The European Journal of Contraception and Reproductive Health Care, 2013; 18: 309–318

Pre-abortion counselling from women's point of view

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ABSTRACT

Objective The value of mandatory pre-abortion counselling 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 counselling in Flanders.

Methods Participating women ($N = 971$) – all requesting an abortion at one of the five Flemish abortion centres – were offered a questionnaire prior to the counselling 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 counselling session.

Results Prior to the counselling, women are hesitant regarding the value of the sessions, feel distressed, yet decisive about their abortion. After the counselling session, women assign an increased value to the counselling, are very satisfied, and experience less distress and greater decisiveness. During counselling 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 counselling.

Conclusions Pre-abortion counselling in Flanders is standardised as well as personalised. The women in this study positively valued it.

KEYWORDS Abortion; Pre-abortion counselling; Counselling needs; Client-centred approach

INTRODUCTION

Abortion has been performed at all times, in all societies, and continues to play an important role in fertility control[1]. Despite its importance in family planning (FP), it remains a complex and controversial issue that challenges the legal, political, moral, religious and economic structures in society. For example, the long-term mental and physical effects following abortion have been extensively studied[2–4]. 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[5]. 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[6]. 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

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DOI: 10.3109/13625187.2013.796586

important difference regarding these services, concerns the existence of a mandatory pre-abortion counselling 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[7]. The law states that every abortion must be performed in a multidisciplinary institution which provides information and counselling services. The law also imposes a mandatory reflection period of at least six days, between the pre-abortion counselling session and the termination itself[7]. Both the counselling and the procedure have to take place in the same institution.

In Flanders (the Northern part of Belgium), five abortion centres (part of the 'LUNA' association) have been established within the primary health care system, next to certain hospitals where abortions are also performed. In practice, the multidisciplinary care which is imposed by law embodies a non-directive counselling 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 counselling session in these centres 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 centres are trained to adopt a non-judgemental and non-directive attitude. This training is inspired by a client-centred approach, which emphasises the importance of empathy and brings the specific needs of each client into focus[8]. Previous studies concerning abortion healthcare have shown the importance of the provision of information by supportive and non-judgemental staff, addressing the needs and interests of the individual client[9–14].

The usefulness of mandatory pre-abortion counselling is a hotly debated subject. Opponents postulate that counselling is superfluous and intrusive since the majority of women already have made their decision when consulting abortion services[10,15–18]. They argue that counselling 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[16,18]. In contrast, literature has indicated women's high satisfaction with the abortion counselling[19], and the possible benefits of the latter on women's mental health post-abortion[20].

However, research has rarely examined pre-abortion counselling. Specific literature on abortion care is scarce, and differs in many respects. The existing studies have focused on women's general experiences with abortion care, ranging from the first appointment with a doctor, to the final abortion procedure in a specific clinic[9–11,19]. 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 counselling.

The present study aims to complement the literature on pre-abortion counselling, both theoretically and methodologically. Theoretically, our study explored the perceived value and preferred content of pre-abortion counselling 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 just before and immediately after the counselling session. This contrasts with how data were gathered in other studies, which took place approximately one month after the abortion procedure[10,11,19]. Therefore, our study was the first to compare women's pre-counselling needs with their post-counselling evaluations. To our knowledge, there is only one other study – which analysed perceptions regarding couples' counselling – that used this methodology[21].

The purpose of our explorative study was to examine pre-abortion counselling in a specific context (i.e., Flanders, where every abortion-seeking woman goes through this counselling 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 centre). We wished to discover (i) what women want to discuss and to what extent this is reflected in the actual counselling session, (ii) the emotional and cognitive state of women when entering and leaving the abortion centre, and (iii) how women experience the counselling session and to what extent they perceive it as useful. By taking the pre-abortion counselling in Flanders as a specific study case, we wanted to provide new insights into the debate about pre-abortion counselling.

METHODS

Procedure

This cross-sectional study involved women requesting an abortion between March 2010 and June 2010 in the LUNA abortion centres. Staff members in the five abortion centres were invited to systematically recruit every abortion-seeking woman who attended the centre. 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 centres 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 counselling session. Most questions were purposely constructed in accordance with the current abortion counselling practice in Flanders and the international literature on pre-abortion counselling. 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).

Counselling content

Two multiple-choice questions dealt with the content of the counselling session, asking which themes women wanted to discuss during the session (pre-counselling), and which themes they eventually did discuss (post-counselling). Based on observation of the participant during the counselling session and discussion with experts, a list was made with 11 themes that covered the content of the counselling. 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-counselling 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[22]. 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 discriminantly valid in clinical populations[23,24]. 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 'vigour' (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 vigour scale, which is positively formulated. Eventually a Total Mood Disturbance (TMD) score was calculated by taking the sum of the four means on the negative subscales ('depression', 'fatigue', 'tension', and 'anger') and subtracting the mean vigour subscale score[27]. TMD scores ranged from 0 to 24. Mood states of the participants were measured prior to the counselling session (Time 1) and immediately after the counselling 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[26]. 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 already made). The use of VAS in the area of mood states has shown high validity and high reliability[27].

Perceived value

One question concerned the usefulness of the counselling session to women, as perceived just before and immediately 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 counselling session and repeated immediately afterwards, except for background information (only pre-counselling) and satisfaction (only post-counselling). 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 counselling. In this way, we improved our cross-sectional study for certain variables by taking into consideration the baseline measurements.

Data analysis

To determine whether the content of the counselling session was in accordance with the women's needs, logistic regressions were performed. Logistic regression models were also used to analyse 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 counselling, 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, counselling content, pre- and post-emotional and cognitive states, and perceived value scores). Participants' age and the city where the abortion centre was situated were used as predictors in the imputation analyses since these variables had no missing values. All analyses were done using the statistical programme SPSS (Version 19.0, SPSS Inc).

RESULTS

Sample

Of all 2087 women requesting an abortion in the Flemish abortion centres during the three months of our study, 971 (47%) agreed to participate. The response rate was highest at the abortion centre in Ostend (58%) and lowest at the abortion centre 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 of 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 over 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 ($\chi^2[2] = 1.73; p < 0.001$). 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%). The counselling sessions were conducted by healthcare providers trained in Social Sciences or Sexology such as 'social nurses' – with a mixed clinical and social work training – (38%), psychologists (30%), sexologists (12%), and social workers (10%). Healthcare providers with a purely medical background, i.e., general nurses, were present in 10% of the sessions.

Counselling content

As shown in Table 1, some of the themes were discussed very often during the counselling 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-counselling, 1% of the women wished to discuss a topic that had not been 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.

Table 1 Discussion of, and client's wish to discuss, themes during pre-abortion counselling sessions in Flemish abortion centres.

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%

Logistic regressions were used to analyse 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 women who wished to talk about the role of significant others eventually had the opportunity to do so, while only 40% of 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).

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.

Table 2 Discussion of the themes during the pre-abortion counselling 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]

OR, odds ratio of discussion of a theme that the woman wished to be taken up; CI, confidence interval.
*$p < 0.001$.

The 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, $p < 0.01$), 'experiences of others' (OR = 0.96, $p < 0.001$), and 'role of significant others' (OR = 0.96, $p < 0.001$), indicating that these themes were discussed less with older women. Furthermore, the more decisive a woman was, the more she talked about 'information about the consequences' (OR = 1.13, $p < 0.001$), 'reasons for the abortion request' (OR = 1.08, $p < 0.01$), and 'experiences of others' (OR = 1.10, $p < 0.001$). The experience of a previous induced abortion meant it was less likely that the theme 'information about the consequences' (OR = 0.62, $p < 0.01$) was mentioned.

Table 3 Logistic regression analyses indicating characteristics of women which were associated with the discussion of six varying themes during the pre-abortion counselling session (OR [CI]).

	Discussion of the varying themes					
Characteristics of women	*Information about the consequences*	*Reasons for the abortion request*	*Alternatives to the abortion*	*Emotions*	*Experiences of others*	*Role of significant others*
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]
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]
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]
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]
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]
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]

OR, odds ratio of discussion of a theme related to women's characteristics; CI, confidence interval.
*$p < 0.05$, **$p < 0.01$, ***$p < 0.001$.

If someone accompanied the woman the themes 'information about the consequences' (OR = 1.51, $p < 0.05$), 'alternatives to the abortion' (OR = 1.42, $p < 0.05$), and 'experiences of others' (OR = 1.49, $p < 0.01$) 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, $p < 0.05$). In summary, although certain themes were almost always discussed, counselling 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 counselling 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, $p < 0.01$; 10.14 vs. 7.79 for 'tension', t = 11.65, $p < 0.01$; and 8.65 vs. 7.98 for 'fatigue', t = 2.88, $p < 0.01$). 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-counselling and post-counselling scores. Post-test TMD scores were significantly lower (t = − 20.50, $p < 0.001$) while scores for decisiveness had significantly increased (t = 7.22, $p < 0.001$). As a result, women were in a more positive and decisive mood compared with the start of the counselling session.

Perceived value

The women's mean score for perceived usefulness of the counselling session was 6.36 out of a maximum of 10 (SE = 0.10), indicating a moderately positive perception. This perceived usefulness significantly rose to a mean score of 8.44 out of 10 (SE = 0.07) after the counselling session (t = 18.75, $p < 0.001$). In addition, high satisfaction with the counselling session was reported. In fact, mean VAS score for satisfaction with the conversation was 8.68 out of a maximum of 10 (SD = 1.43). Further analyses showed a significant difference between scores concerning process evaluation (Mean = 9.04, SE = 0.04) and those related to content evaluation (Mean = 8.67, SE = 0.05), although the difference was small (t = 9.81, $p < 0.001$).

DISCUSSION

Findings and interpretation in relation to other studies

This study aimed at clarifying the value of pre-abortion counselling 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 counselling session when they enter the abortion centre, they highly appreciate the standardised 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 counselling session[9]. However, at the same time, they are quite decisive about their abortion request; this is in line with results from previous studies[10,16,18,28,29]. The emotional and cognitive state of abortion-seeking women can thus be described as ambivalent, since they feel both negative and quite

Table 4 Mean differences between pre-counselling and post-counselling scores for emotional states (TMD) and cognitive states (decisiveness).

Emotional and cognitive states	*Pre-counselling*		*Post-counselling*		*Mean difference*	
	Mean	*(SE)*	*Mean*	*(SE)*	*Mean*	*(SE)*
TMD	9.49	(0.16)	7.24	(0.14)	− 2.25*	(0.11)
Decisiveness	7.86	(0.10)	8.40	(0.08)	0.53*	(0.07)

TMD, Total Mood Disturbance; SE, standard error.
*$p < 0.001$.

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[16,30–33].

The counselling sessions in Flemish abortion centres 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 counselling[14]. The provision of information is considered to be an important aspect of counselling by the women themselves, as previously reported by other investigators[9,11,19], while the use of contraception and the decision-making process are often not a desired topic. Nevertheless, counsellors 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[13] and Rogers[8], it is important to keep in mind the varying needs and the uniqueness of every woman. When younger women seek counselling, sessions deal to a greater extent with alternatives to the abortion, and the role and experiences of significant others. We hypothesise 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[15]. 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. Counsellors 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 counselling 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[9,11,19]. The women we assessed were highly satisfied with the counselling 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 1000 women participating – to question abortion-seeking women 'in the heat of the moment' (i.e., in the clinical setting, when waiting for their counselling session), and at specific points in time (just before and immediately after the session with the counsellor). With the provision of a pre-counselling measurement, our study was able to explore changes in women's feelings, their thoughts about the decision, and their perceptions regarding the counselling session.

Yet some aspects limit the generalisation 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-counselling 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 counselling 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 counsellor 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. Finally, 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 they provided. Also the use of the pre-counselling questionnaire could have resulted in a clearer image of women's profiles and needs, which in turn might have improved the client-centredness during these sessions.

Future research

In view of the limitations to the representativeness of our sample, there is a 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 counselling sessions which are current practice in Flemish abortion centres. 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 counselling.

CONCLUSION

The 971 women in our sample highly appreciated the counselling 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 counselling and add to the standard part of the pre-abortion counselling sessions in Flanders.

Declaration of interest: Carine Vrancken works in one of the five centres whose clients were assessed. The other authors report no conflicts of interest. The authors alone are responsible for the content and the writing of the paper.

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