findings on male partners being personally convinced of the necessity of having the induced abortion in the light of other important goals in life (Kero et al., 1999). It demonstrates the involved male partners' similar implicit desire to be a responsible and competent parent, related to personal criteria such as having a good relationship, having a job, or fully desiring the baby (Kero & Lalos, 2000; Reich, 2008). An important remark here is that the decision to have an induced abortion is for both of the partners not perceived as a completely free "choice" as no woman or man *really wants* or *likes* to have an induced abortion (Furedi, 2016).

They mostly perceive the abortion as a necessary solution to the problem of the unintended pregnancy (Kirkman, Rowe, Hardiman, & Rosenthal, 2011). Hence, intrinsic motivation to have an induced abortion (defined by Self-Determination theory as enjoying the decision made) is non-existent, and internal motivation (which holds the second place at the autonomy continuum) is the best possible option (Deci & Ryan, 2000; Vansteenkiste, Niemiec & Soenens, 2010). Self-Determination theory predicts that a higher degree of internal motivation for reproductive decisions (making these decisions in coherence to other norms, values, and goals in life) predicts better mental wellbeing than more external motives for these decisions (Brenning, Soenens, & Vansteenkiste, 2015). This prediction was found to be true for the abortion-seeking women who were indeed less uncertain about having the abortion when they had more internal motives for the decision. However, this was not the case for the male partners. The degree of internal motivation for having the abortion was also slightly lower in the male partners than in the abortion-seeking women. This corresponds with the data outlined in **Chapter 3,** where it was demonstrated that when there was an imbalance in who's needs were mostly represented in the decision to have the abortion, the imbalance was more often on the women's side. This is not surprising given women's legal ownership of the decision to have an abortion and the clinical implications of this legal imbalance. The veto power of European women in reproductive decision-making has also been demonstrated in studies on planned parenthood (Stein, Willen, & Pavetic, 2014; Testa, Cavalli, & Rosina, 2012). Again however, in a vast majority of couples, both partners were equally likely to want the abortion.

As we expected based on Relational Interdependence Theory (Rusbult & Van Lange, 2003), the findings in **Chapter 4** demonstrated that the women's thoughts and feelings regarding the decision to have the abortion were positively associated with the thoughts and feelings of the male partner (defined by relational theorists as "covariation of interests"). However, the level or degree of dependence differed along the relational context of the two partners. For those who lived together, the degree of dependence on each other was higher than for those who lived apart. This can best be understood from the hypothesis that cohabiting abortion-seeking couples already made a certain commitment to each other. This "objective" form of commitment makes them more designated to each other so that levels of decisiveness on having the abortion ran more parallel between the two partners. This is somewhat in line with the findings described in **Chapter 3,** as we showed that high levels of commitment to the male partner (either subjective or objective in the form of length of the relationship) were associated with high levels of involvement of the male partner in the decision to have the abortion. Involving the male partner in reproductive decision-making implies being influenced by his thoughts and feelings, either intentionally or unintentionally (e.g., Miller, Severy, & Pasta, 2004 regarding fertility decision-making in general). In our study outlined in **Chapter 4** we indeed found interpersonal beyond intrapersonal effects of feelings of decisional autonomy on feelings of

uncertainty. For those partners who lived together, we found that the level of uncertainty of the abortion-seeking woman increased when the male partner reported a higher level of external pressure for having the abortion. Similarly, levels of uncertainty of the male partners decreased when the degree of internal motivation for having the abortion of the women increased. For those who lived apart, we found that the levels of uncertainty of the male partners increased when the abortion-seeking women reported higher levels of external pressure for having the abortion. The findings suggest that male partners depend more on the abortion-seeking women for evaluating how they feel about the abortion than women do depend on the male partners, especially when partners live apart. Again, this might be explained by men's actual fewer power resources in induced abortion decisions as the women are legally entitled to make the decision, while the men are not.

In sum, the findings of **Chapters 3 and 4** refer to the theoretical difference between reproductive power, reproductive autonomy, and reproductive independence (see below). Most European women indeed have legal reproductive power in the decision to have an abortion, which was demonstrated in the possible imbalances between women and male partners. However, abortion-seeking women also depend on the thoughts and feelings of the male partner regarding the induced abortion, demonstrating their relational interdependence. In addition, a male partner might feel autonomous in the decision to have the abortion even without having the legal power to decide (as the woman might involve him in the decision-making process, and he might seek his own reasons for having the abortion). Vice versa, a woman might feel some pressure for having the abortion (less sense of autonomy) even if she has the legal power to decide.

7.1.3 The intrapersonal nature of deciding to have an induced abortion: Cognitive reflection and the value of counseling

In the last two chapters of this dissertation, we focused on the role of intrapersonal factors in the decision to have an abortion. In **Chapters 4 and 5**, we examined how individual differences in decision-making in general, influence the process of deciding to have an abortion, both cognitively and emotionally. In **Chapter 6,** we evaluated how abortion-seeking women perceive, evaluate, and experience the pre-abortion counseling sessions as organized in Flanders, and how differences in women's needs, and differences in women's socio-demographic profiles, influenced the content of these sessions.

In **Chapter 5**, we started from the observation that despite the extensive literature on individual differences in cognitive and emotional *outcomes* of the decision to opt for induced abortion (in terms of mental health, specific positive, and negative emotions, decisiveness, and satisfaction), few studies analyzed individual differences in the *process* of deciding to have the abortion. In the mixed-methods longitudinal study, it was shown that a small majority of abortion-seeking women and involved male

partners remembered at least one moment in which they thought about carrying the term. The other half stated that they did not have any of these moments. This finding might be compared with studies reporting on levels of decisiveness, decision uncertainty and satisfaction (as in Chapters 4 and 6 or for instance Baron, Cameron, & Johnstone, 2015; Cameron & Glasier, 2013; Foster et al., 2012), studies reporting on ambivalent feelings towards the pregnancy or the abortion (e.g., Törnbom, Ingelhammar, Lilja, Svanberg, & Möller, 1999), studies reporting on the rightness of the decision (Rocca et. al, 2015) or studies reporting on clear feelings of doubt (Husfeldt, Hansen, Lyngberg, Nøddebo, & Petersson, 1995). All of these studies, however, measure distinct cognitive and emotional states, other than the prevalence of moments of dialectical reflection we mapped out in **Chapter 5**. Hence, it might be the case that a woman ever had a moment in which she thought about the option of having the baby (e.g., when she imagined how her life would look like with the child), but never felt any positive emotion towards the pregnancy (hence, no ambivalent feelings). Similarly, it might be the case that she is very convinced of the abortion being the best decision for her now (a high feeling of the decision as being right), but that she however had two moments in which she sought solutions for the practical barriers for having the baby. Likewise, it might be the case that she is very certain about having the abortion now, but that she still had a moment in which she felt the desire to be a mother.

As expected, the report of these pre-abortion dialectical moments was not related to pre-, nor post-abortion emotional distress, hence demonstrating that *not* thinking about the alternatives for having the abortion, is equally likely to be adaptive as having one, two, or more of these moments.

The emotional distress of both of the partners was decreased in the post-abortion period. This is in line with the findings of other authors reporting on the transient nature of this distress (Rocca et al., 2015). Emotional distress prior to the abortion is then elevated compared to the levels of emotional distress in the general population, as demonstrated in **Chapter 6**, and shown by others (e.g., Lauzon, Roger-Achim, Achim, & Boyer, 2000). Interestingly, but in contrast to the findings of Lauzon et al. (2000), the distress of the male partners reported in **Chapter 5** was lower than the distress reported by the women, in the pre- as well as in the post-abortion period.

As predicted, women who did not have any of these dialectical moments, had a higher ability to achieve cognitive closure when making decisions in general. Those with a higher ability to achieve cognitive closure in turn reported less emotional distress pre-abortion. In **Chapter 4**, we already demonstrated the association between this personal decision-making ability and levels of decision uncertainty, both for women and male partners. Hence, as predicted, women who are able to seize (reach a decision rather quickly) and freeze (preserve previous knowledge and safeguard future knowledge on the decision) have fewer moments in which they think about continuing the pregnancy, and report less decision uncertainty and less emotional distress prior to the abortion (Kruglanski & Webster, 1996; Roets & Soetens, 2010). Having a memory of a dialectical moment in the pre-abortion

period, however, is in itself not a precursor for elevated levels of emotional distress pre- nor post-abortion, and should as such not be seen as problematic, but as rooted in general cognitive functioning. Previous scholars in the field of decision-making already depicted these individual differences in how one cognitively deals with different sources of information which has to be decided on (Schwartz et al., 2002). The statement about the role of general cognitive functioning in this, is strengthened by the observation that a higher educational level was associated with higher odds of reporting a dialectical moment. This might be due to the cognitive capacities making dialectical reflection possible.

The content of these dialectical moments revealed a wide range of cognitions. It concerned thoughts about a future child wish, hypothesized images on having or carrying the child, anticipating difficulties post-abortion, thoughts about removing the barriers for having the child, thoughts about the (existential) meaning of having children, reflections on others desiring or deciding for a child, reflections on social norms and ethics, and rational considerations of the pros of having a child. Based on our findings, we argue that the presence as well as the absence of these dialectical moments demonstrates women's and male partners' cognitive agency, defined by Kuczynski and De Mol (2015) as the "ability to make sense of the environment, initiate change and resist domination by others".

A special finding, outlined in **Chapter 5**, was the positive association between the post-abortion report of dialectical moments and post-abortion emotional distress, even after controlling for general ability for cognitive closure. Although this relationship should be deepened in future research, it seems to suggest that being able to remember thoughts about carrying the pregnancy to term in the post-abortion period, is associated with a certain level of distress. This relates to the findings on the adaptive function of freezing tendencies once a decision is made (Kruglanski & Webster, 1996). It resembles the process of thinking about a possible divorce when one is still in the relationship with the partner (Baxter & Bullis, 1986). Those who did report these moments in the post-abortion questionnaire nevertheless reported relatively low, and certainly not "pathological" levels of emotional distress.

In **Chapter 6**, we started from the observation that quite a lot of scholars have condemned mandatory pre-abortion counseling, as obliged by law in countries as Belgium, the Netherlands, France (only for minors), and Hungary (Cameron & Glasier, 2013; Foster et al., 2012; Joyce, Henshaw, Dennis, Finer, & Blanchard, 2009; Kumar, Baraitser, Morton, & Massil, 2004; Rowlands, 2008). The main arguments of these scholars are the following: 1) similar to what we found in **Chapter 4**, and again confirmed in **Chapter 6**, women are already quite to very certain about having the abortion when they enter the abortion clinic; 2) women mostly cope well with the decision to have the abortion (indeed demonstrated in **Chapter 5**); 3) most of the women are not pressured by others to have the abortion, which we indeed also found in **Chapter 4**; 4) most women already discussed the abortion with close others (which we highlighted in **Chapter 3**); and 5) counseling does not result in lower induced abortion rates, but only increases the costs, and delays the abortion procedure. In these arguments, there is the

implicit idea that mandatory counseling is paternalistic as women themselves know what they want. In the study outlined in **Chapter 6**, we demonstrated that in line with what Cameron & Glasier (2013) found, most women perceive the pre-abortion counseling session as organized by the Flemish LUNA abortion centers, prior to its onset, not very useful or necessary for them. Also in accordance with other studies, the women in our study mostly wanted information, and did not want to discuss their decision process or their current emotions (Kumar et al., 2004). Interestingly, most of them did not want to discuss contraceptive use either. The latter could have a twofold explanation. On the one hand, women mainly want to have the abortion at that moment, and might only be slightly receptive for information on future contraceptive use (Stewart et al., 2016). On the other hand, abortion-seeking women do not want to be seen by the providers as "irresponsible", and in need for advice on future "responsible" behavior regarding the use of contraceptives (Purcell, Cameron, Lawton, Glasier, & Harden, 2016). The latter "fear for being judged" might also be one of the reasons for the low desire to discuss the decision to have the abortion (Harden & Ogden, 1999).

In the counseling sessions as organized in Flanders, most of the counselors did review the decision process, and did discuss contraceptives however, beyond the necessary transfer of information. Nevertheless, there was a large overlap between the actual content of the counseling sessions and the content desired by the women, demonstrating its client centered nature beyond its standardized content. The variety in needs regarding the content of the session might represent the variety in how people make decisions in general, as outlined in **Chapter 5**. To set an example, while some women want to talk about the alternatives for having the abortion, others want to finish this off, and close their mind to ambiguous, ambivalent or contradictory information. It might also demonstrate the various social and interpersonal contexts in which abortion-seeking women exist. Again, to set an example, certain women want to hear about the experiences of other abortion-seeking women or want to talk about the role of important others in their decision, while others only want to discuss their own thoughts and emotions. Similarly, while some women have a desire to talk about their emotions and to be supported in this, others do not want any form of (additional) support from the healthcare provider. Counselors in the LUNA abortion centers took into account this variety in women's needs and desires. In addition, we found that the content of the counseling sessions depended upon age, previous experience with induced abortion, level of decisiveness, emotional state, and whether someone was accompanying the woman. When the counseling has taken place, women reported to be highly satisfied with the session (similar to the findings of Wu et al., 2015) and they perceived the session as more valuable than before. In addition, their already high decisiveness was still increased and their emotional distress was decreased. These results, in combination with the findings from other studies, suggest that it is the non-judgmental, supportive, and tailored way in which counselors dealt with the abortion-seeking women which is mostly appreciated by the women. Previous scholars have

indeed shed light on the importance of caring staff, partially to compensate for possible judgmental reactions of others, and to deal with the sometimes distressing situation in which abortion-seeking women exist, including the anxiety for the abortion itself (Harden & Ogden, 1999; Lauzon et al., 2000; Slade, Heke, Fletcher, & Stewart, 2001; Wu et al., 2015). It is argued that the discussion of parts of the decision process as well as the discussion of contraceptives is then only accepted by women if they are respected by the staff as autonomous decision-makers (Kumar et al., 2004; Purcell et al., 2016). We hypothesize that specialized abortion centers or family planning centers can build on their extensive expertise as well their more extended time schedule to effectively deal with the balance between women's desire for medical professional help and valid information on the one hand, and their desire for caring, supportive staff on the other.

The results on the hesitating attitude of abortion-seeking women towards counseling particularly suggest that quite a lot of women—even those who would be in need of it—would not seek voluntary pre-abortion-counseling themselves. This is in line with other studies (Cameron & Glasier, 2013; Kumar et al., 2004). Hence, optional counseling (as in the UK), although with the aim of focusing on those who are really in need, might miss its goal as women might be reluctant to admit they would like to have more personal information or they would like to talk about their ambivalent emotions. This phenomenon has been observed in the fertility treatment setting where counseling is offered, but not mandatory for heterosexual couples who use their own genetic material (Machin, 2011). Hence, as stated by others, counseling might have different meanings, varying from the provision of tailored informational, emotional or instrumental support (including, for instance, the transfer of information about the experiences of other abortion-seeking women) to being an opportunity to explore, clarify or valorize thoughts and feelings regarding the abortion (including, for instance, the possibility to reveal an anxiety towards the medical procedure), to being an actual decision-making aid aimed at inducing change (Boivin et al., 2001). Based on our findings, it seems that only for a small minority of abortion-seeking women, the counseling offered is used as a decision-making aid. For the majority of women, the counseling offered might be used for other goals such as the possibility to ask questions about the procedure and the ability to receive tailored answers to these questions. Having this kind of tailored conversation might be a necessary step in the creation of a safe environment in which the woman trusts the staff who will perform the abortion. Although such a pre-operation conversation is evident in other medical settings, in the context of induced abortion it is associated with paternalism.

7.2 General critical notes

Before outlining the different theoretical, clinical, and policy related implications of our findings, we reflect on four important issues which have to be beard in mind when interpreting our findings.

The first is the fact that each of the chapters in this doctoral thesis focused on one specific level in the model of social complexity of Robert Hinde (1997). As outlined in the introduction section, this narrowed focus is obviously a reduction of the reality, as the intrapersonal, interpersonal, and between-group levels obviously interact with each other in a dialectical way. Hence, a truly dialectical relational perspective in which we, for instance, could have investigated how the communication between the two partners on having the induced abortion (interactional level) influenced both partners' intrapersonal dialectical reflections on carrying the pregnancy to term (intrapersonal level) and how these reflections in turn influenced the perceptions on the relationship with the partner (relational level), was absent here. The findings outlined in each of the separate chapters should hence be interpreted as being all different parts of a much bigger picture.

Secondly, caution is urged in extrapolating the findings of this doctoral dissertation. All of our studies occurred in the context of Flanders where policies respect and aim to act upon women's (reproductive) rights, where abortion is legally permitted, and where abortion care as well as access to contraceptives is well organized. We might hypothesize higher rates of unplanned pregnancy, different patterns of male involvement in the decision to have the abortion, other decisional difficulties, and different perceptions on pre-abortion counseling in regions where gender rights are unequal or where abortion is prohibited, such as in many African and Latin American countries (e.g., Dereuddre, Van de Putte, & Bracke, 2016; Tilahun, Coene, Temmerman, & Degomme, 2015). In these countries, the policy focus is evidently more on the provision of medically safe abortions, improving access to contraceptives, and striving for women's reproductive rights and less on how to improve psychosocial care related to having an abortion. The following recommendations for policy and clinical practice should thus be interpreted within the specific context of Flanders. In addition, as our samples have been subject to selection biases (outlined below), we should be cautious in generalizing the findings to *all* abortion-seeking women and we should definitely not generalize the findings to *all* male partners involved in the unintended pregnancy. Furthermore, as our studies focused on elective induced abortions, our findings should not be generalized to therapeutic induced abortions.

Thirdly, the focus of this dissertation was on the decision to have an induced abortion in the specific event of an unintended or unwanted pregnancy. We "isolated" this specific decision from other possible reproductive decisions participants already made or will yet make in their lives, such as the decision to have a child or the decision to use a certain contraceptive method. We might think of an interrelatedness between all of these decisions, which we did not take into account in our study (see for instance Daugherty, 2011). In addition, as most Flemish women and men seem to cope well with the decision to have an abortion, we could question the value of isolated research on those who decide to have an abortion and reflect on the usefulness of studying the small group of women who decide to carry an unwanted pregnancy to term (see Chapter 2). The latter group has been shown to

be at risk for impaired mental health in contrast to those who had an induced abortion (Vandamme, Buysse, & T'Sjoen, 2013). Hence, studying the same intrapersonal, interpersonal and between-person processes in this "vulnerable" group would be a valuable additional research strategy, although this group might be rather hard to reach or to follow-up.

Finally, despite various attempts to contextualize our findings by comparing some of the basic outcomes with an included or a separately recruited "control" group (e.g., in Chapter 2, the unintended pregnancies which did not end up in induced abortion, and in Chapters 3, 4, and 5, couples who decided to have a child), we did not test whether the same intrapersonal, interpersonal or between-group processes found in our study, would be present in other reproductive decisions. We might think of the planned decision to have a child, the decision to seek help for fertility treatment or the decision to terminate an intended pregnancy because of fetal malformations (mostly during the second trimester of the pregnancy)[4].

7.3 Theoretical implications

For several reasons, the findings of our study challenge the value of current theoretical models on reproductive decision-making in general, such as the Theory of Planned Fertility Behavior (TPB; Ajzen & Klobas, 2013), the Social Exchange Theory for fertility behavior (SET; Beckman, 1977) or the dyadic Traits-Desires-Intentions-Behavior fertility model (TDIB; Miller et al., 2004). The SET perceives the decision to have a child as the net result of outweighing the costs and gains of having children. The TPB models fertility decisions as influenced by the combination of personal attitudes, subjective social norms and own perceptions of control. The TDIB looks at these decisions from a more dyadic but still quite rational framework of desires and intentions. None of these models have been used within the context of the decision to have an abortion yet. They would probably fail to explain the systemic processes in the decision to have an abortion outlined in this doctoral thesis. First and foremost, these models indirectly assume a *singular linear* process from reproductive desire and attitude, to reproductive intention, to reproductive behavior. This assumption is related to the idea of men and women being rationally "in control" regarding their reproductive decisions. We demonstrated that in the event of an unplanned pregnancy, however, the process of evaluating the reproductive desire often starts all over again, despite an initial plan or desire to avoid that pregnancy (see Chapter 2). For some women, this process of evaluating, anticipating, and considering might even *continue* after having taken the decision to go the abortion center or even after the abortion is due (see Chapter 5 and 6). Secondly, all of these individual or dyadic models do not explicitly take into account the relational context as a determinant for the outcome as well as the dyadic process of reproductive

[4] To further examine the social complexity of reproductive decision-making in couples in general, we are currently collecting data on these other kinds of reproductive decisions.

decision-making in couples. We however demonstrated the role of the relational context in Chapter 2, 3, and 4. Thirdly, contradictory thoughts and uncertainties about the reproductive desire or the reproductive plan, as outlined in Chapter 4 and 5, are not directly modelled in these frameworks, hence assuming a "self-confident" decision-maker. Fourthly, these models highly focus on reproductive *outcomes* (e.g., the decision to have the abortion) without acknowledging the individual and dyadic processes by which a positive *evaluation* of this reproductive outcome is reached. In Chapter 4, for instance, we indicated the need to look upon women and men's levels of uncertainty regarding the decision to have the abortion as a dyadic, beyond an individual, evaluative process. In Chapter 3, we demonstrated the role of individual, relational, and societal expectations regarding "who should decide" in both partners' evaluations of the decision process. In sum, the existing models on reproductive decision-making have mainly neglected the relational dyadic reality in which "unforeseen" decisions such as the decision to have an abortion occur, as well as did they neglect the intrapersonal differences in dealing with the inherent dialectical nature of these decisions. To some extent, our findings hold similarities with the research on the decision to seek (further) fertility treatments. The latter is an unforeseen reproductive decision as well. Authors in this field have also demonstrated the direct or indirect role of the partner in treatment decisions, the differences between how women and male partners perceive and experience these decisions, and the role of general intrapersonal vulnerabilities above and beyond situational stressors (Pasch, Dunkel-Schetter, & Christensen, 2002; Van den Broeck, D'Hooghe, Enzlin, & Demyttenaere, 2010; Vassard, Lund, Pinborg, Boivin, & Schmidt, 2012). Hence, based on our findings, we advocate a new theoretical framework of reproductive decision-making in which the full range of reproductive decisions, from decision-making on unwanted pregnancies to decision-making on infertility is represented and in which the social complexity of these decisions is acknowledged.

The specific findings on the decision to have an abortion outlined here also demonstrate the need to disentangle the psychological concepts of reproductive autonomy (see Chapter 4), reproductive control, reproductive process power, reproductive outcome power (see Chapter 3), reproductive independence (see Chapter 4 and 5), and reproductive agency (see Chapter 5). Similarly, shared reproductive decision-making should be separated from a shared reproductive decision (see Chapter 3). Although all of these variables are to a certain extent interrelated with each other (outlined in theoretical papers such as Godwin & Scanzoni, 1989; Kuczynski & De Mol, 2015; Simpson et al., 2015; Zeiler, 2004), subtle and important differences need to be acknowledged as well. *Reproductive autonomy* (see Chapter 4) in psychological terms might then be understood as "making a reproductive decision for mostly internal, personally valued compared to external reasons" (see Self-Determination theory; Deci & Ryan, 2000). The psychological concept of autonomy used here relates to having a *sense* of autonomy as it describes motivational issues underlying a certain decision. It differs from the philosophical

concept of autonomy in terms of having the *ability* to reflect upon the values underlying each of the alternatives in the decision, and the *ability* to also act upon these values (Zeiler, 2004). *Reproductive process power*, as demonstrated in Chapter 3, concerns the degree to which one is involved in the decision-making process and hence able to influence the other partner. It relates to the reproductive decision-process as being either shared or mainly individual within the couple (e.g., Meier et al., 1999). *Reproductive outcome power* relates to the question "Who dominated the final outcome of the reproductive decision?" or "Who had the final say in the reproductive decision?" (e.g., Meier et al., 1999). The latter relates to having an *actual* influence on the outcome of the decision. Male partners, who do not have the *legal* power to decide about the unwanted pregnancy, might hence experience a sense of autonomy in the decision to have the abortion when they find their own good reasons for having the abortion together with the abortion-seeking woman. Even if he would have liked to carry the unintended pregnancy to term, he might *feel* autonomous in the decision to have the abortion if he values being in a happy relationship with the abortion-seeking woman. Likewise, although a woman might have the legal power to decide, she might opt for abortion because she expects that the male partner will be unsupportive of her having a child. *Reproductive control* could best be looked upon as the motivated attempts to modify the position of the partner regarding the reproductive issue and is the effective exertion of reproductive power *over* someone (see Godwin & Scanzoni, 1989; Simpson et al., 2015). It is hence the *exercise* of the ability to influence (e.g., when the male partner persuades the woman to have the abortion). The latter is only possible when there is a basic level of involvement of that partner in the decision process. *Reproductive independence* would mean that no one has influenced the reproductive decision. As reproductive decisions, however, occur within relationships (with the involved partner, but also within relationships with peers, parents, ….) in which there is a certain degree of interdependence and as a consequence, a certain degree of influence (e.g., Rusbult & Van Lange, 2003), complete reproductive independence is impossible, as demonstrated in Chapters 3, 4, and 5. Finally, *reproductive agency* in psychological terms would refer to making sense of the reproductive decision (the cognitive component of agency, as demonstrated in Chapter 5), and making a decision about whether or not to act upon these reflections (the behavioral component of agency; Kuczynski & De Mol, 2015). Consequently, male partners who become aware of the unintended pregnancy, who are requested to give their advice about the pregnancy, but who decide to let the woman decide, might *feel* a high degree of agency without *actually* having exercised influence in the decision about what to do with the unintended pregnancy. Full reproductive autonomy for women, as defined by others (Upadhyay, Dworkin, Weitz, & Foster, 2014; Zeiler, 2004) then only becomes possible when all of the other elements outlined above are present as well: being free from coercion (not being under the direct control of others), being able and having the opportunity to review all the options available (being involved in the decision process as an agentic, self-governing decision-maker who

might reflect on the various relationships with others), and being able and having the opportunity to execute the decision (having outcome power).

A third theoretical implication based on our findings is the necessity of modelling women's and men's individual, relational or societal expectations regarding the reproductive decision process in the prediction of decision satisfaction. In Chapter 3, we hypothesized that satisfaction scores were low when the women did not had the final power in the decision to have the abortion as this is at odds with the societal expectation in Flanders that women should decide upon abortion. In Chapter 6, we hypothesized that Flemish women are highly satisfied with the pre-abortion counseling session, as counselors take into account the individual needs of the abortion-seeking women. As put forward by scholars in the field of decision satisfaction (Oliver, 1980; Schwartz et al., 2002), when people evaluate their decisions, they indeed compare the actual outcomes with the expected outcomes. Hence, including women's and men's expectations regarding how the reproductive decision should be made (e.g., whether the male partners should be involved or whether the counselor should ask questions about ambivalent feelings), is highly valuable for theories on reproductive decision-making.

7.4 Implications for practice

In general, the findings of our study demonstrate the need for tailored instead of standard abortion care, and call for a critical and nuanced perspective on family planning policies. In the following, both the clinical implications of our findings and the policy related recommendations will be outlined.

7.4.1 Clinical implications

Based on the findings outlined in Chapter 5, and in line with the findings of previous scholars (e.g., Major et al., 2009; Rocca et al., 2015), most women are not in need of standard psychological care post-abortion as the emotional distress they encounter is mainly transient. Our findings additionally shed light on the same transient pattern of emotional distress for the involved male partners of the abortion-seeking women. Hence, also for them, standard psychological care post-abortion is unnecessary.

Nevertheless, the abortion-seeking women as well as the involved male partners are in a more distressing and uncertain situation when they enter the abortion center compared to other daily live situations. Health care providers should acknowledge this pre-abortion distress and uncertainty when it is present. As shown by others, and also demonstrated in Chapter 5, in both partners, there might be a fear for the abortion procedure, a concern about the impact of the abortion on the relationship, a feeling of anger, guilt or shame because of the contraceptive failure, a feeling of sadness because of the impossibility to become a mother or father ever again or worries about the reaction of others

(Halldén & Christensson, 2014; Lauzon et al., 2000; Stålhandske, Ekstrand, & Tydén, 2011). These concerns, worries, and reflections are certainly not confined to the decision to have an abortion, but are also present in couples making the planned decision to have a child (see Chapter 5, and also Pinquart, Stotzka, & Silbereisen, 2008), in parents' daily decisions regarding how to raise their child (see Weille, 2011), and even in other health care decisions such as the decision to have a knee surgery (Ralph, Foster, Kimport, Turok, & Roberts, 2016). Our findings confirmed the idea that these concerns, worries, and reflections should not be treated as problematic. Neither should they be treated as standard, as some women and men are more prone to having these concerns than others (see Chapters 4 and 5, and also Pinquart et al., 2008). Hence, abortion health care providers should not ignore these thoughts and feelings in those who have them, nor should they "evoke" them in those who do not have them, as also proposed by Stålhandske and colleagues (2011). Apparently, these thoughts and feeling have nothing to do with being in doubt about having the abortion, as much more women and men have dialectical thoughts and feel a certain degree of uncertainty than there are women and men who are really indecisive about whether or not to have the abortion. As such, the call of previous scholars for making counseling sessions voluntary and only open for those who are in need for it or for those who are hypothesized to be at risk (i.e., those who are still in doubt, those who are highly distressed, those who are under external pressure or those who express a clear need to talk; e.g., Cameron & Glasier, 2003; Kumar et al., 2004), is understandable, yet entails an endanger too. First and foremost, it depends on how counseling is defined. If counseling is defined as weighing with the women the different options or alternatives for the abortion or educating them about another method of contraception, then indeed this should not be part of "standard" abortion care as most of the abortion-seeking women are already very decisive, and do not want to discuss alternatives nor contraceptives (see Chapter 6). The mandatory transfer of information on possible alternatives for having the abortion or on future prevention of unplanned pregnancies–as included in current Belgian abortion law–should indeed be left out of the guidelines for qualitative abortion care. However, if counseling is defined as providing women *and* the male partners the support they *need* (either emotional, practical or instrumental) (see also Rowlands, 2008), then we argue, based on our findings, that every woman should have a pre-abortion conversation in which their own needs and desires regarding good abortion care could be discussed. We learned from Chapter 6 that these needs and desires vary and, as a consequence, counselors should be able to tailor the *content* of that conversation, not the availability of it. In practice, this should create the possibility of a woman stating that she only wants to be informed about when she can have the abortion and how the abortion will be performed, nothing more. Not including a kind of exploring conversation in standard abortion care (and replacing it for instance by an informational leaflet) could lead to women feeling "abandoned", as some women will not dare to state they are in need of more or other kinds of support than the

medical help which is provided by the medical doctor or the information leaflet they received (shown in Cameron & Glasier, 2013 or Machin, 2011).

Secondly, designing a questionnaire to detect the women who are at "high risk" for post-abortion problems and who should be offered counselling (as proposed for instance by Ralph et al., 2016) entails a possible danger too, as it could stigmatize those women who would fall into the "at risk"-category. Furthermore, it is difficult to categorize women or male partners into being at risk or not as there is mostly a continuum from being very certain to being highly uncertain or from being not distressed at all to being highly distressed. Where a woman or male partner stands on this continuum is based on various intrapersonal, interpersonal, and between-group factors as well as on the specific moment in which the woman or man exists. Finding a "cutoff" for those who are "in need" for counseling would thus be very difficult.

Based on our findings, we argue that some of the contra arguments for mandatory counseling sessions could be taken away by defining these sessions as standard, yet *tailored, psychosocial conversations*. Women themselves have stated that, while the uncertainty levels regarding having the abortion might be equal to other health care decisions such as a knee surgery (as demonstrated by Ralph et al., 2016), a different attitude from medical doctors is expected when it comes to reproductive decisions than when it comes to knee surgeries (Dehlendorf, Diedrich, Drey, Postone, & Steinauer, 2010; Dehlendorf, Levy, Kelley, Grumbach, & Steinauer, 2013). According to Dehlendorf and colleagues (2010, 2013), this includes expecting the medical doctor to be a friend with whom one might share worries or concerns regarding the reproductive decision on the one hand, and someone who respects the patient's high need for autonomy on the other. In addition, also for knee surgeries, most patients have a conversation in which they can discuss their fears, their frustrations, and their worries or in which they can ask questions to the medical doctor, before the operation is conducted.

Based on our findings, we also propose that women who have or had an abortion should have the right for cognitively closure of the decision process (described by a participant in the study of Kjelsvik & Gjengedal (2011) as "closing the emergency exit"). Hence, health care providers, media, and close others should avoid standardly asking women who had or will have an abortion about the possible presence of doubts, ambivalence, or regret. Having moments of dialectical thinking is indeed not standard for everyone, and some women consciously *want* to close their mind to ambiguous or ambivalent information. On the other hand, some women might have moments of doubt, ambivalence or regret in the post-abortion period. The presence of these feelings might be unpredictable as a lot of events in the post-abortion period might create them (for instance, the birth of a baby of a friend). For women being distressed because of these feelings, adequate support should be available.

The results outlined in Chapter 3 also suggest that involvement of the male partner in the final decision to have an abortion should neither be seen as problematic nor as necessary. Both options

result in the same satisfaction scores and are rooted in the relational context of the women. Health care providers should hence avoid standard inclusion of the male partner in abortion care (e.g., Altshuler, Nguyen, Riley, Tinsley, & Tuncalp, 2016), neither should they avoid standard exclusion of them. Sometimes these men should thus be treated as equal partners in the decision process, with own needs, and uncertainties (mostly in long-term relationships) while at other times they should be treated as witnesses at the sideline (in non-significant or non-romantic relationships) (e.g., Dudgeon & Inhorn, 2004; Reich & Brindis, 2006). As both involved partners were mainly highly satisfied with how the decision has occurred, most couples do not need special relational care during that process. As satisfaction with the role of the male partners was however somewhat lower than satisfaction with the role of the abortion-seeking woman, health care providers (both in and outside the abortion centers) could aim to increase the male partners' sense of agency. They could do this by reflecting with them on how they could "matter" or how they "have mattered" for the women even in the situation of unequal decision power (see also Halldén & Christensson, 2014). The concept of mattering has been linked to the agency of children, who are also in a situation of unequal power with their parents (Marshall, 2001; Kuczynski & De Mol, 2015). Health care providers could also increase the male partners' agency by helping them to construct their own personal meaning about the induced abortion. Very often, however, the involved male partners have their own personal reasons for having the abortion (see Chapter 4).

Finally, despite the elevated levels of distress in the involved male partners of abortion-seeking women, the focus of psychosocial abortion care should be on the women. They report the highest levels of emotional distress, and for them, making an autonomous decision is important for their own wellbeing.

7.4.2 Policy related recommendations

First and foremost, the results outlined in Chapter 2 reveal the need to step away from the illusion that unwanted pregnancies and hence induced abortions will ever disappear (Furedi, 2016). On the one hand, despite the high use of effective contraceptives in Flanders (e.g., Elaut et al., 2015), there are still unplanned pregnancies. As Furedi (2016) puts forward, this is due to contraceptives failing, because women and men sometimes fail to use them or because men and women sometimes do not *want* to use them. On the other hand, whether a pregnancy is unwanted or ends up in induced abortion depends on various situational factors (age, parity, relational context) and these factors vary across women's and men's lives. As a consequence, the same planned *or* unplanned pregnancy can be an unwanted pregnancy at one point in time and a wanted one at another point in time (Biggs et al., 2013). Policies do not have an influence on these variable private, personal circumstances in women and men's lives. Policies should then evidently try to minimize the unplanned pregnancy risk by

removing the various barriers to effective family planning (e.g., Bongaarts & Bruce, 1995). Indeed, for most of the women and men, independent of ethnic descent or country of birth, there is a desire to spread or to limit the number of childbirths (Furedi, 2016) and hence, unplanned pregnancies are for most of the women and men an unpleasant experience. As shown, especially in men and women with lower levels of educational attainment, the barriers to achieve family planning goals might be higher (e.g., Elaut et al., 2015; Wellings et al., 2013). Ethnic minority groups such as the Turkish minority group in Flanders are then vulnerable for unplanned pregnancies *because* of their often lower educational level, not because of their ethnic descent per se. Hence, family planning policies should not additionally focus on couples from these more traditional cultures per se, but should pay attention to the people with lower levels of education in Flanders in general. In these prevention strategies, there is certainly a role for male partners (e.g., Beenhakker et al., 2004; Ekstrand et al., 2007) as they equally *dislike* unplanned pregnancies (see Chapter 2) although they might lack the awareness, attitude, knowledge or the means to act upon the desire to avoid unplanned pregnancies (Marsiglio, Hutchinson, & Cohan, 2001). But as demonstrated, the relational context should always be taken into account as women sometimes do not want to share their reproductive decisions (including their contraceptive decisions) or as relational issues might sometimes hinder to use a "shared" method of contraception (e.g., Buysse, 1998). Even in the physical absence of the male partner in contraceptive counseling, his direct or indirect role and the impact of the broader relational context in which the decision for a certain contraceptive method occurs, could be discussed with the woman. Apart from the prevention of unplanned pregnancies, policies should provide feasible access to abortion services and should try to remove the societal, moral or relational factors hindering women to have an induced abortion when they actually need one, including the presence of abortion stigma (e.g., Shellenberg & Tsui, 2012). Hence, policies should deal with the two-fold process and associated paradox of reproductive decision-making (e.g., Bajos et al., 2014). They should supply all the means to plan childbirths if couples want it to, but they should also make couples aware of the possibility that reproductive planning might fail and, as a consequence, full reproductive control is impossible. The de-stigmatization of induced abortion might furthermore help to demonstrate that unplanned pregnancies might occur to everyone, and in this case, opting for induced abortion might be a very responsible decision.

Following the results on the role of the relational context, we also recommend family planning policies to make use of a couple based perspective in addition to a gender based perspective. In a gender based perspective, women's rights are contrasted against men's rights. This perspective ignores the impact of the relational bond on the degree to which partners depend on each other for their reproductive decisions (see also Brown, 2015). Hence, a gender based perspective creates a one size fits all approach which will necessarily fail to explain the relational complexity in which reproductive decisions occur (as indicated by Reich & Brindis, 2006). We put forward that a useful

strategy would be to encourage constructive communication between sexually active partners about the division of reproductive power within their specific relationship. This would give both partners the opportunity to reveal their needs, expectancies, and goals regarding current or future reproductive processes and current and future reproductive outcomes (e.g., Buysse & Ickes, 1999). This focus on the within-couple communication of reproductive expectancies, needs, and goals should moreover not be narrowed to teenagers as we found a high number of pregnancies which are reported as unplanned in the oldest reproductive age groups too.

Finally, we recommend policies, in line with the findings of Bajos et al. (2014), to avoid comparing induced abortion rates between groups of people as well as to avoid comparing these rates over time. A difference might namely be due to different reasons, ranging from a different incidence of contraceptive use (for instance, differences in the accessibility of the emergency pill or changed attitudes towards the contraceptive pill) to different social norms on parenthood, and family planning (for instance, the still ongoing postponement of first childbirths). When policies hence publish induced abortion numbers in a certain country or region, these should always be accompanied by contextual factors such as the prevalence of effective contraceptive use, the overall rate of women of reproductive age, and the general number and timing of pregnancies within that group.

7.5 Strengths and limitations

The findings presented in this doctoral thesis help to fill the gaps in current research on the decision to have an induced abortion by focusing on three different contexts: the intrapersonal context, the interpersonal context, and the between-group context. Taken together, this doctoral thesis reflects the multidimensional and multilevel complexity of induced abortion in which personal needs and goals are mixed up with relational and societal needs and expectancies (Furedi, 2016). We did not evade some topics of "taboo" regarding induced abortion: the role of the male partners, the occurrence of dialectical moments, and the value of counseling. Five different samples (a population based sample of people living in Flanders, a representative Turkish minority sample, two different samples of abortion-seeking women, and a subsample of involved male partners) were recruited in both cross-sectional and longitudinal (Chapter 5, and 6) setups. The quantitative analyses, used to test specific top-down hypotheses on the one hand, and to answer explorative questions on the other, were complemented with one qualitative analysis in which participants' own stories were explored (Chapter 5). Theoretical, clinical as well as policy related questions were answered. The study presented in Chapter 2 enabled us to present representative data on family planning issues in Flanders. These data were completely lacking at the time we started the study and are indispensable for organizations whose task is to improve reproductive health in Flanders. By making use of a multilevel approach in which pregnancies within participants were the unit of analysis, we met the situational,

and hence dynamic reality in which reproductive decisions occur (Bajos et al., 2006; Biggs et al., 2013). In addition, by studying one of the largest ethnic minorities in Flanders, we met the demand to unravel the (complex) reasons for a possible overrepresentation of foreign women in the abortion-seeking population (Neefs & Vissers, 2005). Only the studies of Lodewijckx (1997) at the end of the previous century had dealt with the issue of family planning in women and men from the traditional Islamic migration countries Turkey and Morocco. No thorough comparison between this group and a representative group of women and men from Flemish origin regarding unplanned pregnancies and induced abortions had been undertaken until then, however. In Chapters 3, 4, and 5 we had the opportunity to add to the very few literature available on male partners' experiences with induced abortion. We had a quite large sample of male partners of varying ages, compared to previous studies where often qualitative designs with small sample sizes were used (e.g. Naziri, 2007; Reich & Brindis, 2006), and mainly a focus on adolescent men (Halldén & Chrisensson, 2014; Holmberg & Wahlberg, 2000). By making use of a quantitative design and the simultaneous recruitment of the abortion-seeking women, we had the opportunity to perform between-partner analyses as well as a within-couple analysis in a quite large sample of couples (N = 106). To compare, the only couple level study available to date (Costescu & Lamont, 2013) questioned 30 couples. We explicitly investigated the interdependence between partners' experiences, which was never done before. In addition, in contrast to various other studies (e.g., Kero & Lalos, 2000; Lauzon et al., 2000), we started from clear theoretical hypotheses on decision-making in couples and individuals. As such, we could fine-tune the theoretical knowledge on the decision process towards induced abortion. Finally, in the last chapter, we touched upon a topic which has never been examined before: the value of pre-abortion counseling as organized in Flanders. We did this by making use of a very large sample (N = 971) of abortion-seeking women. As a consequence, we were able to make representative clinical recommendations.

Despite the above mentioned strengths, several limitations need to be discussed as well. Firstly, we built upon retrospective self-report data retrieved from three different survey studies. As mentioned earlier, questionnaires only capture a certain aspect of the decision-making process and are unable to reveal the overall complexity underlying these decisions. For instance, we did not explicitly outline the role of other important close others, such as parents or peers, although these might also have a role in the decision to have an abortion (Ekstrand, Tydén, Darj, & Larsson, 2009)[5]. Similarly, although we examined several interactions between factors at the different levels under study, the investigation of complex *processes* by which partners reach a reproductive decision (for

[5] We did include this information in the questionnaire, but we did not discuss the results in this doctoral thesis. Analyses on these data revealed that only for a small minority of participants, the parents, friends, or others had a certain role in the decisional process. This shows the rather "private" nature of these kind of decisions (e.g., Provoost, Pennings, de Sutter, & Dhont, 2012).

instance, *how* the woman talked about the abortion with the male partner) needs qualitative research techniques beyond survey research. In addition, more person-oriented in addition to variable-oriented quantitative analyses would have provided a deeper insight into the unique patterns of decision-making in certain groups of women or couples. To set an example, a post-hoc ANCOVA Repeated Measures analyses on the counseling data revealed that the degree of decrease in emotional distress was related to the degree to which women's wishes to discuss certain themes were fulfilled during the counseling session. With these kind of interactional analyses, we could have elaborated on the findings regarding general patterns of deciding to have an abortion (such as the mean decrease in emotional distress). In addition, although we adapted certain standardized questionnaires so that they would fit into the context of induced abortion, and although we checked the face, content, and ecological validity of the questions with abortion health care providers and with abortion clients, we do not know for sure whether the questions or response codes completely fitted the real life experiences of the respondents (Schwarz, 1999). We also do not know the exact meaning of certain answers respondents have given (Schwarz, 1999). To set an example, when we asked female respondents to report on the degree to which they were satisfied with the role of the male partner in the decision process, we do not know what being dissatisfied about it would exactly mean for them. Furthermore, self-reports are bound to several other biases, such as social desirability (van de Mortel, 2008) and recall bias (Schwarz, 2004). Although we made attempts to minimize these biases by, for instance, questioning *current* emotional distress and satisfaction instead of retrospective reports on it, by providing participants with the information that no correct or fault answers are requested, and assuring them the anonymity of the answers, these biases might have been present after all. Again, to set an example, when we asked women and male partners to report on the degree to which the male partner had been involved in the decision process, it might be the case that the scores for shared decision-making were set higher because of the prevailing expectancy that couples in long-term relationships make shared decisions. Likewise, it might be the case that when participants were asked to indicate the topics which were present in the counseling sessions, their responses would differ from the actual topics discussed.

Related to the recall bias, a second limitation concerns the fact that participants in the longitudinal survey outlined in Chapters 3, 4, and 5 were recruited at the moment they were already in the abortion center. When we asked them to report on their current levels of uncertainty or emotional distress, we do not know how this distress or uncertainty has evolved over time since the confirmation of the pregnancy. Based on previous studies (e.g., Rowlands, 2008) and based on our own retrospective measure of perceived stress (data not shown), however, we might think of an increase in decisiveness over time, and an initially high distress which firstly decreases and then again increases, the more the counseling session is approaching.

Thirdly, our studies have been subject to several selection biases. The study outlined in Chapter 3 to 5 required having and being used to a computer with internet connection. It might be the case that women or men in socio-economically vulnerable situations might have been disadvantaged here[6]. This hypothesis is confirmed by the fact that in the second data wave (where data were collected online), a difference in educational status was found between the participants and the non-responders. This was not the case for the responders in the first data wave, where a paper-and-pencil questionnaire was used. We might also have disadvantaged the women and men who had privacy concerns related to filling out the online questionnaire at home, where partners or parents might have been around. Certain non-responders stated this as their main reason for non-participation. In addition, all of our questionnaires were in Dutch, except the one used in Chapter 6 (which was translated in French and English). Hence, we probably have lost foreign born people who had difficulties with the Dutch language. Despite the fact that we did not found clear evidence for an extensive underrepresentation of this group, we have some signals referring to this selection bias. These are the underrepresentation of foreign born women in the post-abortion data wave (outlined in Chapter 5), certain non-responders referring to language barriers as the reason for non-participation, and a quite low number of respondents with a foreign origin compared to what is reported by the Belgian Evaluation Commission on induced abortion (SENSOA, 2011). While nationality differed between the non-responders and the participants in the study outlined in Chapter 6 (despite the use of translated questionnaires), no difference was found in the study outlined in Chapters 3, 4, and 5. In addition to language barriers, a selection bias regarding the level of distress of the participating women might have been present too. Although we did not found a difference in level of distress or uncertainty between those who participated in the post-abortion-data wave (see Chapter 6) and those who did only take part in the pre-abortion measurement, based on the reasons for non-participation, we hypothesize that those with a higher level of distress or uncertainty might have been more reluctant to refuse participation in the longitudinal abortion study. Finally, as already mentioned in Chapters 3 and 4, the male partners who did take part in this study are certainly not representative of all the men involved in induced abortions. We demonstrated that women for whom the male partner participated in the study as well, did not differ in civil status from those for whom the male partner did not participate, but these women did report a higher level of relational depth, a higher level of involvement of the male partner in the decision, and a slightly higher satisfaction with his decisional role. We also saw that the level of shared decision-making reported by the participating men was generally higher than the main level of shared decision-making the women reported. This shows that the men who

[6] During the pre-test phase of the study, we offered participants the possibility to fill out paper-and pencil-questionnaires instead of online questionnaires. However, due to logistical reasons, this option was dropped at the start of the study.

participated in our study, are only a subgroup of all men involved in induced abortion (we defined them as the "involved" male partners, to differentiate them from the overall group of male partners of abortion-seeking women; see Reich & Brindis, 2006).

Fourthly, in addition to selection bias, we also excluded certain groups of men and women. For logistical reasons (informed consent) and because of the already extensive literature on adolescents, we excluded minors in the studies reported in Chapters 3 to 6 and we excluded youngsters who were still attending school, in the study outlined in Chapter 2 (due to methodological reasons). Moreover, for the studies reported in Chapter 3 to 6, we relied on the group of women who requested an abortion in one of the five Flemish abortion centers. Hence, we excluded those who had an abortion in a Flemish hospital (which is, however, a smaller group). As a consequence, our findings on unplanned pregnancy rates (see Chapter 2), involvement of male partners (see Chapter 3), levels of ambivalent thoughts and uncertainty (Chapter 4 and 5), and value of counseling sessions (see Chapter 6) might not be generalized to girls and boys younger than 18, nor to women and men who had counseling sessions in a hospital.

Fifthly, despites several attempts to maximize the response rate and to minimize the dropout in the several studies (for instance training the staff and the interviewers in motivating techniques, sending reminders, providing an incentive, offering the opportunity to participate in a light-version of the study, guarantying confidentiality, or shortening the length of the questionnaire), response rates never reached 60% and dropout was often more than 50%. Several general reasons for non-participation and dropout might be found. As indicated by Newington and Metcalfe (2014), non-participation in research might be due to the following factors: infrastructure, nature of the research, recruiter characteristics, and participants characteristics. From the side of the recruiters, we hypothesize that the fact that various psychosocial health care providers (in the longitudinal diary study and the counseling study) and various professional interviewers (in the Sexpert study) asked eligible respondents to participate, and not the main researcher, might have negatively affected the response rate. The request to fill out one or more quite lengthy, time consuming questionnaires in combination with logistical barriers (such as logging on to the survey with a personal code in the longitudinal diary study or being at home in the Sexpert study) might have decreased the response rate and increased the dropout rate as well. Finally, as already mentioned above, we might have been selective to those respondents with a higher level of education, and better language abilities, but also to those with a lower workload, and rather acceptable levels of distress. We however made every attempt to test selection biases towards the non-responder groups and the dropout groups by obtaining as much information as possible about them.

A sixth limitation concerns the measurements we used to examine decision uncertainty (Chapters 4 and 6), emotional distress (Chapters 5 and 6), and unintended pregnancy (Chapter 2). Although in our longitudinal study, we did include the measurement of "typical" emotions which have

been linked with abortion, such as feelings of guilt, shame or relief[7] (e.g. Kero & Lalos, 2000), we did not associate them with our main decisional variables (shared decision-making, autonomy….). We instead focused on an overarching measure of emotional distress. Both in Chapter 5 and 6, we also used non-specific measures of decision uncertainty which might have produced other results than the recently designed abortion uncertainty measure (e.g., Ralph et al., 2016). Also the measure of pregnancy intent we used in Chapter 2 was rather outdated compared to more recently designed questionnaires (Barrett, Smith, & Wellings, 2004).

Finally, as outlined below, we did not focus on the specific interactional processes of decision-making within couples. Although we did include measures of constructive versus destructive couple level communication (e.g., Buysse & Ickes, 1999) about the unintended pregnancy, we did not focus on this interactional level in this doctoral thesis. Information about this interactional level might have given rise to a more profound interpretation of the findings outlined in Chapters 3, and 4.

7.6 Recommendations for future research

Although this doctoral thesis added significant value to the research on induced abortion, new research questions were raised and other questions remained unanswered.

As we demonstrated that despite both partners being fairly satisfied with the role of the male partner in the decision process, satisfaction with his role was still somewhat lower than satisfaction with the role of the abortion-seeking women, we suggest future research to deepen the knowledge on how male partners perceive and evaluate the existing abortion services (see Makenzius, Tydén, Darj, & Larsson, 2012), and more broadly, how they evaluate and perceive the existing family planning services and policies in Flanders. It would be especially interesting to investigate the involved male partners' own experiences with pre-abortion counseling in Flanders. If we should increase male partners' involvement (and responsibility) in family planning issues such as the prevention of (future) unplanned pregnancies (e.g., Altshuler et al., 2016; Ekstrand et al., 2007), we should ask *them* about their personal, interpersonal or societal barriers for being involved. We should also ask *them* about how they could be agentic even in the situation of unequal division of reproductive power. We hence follow the recommendation of others to further involve men in research on reproductive health issues (Greene & Biddlecom, 2000). Scholars should also broaden the focus from adolescent men (e.g., Brown, 2015; Ekstrand et al., 2007; Marsiglio & Shehan, 1993; Sharp et al., 2015) to men of varying

[7] Post-hoc analyses (not included in chapter 5) revealed that also the degree to which participants felt guilty or ashamed, significantly decreased from pre- to post-abortion while the degree to which they felt relieved significantly increased. The mean score on the items measuring these emotions was, however, rather low, even in the pre-abortion questionnaire (about one in four women and one in seven male partners experienced high to very high levels of guilt and shame pre-abortion). The mean score on the relief item was for both of the partners very high post-abortion, in line with various other studies.

ages, and in varying relational contexts to capture the full range of relationships in which abortion-seeking women - and more broadly women of reproductive age in general - exist.

Secondly, as we shed light on differences between male partners' involvement in the process and outcome of the decision to have an abortion, scholars should further investigate *how* partners negotiate with each other on this decision (e.g., Zeiler, 2007), how this negotiation process affects both partners' wellbeing and which (relational or moral) factors shape this negotiation process. The Relational Interdependence framework would be valuable in this investigation as it models how partners transform their decisional motives as a result of broader relationship goals (Arriaga, 2013). This kind of research needs process oriented designs such as qualitative research techniques (e.g., dyadic couple interviews), and micro process analyses including semi-experimental designs (e.g., scenario based research). An interesting research question would be how reproductive decisions preceding the unintended pregnancy within the couple (e.g., the decision to use a certain contraceptive method) contribute to how partners negotiate on the decision about the unintended pregnancy. It would for instance be interesting to test the impact of feelings of guilt about the contraceptive failure in this negotiation process (e.g., Wietzker, Buysse, Loeys, & Brondeel, 2011).

Thirdly, as already mentioned, future scholars should make attempts to examine the group of women and male partners who decided to carry the unwanted pregnancy to term, as these people are a vulnerable for impaired wellbeing (Vandamme et al., 2013). Although American scholars have investigated those who were obliged to carry the unwanted pregnancy to term because of gestational limits (Biggs, Upadhyay, McCulloch & Foster, 2017), to our knowledge, no study has mapped the *relational process* of "voluntary" deciding to carry an initially unwanted pregnancy to term. One of the recruiting strategies here could be to focus on the women who seek an induced abortion and later on, change their minds. However, this group is only a subgroup of the couples who decide to carry an unwanted pregnancy to term. Hence, this recruiting strategy should be combined with the recruitment of a representative sample of pregnant women and involved male partners from which a subgroup could be drawn for whom the current pregnancy is unwanted [8].

Fourthly, as already outlined above, as we shed light on the similarities as well as the possible differences between the decision to have an abortion and the decision to have a child (see also Törnbom et al., 1999), we recommend future researchers to test one overarching theoretical model in which different kinds of reproductive decisions (including the decision to stop a fertility treatment or the decision to use a certain contraceptive method) could be modelled. Experimental designs could then help to test the different elements affecting both the outcome and the process of reproductive

[8] We are currently recruiting this kind of sample. We investigate the degree to which the pregnancy was intended with Barrett's multidimensional measure of unplanned pregnancy (Barrett et al., 2004).

decision-making in couples. Such a model would bring together all the available evidence on reproductive decision-making, and would be in line with the complex reality of relationships in which different reproductive decisions made by the two partners are interrelated.

Furthermore, as Belgian abortion law includes the necessity of a mandatory waiting period beyond the necessity of a mandatory counseling session, it would be interesting for future scholars to examine women's and involved male partners' own perceptions on this waiting period, both before and after it has occurred (similar to the methodology used in the study described in Chapter 6). Based on our results, and in line with other authors, we could question the value of this waiting period, as abortion-seeking women and involved male partners are already quite certain about having the abortion. Others already pointed to the possible harmful effects of mandatory waiting periods on women having an abortion (Joyce et al., 2009). However, we should ask Flemish women and the involved male partners themselves about how they perceive and evaluate this waiting period to make evidence based conclusions on this issue in our own country. It might be the case that, similar to what we found on the counseling sessions, women would value the possibility of tailoring this waiting period to their own needs and desires.

Finally, as Neefs and Vissers (2005) demonstrated the overrepresentation of certain ethnic minority groups in the Flemish abortion-seeking population, scholars should investigate the occurrence of unmet need for contraceptives, and the occurrence of unplanned pregnancies and induced abortions in other ethnic minority groups than the Turkish minority group living in Flanders. In addition, a focus on the first generation immigrants above and beyond the focus on second generation immigrants would be useful as well. In general, it would be interesting for family planning policies to investigate satisfaction with role division regarding the involvement of the male partner in the induced abortion or satisfaction with pre-abortion counseling, at a country-based level. As such, country-level factors such as the level of gender equality in a certain region or the general quality of abortion care could be associated with these important outcome measures.

7.7 General conclusion

In this doctoral thesis, we demonstrated how intrapersonal, interpersonal, and between-person contexts affect the process as well as the outcome of deciding to have an induced abortion. We shed light on the role of sociodemographic and sociocultural factors, relational and interactional factors, and personal needs and vulnerabilities. Our studies also revealed similarities as well as differences in how women and involved male partners experience the decision to have an abortion. In addition, we showed the impact of timing (pre- versus post-abortion) and the specific situation in which the pregnancy occurs. Furthermore, we outlined the value of pre-abortion counseling and demonstrated the cognitive agency of both partners involved in the decision. This doctoral thesis proves the

multilevel complexity in which the decision to have an abortion occurs and demonstrates the necessary failure of a single-level approach. An intrapersonal stress- and coping approach will then fall short to take into account the role of the sociocultural context in which the induced abortion occurs. Similarly, a gender based perspective in which women's rights are contrasted to men's rights will fail to see the role of the relational context for women seeking an induced abortion. Bringing together all these different levels is the most evidence based approach to deal with the decision to have an induced abortion, in policy, in theory as well as in health care.

7.8 References

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ABOUT THE AUTHOR

Joke Vandamme was born on the 5th of November, 1988 in Roeselare, Belgium. After finishing her High School education at the Broederschool in Roeselare, she started her Psychology studies at the University of Ghent. In 2011, she obtained her Master degree in Clinical Psychology (magna cum laude). Then, she started working as the logistic coordinator of the IPOS project, a multidisciplinary project on divorce in couples, led by Prof. dr. Ann Buysse. Later on, she became a member of the SEXPERT project, a multidisciplinary project on sexual health in Flanders, led by Prof. dr. Ann Buysse as well. Prof. dr. Guy T'Sjoen was also promotor of the project and became Joke's supervisor of her own PhD project. In 2013, she applied for a research grant at the Flemish Research Foundation (Fonds Wetenschappelijk Onderzoek Vlaanderen; FWO). Her project, entitled "Shared reproductive decisions: An integrated research approach", was approved, and Joke started her Phd Fellowship under the supervision of Prof. T'Sjoen and Prof. Buysse. Joke is currently (co-)author of international as well as national publications on reproductive health issues. She has also been able to present her work at different national and international conferences on reproductive, sexual, and relational health. In addition, she commented on actual themes regarding reproductive health in newspapers, and popular magazines, and she has several times been a member of a discussion panel.

Besides her work as a researcher, she is committed to psychotherapeutic work (with a focus on couples), and she is involved in various research projects and field organizations related to her topic of research. She is for instance a member of the General Assembly of SENSOA (the expert organization on sexual health in Flanders), and she is an active member of the international ANSER network (Academic Network for Sexual and Reproductive Health and Rights).

As a member of the Family Lab team at the Faculty of Psychology and Educational Sciences, she supervised 17 Master thesis of Clinical Psychology students. In addition, she has been involved as a tutor in the course "Clinical-psychological abilities and diagnostics".

Publications in journals with peer review

2017 Vandamme, J., Buysse, A., Loeys, T., Vrancken, C. & T'Sjoen. G. (2017). The decision to have an abortion from both partners' perspectives: A dyadic analysis. *The European Journal of Contraception and Reproductive Health Care*, *22*, 30-37. doi:10.1080/13625187.2016.1255940 (A1, original paper, IF 1.236, ranking Q2 in Medicine, miscellaneous)

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2015 Elaut, E., Buysse, A., Caen, M., Vandamme, J., Vermeire, K., & T'Sjoen, G. (2015). Contraceptive use in Flanders (Belgium): A comparison between a general population sample and a Turkish ethnic minority sample. *The European Journal of Contraception & Reproductive Health Care*, *20*, 283-295. doi:10.3109/13625187.2015.1015717 (A1, original paper, IF 1.236, ranking Q2 in Medicine, miscellaneous)

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2013 Declercq, E., Vandamme, J., Elaut, E., & T'Sjoen, G. (2013). Seksualiteit bij chronische internistische aandoeningen. *Tijdschrift voor Geneeskunde*, *69*(22), 1085–1092. (A2, original paper)

2013 Vandamme, J., Wyverkens, E., Buysse, A., Vrancken, C., & Brondeel, R. Pre-abortion counselling from women's point of view (2013). *The European Journal of Contraception and Reproductive Health Care, 18*, 309-318. doi:10.3109/13625187.2013.796586 (A1, original paper, IF 1.835, ranking Q1 in Medicine, miscellaneous)

2013 Vandamme, J., Buysse, A. & T'Sjoen, G. (2013). Reproductief welzijn. In A. Buysse, M. Caen, D. Dewaele, P. Enzlin, J. Lievens, G. T'Sjoen, … H. Vermeersch (Eds.), *Seksuele gezondheid in Vlaanderen [Sexual health in Flanders]* (pp. 155-191). Gent, Belgium: Academia Press. (B2, book chapter, GPRC-label)

2013 Buysse, A., Enzlin, P., Lievens, J., T'Sjoen, G., Van Houtte, M., Vermeersch, H., …. Brants, S. (2013). *Sexpert: Basisgegevens van de survey naar seksuele gezondheid in Vlaanderen*. Gent, Belgium: Academia Press. (C4, data report)

Oral presentations

2016	National SENSOA Conference (Brussels, Belgium). Vandamme, J., Buysse, A., & T'Sjoen, G. De rol van mannen in de beslissing tot abortus.
2016	Conference of the International Association of Relationship Research (Toronto, Canada). Vandamme, J., Buysse, A., Loeys, T., & T'Sjoen, G. Both partners' involvement in the decision for abortion: An interpersonal analysis.
2014	FIAPAC Conference (Ljubljana, Slovenia). Vandamme, J., Buysse, A., Loeys, T., & T'Sjoen, G. Distress and dyadic coping when opting for induced abortion: An interactional analysis within couples.
2014	7de Vlaamse Geestelijke Gezondheidscongres (Antwerp, Belgium) Vandamme, J., Buysse, A., & T'Sjoen, G. Etnische afkomst en gezinsplanning: Data van twee populatiesteekproeven.
2014	Symposium on Stress and Coping in Families (Ghent, Belgium) Vandamme, J., Buysse, A., & T'Sjoen, G. Coping with unintended reproductive decisions -The abortion case.
2012	FIAPAC Conference (Edingburgh, UK). Vandamme, J., Wyverkens, E, & Buysse, A. Pre-abortion counselling in Flanders (Belgium).

Poster presentations

2016	FIAPAC Conference (Lisbon, Portugal) Vandamme, J., Todts, S., Buysse, A., T'Sjoen, G., Rötgens, A., & 't Hooft. Evaluating abortion care in Flanders: Clients' and experts' perspectives.
2016	FIAPAC Conference (Lisbon, Portugal) Vandamme, J., Buysse, A., Loeys, T., & T'Sjoen, G. The involvement of the male partner (MP) in the decision for abortion
2014	European Conference on Systemic Research (Heidelberg, Germany) Vandamme, J., Buysse, A., & T'Sjoen, G. The need for appropriate support to couples terminating their unwanted pregnancy: The case of home abortions.
2013	Conference of the International Academy of Sex Research (Chicago, US) Vandamme, J., Buysse, A., Loeys, T., & T'Sjoen, G. The past help-seeking

	trajectory for subfertility: Does it make a difference for current sexual and mental wellbeing?
2013	Conference of the European Society of Contraception and Reproductive Health (Copenhagen, Denmark)
	Vandamme, J., Buysse, A., & T'Sjoen, G. Time dependent decisions: Planning of pregnancy and induced abortion in a large-scale representative study.