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Preferences and Experiences Regarding Pregnancy Options Counseling in Adolescence and Young Adulthood: A Qualitative Study

Lauren A. Bell, MD, MPH[1], **Crystal P. Tyler, PhD, MPH**[2], **Margaret R. Russell, MD**[3], **Nicholas Szoko, MD**[3], **Elizabeth I. Harrison, MD, MS**[3], **Traci M. Kazmerski, MD, MS**[3], **Tahniat Syed, MD, MPH**[3], **Laura Kirkpatrick, MD**[3]

[1]Division of Adolescent Medicine, Indiana University School of Medicine, Indianapolis, IN

[2]University of Chicago, Chicago, IL

[3]UPMC Children's Hospital of Pittsburgh and University of Pittsburgh, Pittsburgh, PA

Abstract

Purpose: Perspectives of adolescents and young adults (AYA) experiencing pregnancy options counseling (POC) are absent from the literature. This study explores AYA experiences and preferences related to POC to inform best practice guidelines.

Methods: We conducted semi-structured phone interviews in 2020–2021 among US-based individuals 18–35 years old who experienced a pregnancy under 20 years old. We performed qualitative descriptive analysis of positive and negative attributes of AYA's experiences with POC.

Results: Fifty participants reported 59 pregnancies (16 parenting, 19 abortion, 18 adoption, 3 miscarriages) between the ages of 13–19 years. Positive attributes of POC experienced included: 1) Provider communication that was compassionate, respectful, supportive, and attentive to non-verbal cues, 2) Provider neutrality, 3) Discussion of all pregnancy options, 4) Asking about feelings, choice, life plans, and additional supports, 5) Provision of informational materials, and 6) Warm handoffs/follow-up facilitation. Negative attributes of POC experienced included: 1) Judgmental, impersonal, or absent communication, 2) Lack of counseling on all options and/or coercive/directive counseling, 3) Insufficient time and supportive resources, and 4) Confidentiality concerns. We identified no differences in these perspectives across pregnancy outcomes reported. Participants generally desired counseling about all options, with rare exceptions of ambivalence.

Corresponding Author: Lauren A. Bell, MD MPH, 410 w 110th Street #1001, Indianapolis, IN 46202, belllaa@iu.edu, Lauren.arnold.bell@gmail.com, Cell: 901.413.5135, Office: 317.274.8812, Fax: 317.968.1223.
Margaret R. Russell is no longer at UPMC Children's but was at the time the research took place. She recently started fellowship in Child Abuse Pediatrics at University of Utah School of Medicine.
Crystal P. Tyler is no longer at University of Chicago but was when research took place. She is now working at Rhia Ventures.

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Conclusions: Individuals who experienced an adolescent pregnancy described similar positive and negative attributes of POC regardless of preferred pregnancy outcome. Their perspectives highlight how crucial interpersonal communication skills are for effective POC for AYA. POC training across healthcare specialties should emphasize confidential, compassionate, non-judgmental care for AYA patients.

Keywords

Pregnancy options counseling; adoption; abortion; parenting; pre-implementation; adolescent pregnancy

Implications and Contribution

Through qualitative analysis of interviews of individuals who experienced pregnancy during adolescence, this study provides patient-derived perspectives on positive and negative attributes of provision of pregnancy options counseling for adolescents and young adults, expanding upon current best practices in pregnancy options counseling for this vulnerable population.

Despite decreasing birth rates in the United States (US),[1] there were over 318,000 pregnancies among youth aged 15–19 years in 2017.[1,2] The adolescents and young adults (AYA) in the US that comprise this age group face social and structural barriers that limit their reproductive autonomy. Some pregnant AYA desire to parent or are ambivalent, but face stigma around adolescent parenthood and pressure to choose adoption or abortion;[3–5] those with intersecting identities experience more bias and coercion from healthcare workers.[4–6] Other AYA desire pregnancy prevention or abortion but experience barriers to contraception, comprehensive sexual education, and abortion such as requirements for parental consent/notification and abstinence-only education, which have been linked to increased local birth rates.[7–10] In addition, AYA are more likely to present to care later in pregnancy than older adults,[11] likely due to not recognizing pregnancy symptoms, concern regarding parental discovery, and economic factors.[12] Late presentation can result in more complicated, costly, or limited access to abortion and limited, delayed, or no prenatal care.[13] Following the Dobbs v. Jackson Women's Health Organization ruling[14] and increasing state legislation limiting abortion access,[15] AYA in the US especially need timely, developmentally-appropriate, patient-centered, and accurate pregnancy options counseling (POC).

Comprehensive POC includes discussion of parenting, adoption, and abortion. There is variability in US POC delivery,[16] including racial disparities surrounding abortion referrals and discussion.[17] The American Academy of Pediatrics (AAP), American Academy of Family Physicians, American College of Nurse-Midwives, and the American College of Obstetricians and Gynecologists endorse the importance of respectful, unbiased counseling pertaining to parenting, adoption, and abortion, and the AAP explicitly endorses this practice for adolescents.[18–21] Despite efforts to create provider education materials and define best practices in POC for AYA,[22–26] to our knowledge, no studies have explored perspectives of both adolescents and young adults on their experiences of and recommendations

surrounding POC, though some research has explored young adult perspectives.[27] After piloting a training curriculum for pediatric residents in adolescent-focused POC,[26] we conceived this study to inform further training iterations with patient perspectives.

Methods

We recruited a purposive sample of US-based individuals 18–35 years old who self-reported pregnancy before 20 years old. We recruited up to age 35 to allow reflection from a breadth of experience and evaluate salience over time. We continued recruitment until reaching data saturation for participants choosing parenting, adoption, and abortion. We also included participants reporting miscarriage/pregnancy loss but did not require data saturation on this outcome. We recruited participants through local obstetrics-gynecology and family planning clinics, adoption-related organizations, Facebook, Craigslist, and a university-based research registry. Exclusion criteria included speaking exclusively a non-English language. We compensated participants with $50 gift cards.

The research team developed the interview guide, which includes questions about the overall experience such as *"Did you go to see a healthcare provider? Tell me what that was like."* as well as probes exploring POC content, for example *"Did the healthcare provider talk to you about your options such as choosing to become a parent, pursuing adoption or having an abortion?"* Three team members conducted semi-structured telephone interviews between 11/2020 and 4/2021. The interview guide is available as Appendix 1. We recorded and transcribed all interviews. Two independent coders (LK and LB) conducted qualitative descriptive analysis.[28,29] We identified positive and negative attributes of POC experiences utilizing inductive and deductive analysis in Dedoose (9.0.17). After generating the initial codebook based on literature review anticipating categories of experiences and locations of POC, both coders added and refined codes to reflect and organize data into larger thematic categories. Both coders independently coded all transcripts, with support from senior co-investigators (TMK, TS) in the event of coding disagreement. When the final codebook was completed after analysis of the final transcript, we re-reviewed all previously analyzed transcripts using the final codebook. We utilized Dedoose's Analyze feature to stratify codes by pregnancy outcome (parenting, adoption, or abortion), duration of time elapsed between pregnancy and interview, race, sexuality, and age when pregnant, collapsed as outlined in Table 1. We chose not to stratify formally by gender given the small number (n=1) of nonbinary individuals and qualitative assessment that this transcript showed no marked dissimilarities. We assigned pseudonyms. The University of Pittsburgh Institutional Review Board deemed this study exempt.

Results

The final sample included 50 participants describing 59 pregnancy experiences (16 parenting, 18 abortion, 17 adoption, and 4 miscarriage, with 4 participants reporting multiple pregnancies) (Figure 1). Two reporting miscarriage were considering abortion, one was planning on kinship adoption, and one did not describe intentionality but stated "luckily, [the pregnancy] resulted in [miscarriage]." Participants reported experiencing pregnancies in 4 US census regions: Midwest (n=6), Northeast (n=21), South (n=13),

and West (n=10). Participants described interactions with physician, nursing, social work, and adoption professionals (i.e. lawyers) at first discussion of pregnancy in environments including emergency departments; obstetric/gynecologic, family medicine, family planning, and pediatric clinics; urgent care and pregnancy crisis centers; school nurses' offices, and adoption agencies. Age at pregnancy ranged from 13–19 years and at interview from 18–35 years; forty-nine participants identified as female and 1 as non-binary (Table 1). We interviewed most participants less than 15 years after the pregnancy discussed in their interview (Table 1).[30] Interviews lasted between 18–70 (median 36) minutes.

Participants named multiple positive and negative attributes of their experiences with POC during adolescence.

Positive Attribute 1: Provider communication that was compassionate, respectful, supportive, and attentive to non-verbal cues

Participants described positive provider communication skills such as compassion/kindness, respect, attention to nonverbal cues, and validation of the participant and decision as essential parts of POC. Participants associated these skills with trust in and connection with their provider. Shelby (16 when pregnant, parenting) described: *"One thing, when you see the doctor talking to you in a respectful manner, it makes you have a little hope in the situation."* She further identified signaling of respect as *"they just directed all of the questions and all the statements, and all of the signing of the paperwork I did"* directly to her, contrasting this with her prior experiences of visits to emergency departments in which providers directed questions to her guardian. Participants such as Shelby equated such interaction with being treated "as a woman"/as an adult, which was desirable and led to them feeling empowered.

One participant (Elise, 18 when pregnant, parenting) contrasted undesirable and desirable disclosure of a pregnancy by a provider, highlighting a common thread of attending to the nonverbal communication of the pregnant individual:

> "I would want them not to just barge in and say, "I have your results," and tell me. How she came in was nice, and said, "I have your results. Are you ready to hear them?" And then I said, "Yes." And then she looked at me and said, "You are." And she observed my face. And that's whenever she talked to me about it. So…I wouldn't really change anything about that. How she did it was perfect…"

Participants described positive communication skills that led to feelings of support and connection allowing their engagement in POC, contrasting with negative communication skills, which are explored further below.

Positive Attribute 2: Provider neutrality

Participants overwhelmingly desired provider neutrality when discussing options during pregnancy disclosure and at initial visits. Danita (18 when pregnant, adoption) explained the optimal way for a provider to approach counseling: *"You operate very neutral and kind of just very middle-of-the-road and very moderate in your decision and not show your feeling one way or the other. Like, I look at it like be Switzerland."*

Participants preferred providers to be factual and direct instead of relying on personal experience when presenting all options in an unbiased way. Marcy (17 when pregnant, abortion), specified providers should *"communicate with people in language they can understand, that isn't euphemistic."*

Positive Attribute 3: Presentation of all options

Almost all participants, including ones who expressed having already decided their desired pregnancy outcome prior to POC, noted they wanted presentation of all options. Neveah (19 when pregnant, parenting) explained the ideal approach to counseling: *"Just lay all the options on the table like, 'Hey, if you think you can [parent], you can. If you wanna have an adoption, this is how it'll work. There's a lot of great programs. If you wanna have an abortion, this is how it would work.'"* Two participants (15/16 when pregnant, parenting/parenting) were ambivalent around inclusion of abortion within every instance of POC but agreed it should be included in some or most circumstances.

Positive Attribute 4: Asking about feelings, choice, life plans, and additional supports

Participants noted comprehensive counseling included asking the AYA about feelings, choice, life plans, and available supports. Annaliese (16 when pregnant, abortion) stated about her provider: *"She was the first person who was like, like, "Are you okay?" [Laughter] Like, "How are you doing with all of this?" And then I felt comfortable disclosing that it had been non-consensual."* Participants described that when a provider took time to ask about these elements of their life and decision, it signaled compassion and helped them feel supported if they were facing uncertainty.

Positive Attribute 5: Provision of informational materials

Participants mentioned the importance of materials such as handouts or videos during POC, with the option to consider more later, given their frequent report of feeling overwhelmed at the time of initial discussion. Participants endorsed the idea of a scheduled check-in with a provider as complementing materials provided. For example, Reina (18 when pregnant, abortion), stated: *"I would want [options] to be spoken about, and then I would want to have something that I could reference later on and make a more educated opinion, be it a website or, you know, reading material or maybe even a follow-up counseling visit."*

Positive Attribute 6: Warm handoffs/follow-up facilitation

Participants requested warm handoffs to outside resources/providers and/or scheduling of follow-up visits with the counseling provider at the conclusion of POC. Named resources included parenting classes, AYA pregnancy support groups, and counselors/therapists. Examples of warm handoffs/follow-up scheduling included help making appointments with prenatal care, abortion providers, and adoption agencies, or having a provider check-in if the individual remained undecided. Dori (19 at time of 2 pregnancies, 2 abortions), mentioned facilitating external referrals when asked what information should be provided for AYA not yet sure of their decision: *"If somebody maybe needed counseling or something, giving them the resources for that, like, how they would go about getting that help."*

Participants who expressed interest in parenting emphasized that providing connection to state assistance was insufficient to support their decision. Participants desired additional connection to community organizations and skill-building resources. As Bobbi (18 when pregnant, parenting) described, AYA who chose parenting desire *"the tools and the knowledge and, hopefully, the resources to get support from somewhere else or to get out of a bad situation or to help themselves."*

Negative Attribute 1: Poor provider communication skills

Participants cited poor provider communication skills as a barrier to effective POC. Areas of poor communication included being judgmental, not individualizing discussion content, and providing insufficient information about the pregnancy or options discussed. Alex (16/19 when pregnant, adoption/parenting) described a judgmental interaction during POC: *"It felt like there was that judgment that I had talked about of, 'You're in the situation, and you shouldn't be. And so to kinda fix it, you should choose adoption.' It just didn't feel supportive. It felt more judgy and invalidating to what I needed at that point."* When participants noted negative communication skills, especially when they perceived judgment because of their age, they reported disconnecting from the discussion with their provider.

Negative Attribute 2: Incomplete or directive counseling

Many participants reported absent, incomplete, and/or directive counseling. Eighteen individuals reported not receiving POC when discussing a pregnancy with a provider, and eight reported directive/coercive counseling. Participants reported occurrences of incomplete/absent options counseling across multiple settings and professional types. Mimi (19 when pregnant, adoption) explained her interaction with a "pregnancy counselor" at an adoption agency: *"I definitely didn't get like, the encouragement…to parent…I came in with the intent to place and there was no talk of anything else. There was no like, 'Well, let's look at your options,' kind of thing."* One participant (Neveah, 19 when pregnant, parenting) who was not provided POC and directed exclusively toward abortion, reported subsequent withdrawal from engagement in further discussion.

Negative Attribute 3: Insufficient time and supportive resources

Individuals described rushed environments as limiting their provider's ability to provide adequate POC; when rushed, they described feeling like a number rather than an individual and not connecting with the provider. Participants reported an insufficient connection to or explanation of material resources to support their ability to consider parenting as an option, further describing the inadequacy of state-funded housing and supplementation systems in place. Natalie (18 when pregnant, adoption) noted this structural issue:

> "There aren't resources available that can immediately take you from, living paycheck-to-paycheck to, 'Okay. Now I have this scholarship to get me into a certification,' or something to help me get that next level up to take care of my child and to take care of myself, and not have to worry about if I'm going to have a roof over their heads or food on the table. I think it's more of a deep issue than it is of just what information, or how a healthcare provider could help in that situation."

Negative Attribute 4: Confidentiality concerns

Participants noted many experiences in which confidentiality was not respected or offered during POC when they were accompanied by a partner or parent. Destiny (15 when pregnant, adoption) described how after her confidentiality was not respected at a family planning clinic at the start of her interaction, she withdrew from later questions around POC:

> "My stepmom took me. They start asking me questions about my sexual experiences and things like that. And it was just really awkward 'cause I'm like, 'Can you guys do this alone?'….At this point, I was just like, 'You guys already made me uncomfortable'….And so I was upset and irritated…everything they were asking me, I kinda just brushed it off and didn't really care to answer anything else."

Other participants explained how the presence of a partner/parent limited their ability to participate in POC because of their attempts to evaluate and manage the emotions of the other person present rather than attend to their own questions or concerns.

Participants reported some intentional breaches of confidentiality with pregnancy disclosure to a parent/guardian and involuntary disclosures (result phone calls, insurance paperwork). Overall, participants listed confidentiality concerns as a barrier to feeling they had access to all options during POC as well as to their ability to independently participate in the counseling discussion.

In addition to representative excerpts included in the text above, tables 2 and 3 showcase additional examples of facilitators (Table 2) and barriers (Table 3). When stratified by pregnancy outcome and duration of time elapsed between pregnancy and time of interview, we identified no differences in these eight major themes of facilitators of and barriers to POC for AYA. We also did not identify differences when stratified by race, sexuality, or age when pregnant.

Discussion

Individuals who experienced AYA pregnancies reported suboptimal POC including directive and incomplete counseling but identified many positive attributes of the POC they experienced. This study is the first to provide patient-derived perspectives on optimal POC for both adolescents and young adults, which is especially timely given the abortion landscape in the US today. Complete, nonjudgmental options counseling with subsequent supports as desired by participants can facilitate timely steps toward access to parenting, adoption, or abortion. AYA already face numerous barriers to abortion care. In states with parental consent laws for abortion, inconsistent and/or subjective methodology to assess AYA maturity during the burdensome process of judicial bypass further limits access to care.[31] These barriers are compounded by intersectionality, with individuals from diverse racial, ethnic, and religious backgrounds facing additional systemic barriers to care including community-level stigma around abortion.[32] Since the Dobbs v. Jackson Women's Health Organization ruling, U.S. state legislatures have implemented increasing abortion restrictions including gestational age limits, limiting counseling and referrals pertaining to abortion, and making any abortion illegal.[15] As such, AYA who present in need of POC to

their healthcare provider in a state with limited or no abortion access—or to a new provider in an adjacent state maintaining access—will experience additional barriers if they choose abortion. Individuals who lack financial and social capital to navigate existing restrictions will rely even more heavily on their provider for guidance, explanation of resources, and facilitated connection to abortion services. With each week of increased gestational age, the cost of an abortion as well as the risks of abortion increase,[33,34] making nonjudgmental, early, effective, accurate, and supportive POC imperative to support the optimal physical and financial well-being of AYA choosing abortion. Unfortunately, even this counseling may be limited by legislative restriction around discussion of/referrals to abortion providers.

All pregnant AYA, no matter their desired option, deserve POC following best practices. This research highlights the pervasive desire of AYA to receive neutral delivery of POC, which is in direct conflict with legislative efforts seeking to limit counseling around abortion. Our findings provide a roadmap for improving patient-centered POC and promoting AYA-provider engagement to inform updates to implementation of existing guidelines. There is overlap with our findings and the AAP's endorsement of presenting parenting, adoption, and abortion as options, providing developmentally-appropriate, accurate information about each option, supporting the decision-making process, connecting AYA to next steps/community resources, and assessing one's beliefs to ensure nonjudgmental, unbiased performance of counseling or immediate referral for a different provider to perform counseling.[18] However, our research exceeds those guidelines in emphasizing the importance of provider inquiry about the patient's feelings and mood, the need for formal follow-up conversations for undecided AYA, and the value of exploring practical aspects of a patient's decision to determine areas of need for additional support. Our findings also provide examples of functional and dysfunctional communication patterns at the individual level for providers to implement optimal counseling. The AAP's POC guidelines emphasize clear documentation of reasons to not breach confidentiality. Our research adds the need for ensuring the adolescent has the opportunity for a private, confidential discussion with the provider at the time of pregnancy disclosure including clear delineation of the limits of confidentiality based on local regulations. These added recommendations are consistent with the increased protections for adolescent confidentiality called for by professional pediatric and adolescent medical organizations,[35–37] which varied state legislation ranges from supporting (as in minor consent laws), to ignoring (in which cases providers can use federal regulations regarding the confidentiality of other sexual health decisions as being theoretically permissive of confidentiality), to attacking (as in laws requiring explicit parental consent for abortion).

The inadequate, judgmental, and coercive/directive POC reported by participants across settings highlights the need to increase the existence and quality of POC for AYA through educational and policy initiatives. These perspectives and recommendations should be incorporated into training all specialties that interact with pregnant AYA, possibly using shared decision-making frameworks to improve POC quality.[23] POC policies and guidelines within health systems should include the protection of time, provision of resources, and formal coordination of next steps for AYA. In the current US political setting, efforts to improve the quality of care for AYA through education, institutional guidance, and policy

may have larger immediate impacts on health outcomes for AYA than efforts to change legislation.

Limitations

There were several limitations of our study. The length of time that elapsed from pregnancy to the interviews may predispose to recall bias. However, the experiences that we recorded were highly salient, emotional experiences–-likely to support the adequate reporting of experiences recounted given data on increased accuracy of recall in situations with higher emotional valence[38,39]—and the purpose of the study was to elicit qualitative reflections on recommendations for best practices rather than a detailed recall of events. Additionally, when we stratified participants by years lapsed between their pregnancy and interview, we did not find differences in the described themes. This finding suggests persistence of these themes over the past several decades in the US, affecting both AYA who experienced pregnancy two decades ago and those who experienced pregnancy within the past 5 years. Future similar studies exclusively of youth under age 20 years who have recently experienced POC could further suggest thematic persistence. Another limitation is the purposive, non-random sampling of participants, which allowed us to obtain a diverse, informing sample for this qualitative study but cannot be analyzed quantitatively as representative of the overall US population. As such, future studies using survey-based data could evaluate these themes systematically.

Conclusions

No prior study to our knowledge has documented the experiences of adolescents experiencing POC. Despite differences in timing, location, and demographics, individuals who experienced a pregnancy in adolescence described similar positive and negative attributes of POC. Their perspectives expand and refine our understanding of adequate POC beyond that provided by current guidelines and should inform policies that support adequate training in the performance of POC for AYA, with an emphasis on providing compassionate, non-judgmental, confidential care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Abbreviations

AYA	Adolescents and young adults
US	United States
POC	Pregnancy Options Counseling

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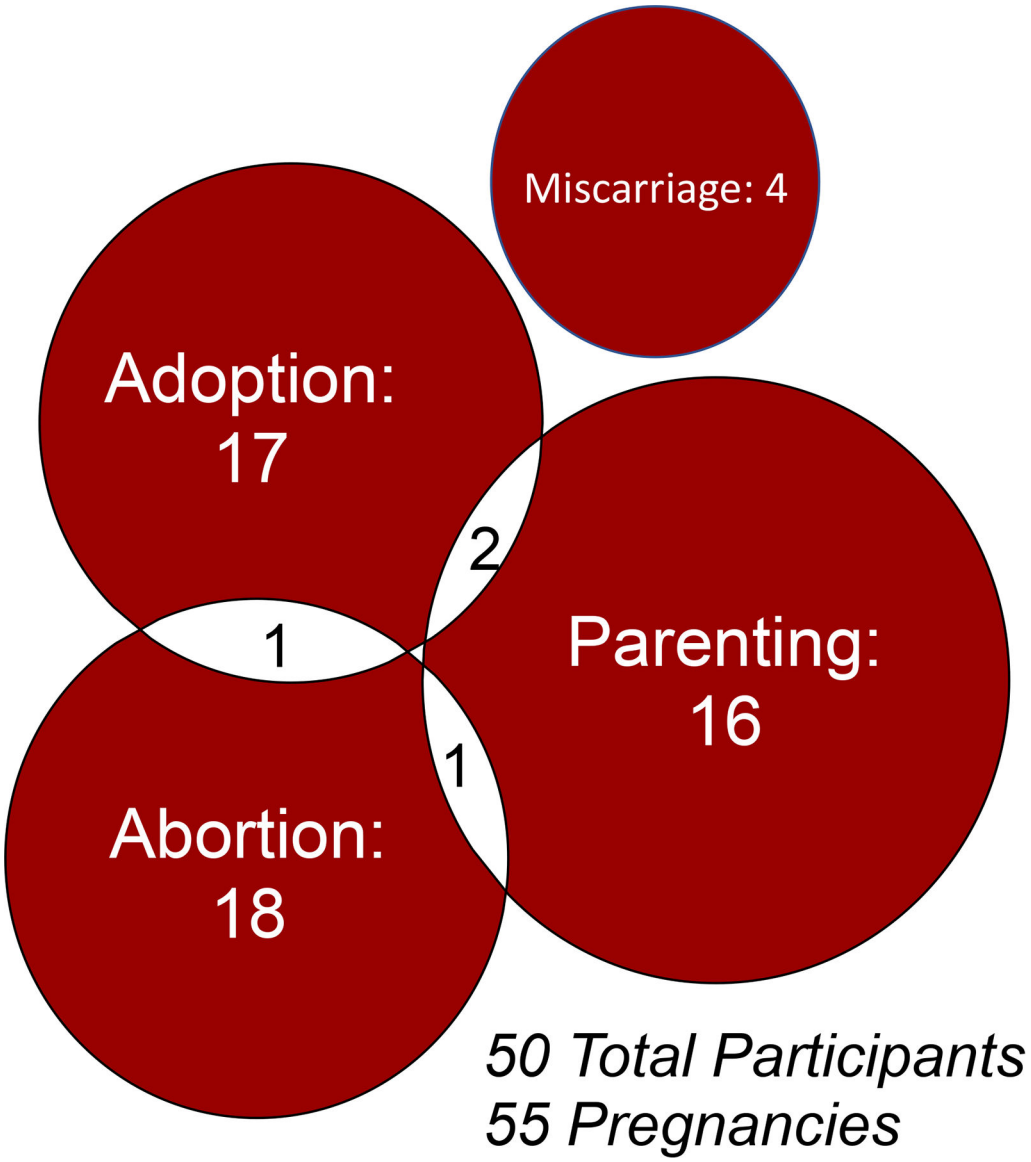

Figure 1 –.
Pregnancy Outcomes of Participants

Table 1 -

Participant Demographics

Age at pregnancy	**n (%) pregnancies**
13–15	6 (11)
16–17	17 (31)
18–19	32 (58)
Age at interview	**n (%) participants**
18–21	5 (10)
22–26	17 (34)
27–35	28 (56)
Race and ethnicity	**n (%) participants**
African American or Black	8 (16)
Asian	3 (6)
Mixed Race	5 (10)
White, Hispanic	7 (14)
White, non-Hispanic	26 (52)
Other[1]	1 (2)
Sexual orientation	**n (%) participants**
Bisexual	8 (16)
Gay or Lesbian	4 (8)
Straight	36 (72)
Other	2 (4)
Gender identity	**n (%) participants**
Female	49 (98)
Nonbinary	1 (2)
Years elapsed between pregnancy and interview	**n (%) pregnancies**
<=5	10 (18)
6–10	13 (24)
11–15	17 (31)
16–19	15 (27)

[1] One participant described a race not listed in the categories in the table.

Table 2 -

Illustrative Quotations of Positive Attributes of Pregnancy Options Counseling for AYA, by Theme

1) Positive provider communication skills	
compassion/ kindness	"You're just so, so sensitive. You're so overwhelmed. Um, and so even a teeny, teeny, teeny bit of, you know, friendliness just goes such a long way." -*Mimi, 19 when pregnant, adoption*
respect/being treated as an adult	"…especially being that young, the fact that they took me seriously and listened to me as an adult… just they empowered me by giving me all the information and having a conversation with me." -*Natalie, 18 when pregnant, adoption*
attention to nonverbal cues	"just gauging emotionally where they're at because I think that gives a context for where you can meet them, like, mentally and practically." -*Annaliese, 16 when pregnant, abortion*
support, validation of choice	"I love the doctors who support the women… in all the choices that they make, and they don't make them feel as if, you know, it's a bad thing that they didn't want to keep the child… I like the doctors that make the women feel like… even though she made the choice to have a termination, that, you know, it's okay…and that they're gonna be supportive no matter what." -*Ruth, 17 when pregnant, abortion*
2) Provider neutrality	
	"really just make sure that their opinions and beliefs are really set at the door and that they're doing their very best to speak about all the options evenly and fairly and-and making sure that they're not trying, even unconsciously, trying to cause any influence one way or another, so that the person really feels that they have the opportunity to make the decision and-and feel that they'll get support from that provider, um, whatever that decision may be." -*Grace, 16 when pregnant, miscarriage* "very nonjudgmental, please keeping their religious and prolife beliefs aside and not—try to not sway them. Try to not show them all, "This is the heartbeat of your child."…The last thing you need at that moment is to be made feel like you're a murderer." -*Anya, 19 when pregnant, parenting* "It was just professional like, "Okay." Very matter of fact. I think we just mentioned [the decision] once and that was it, kind of thing…No one in the office seemed against it. No one questioned me. No—there were no judging eyes…just very, very professional and matter of fact." - *Elizabeth, 19 when pregnant, adoption*
3) Discussion of all pregnancy options	
	"Just lay all the option on the table like, "Hey, if you think you can do this, you can. Um, or, if you wanna have an adoption, this is how it'll work. There's a lot of great programs. Or, if you wanna have an abortion, this is, you know, how it would work." -*Neveah, 19 when pregnant, parenting* "Just to be as factual as possible with the three options…you wanna give someone who's in that situation enough reality that they can handle without scaring them even more. When it comes to…access to abortion in their state, like, whatever the laws are and what they have access to and then parenting, and what that can look like, and then same with the state and adoption 'cause—I don't think people are aware that every state has different policies…have, like, prepared, depending on their state, just, like, a minute or two of what each will look like if they choose, you know, either route." -*Reagan, 16 when pregnant, adoption*
4) Asking about feelings, choice, life plans, and available supports	
	"Read between the lines, ask questions pertaining to their mental health. Ask them are they okay at home? Are they able to—if they did wanna keep their child, are they able to?" -*Destiny, 15 when pregnant, adoption* "You know, take a moment and say, "Okay. Like, emotionally, how are you dealing?" You know? "How are you doing?" Because I did suffer from prenatal depression and that could've been something that I could have either gotten medication or therapy for or just like, additional care." -*Mimi, 19 when pregnant, adoption* "They asked what my situation was, where I was in life, and why I wanted to do—why [abortion] was my decision. And they asked if I wanted to discuss other options, and, basically that was kind of about it. They wanted to make sure that I was makin' the right decision for myself and my situation." -*Jillian, 19 when pregnant, abortion*
5) Provision of informational materials	
brochures/ pamphlets	"I think not [options should be not] just discussed. I think they should give the pamphlets out, all three pamphlets, and then she can read it on her own time because she's probably super in shock. And-and-and the words are not sinking in [laughs]. She might not remember." -*Maia, 18 when pregnant, abortion* "I would have liked to have some pamphlets, and for them to tell me that maybe these - these are the options, maybe these are the places and the resources you can use. Maybe that could be included in the pamphlet itself. Resources that you can use to get more information on these things. And they send home those pamphlets with me and they have a - a little conversation with me about each of those parts." -*Anya, 19 when pregnant, parenting*
videos	"They can have a video drawn up ahead of time…where they can have the patient watch it. And this way it's-it's, like, proofread in a sense because you never know what can come out of the mouth of a person." -*Isabel, 18 when pregnant, parenting*

6) Warm handoffs/follow-up facilitation	
Connections to resources: parenting classes, support groups, counselors/ therapists	"You know, this is where I am right now, but how do I do it? How do I move forward? And so having those resources—connecting to Medicaid or, um, connecting to pregnancy resource centers that will help them educate them on - um, on labor classes or getting diapers or parenting classes." -*Alex, 16/19 when pregnant, adoption/parenting*
Connections to next steps: provider check-in, prenatal care, abortion provider, adoption agency	"You can talk to them at the facility, but…when you cram somebody so young with all of that information…following up even just a phone call after the fact, just to check in and see…if they had any kinda question…instead of just cramming them with all this information and kinda just sending them on their way, you know?" -*Sarah, 19 when pregnant, adoption* "Um, they asked me if I wanted to make an appointment then and there or if I wanted to wait a little bit and think about it a little bit more, and II just said I've-I've—like I said, I had my mind made up, so I just made my appointment." -*Jillian, 19 when pregnant, abortion*

Table 3 -

Illustrative Quotations of Negative Attributes of Pregnancy Options Counseling for AYA, by Theme

1) Poor provider communication skills	
judgmental stance	"It was just very judgmental, like, you know, with the age and going through this situation, it was just judgmental and, like, very, just, those glares, and, "O-oh, okay. You're-you're 18, and oh. Okay. And what do you plan on doing, and how do you plan on handling this situation you got yourself in?"" -*Danita, 18 when pregnant, adoption*
lack of tailoring information to patient interest	"I just don't think [options counseling] needs to be, like, shoved in their faces. Like, for me, it was a very brief like, "Are you aware that these are [the] options?" "Uh, if you want them, here is resources to look at that could help you with them…" And gauging my-my interest in that, and if I wasn't, then not pushing any further." -*Annaliese, 16 when pregnant, abortion*
too little information	"Um, at least just get an initial sit down before I even walk into the ultrasound room. That was the most overwhelming thing, by myself, not knowing what was going on, not knowing what my results were and the fact that I'm just walked to ultrasound to find out that my legs are up and I'm pregnant. I really, really wish that someone could have just sat me down right as they found the result, you know, after they found the results and evaluate my choices and what's going on instead of just throwing it in my face." -*Maria, 18/19 when pregnant, abortion/abortion*
2) Incomplete or directive counseling	
lack of counseling on all options	"I think she should have just have been like, "Okay, you're young, but you have lots of - lots of options," instead of just saying, "Hey, there's an abortion clinic a couple hours from here." Like, she should have said, "You know, you can choose to keep the baby, adoption, or abortion," like, not just give me one option." -*Neveah, 19 when pregnant, parenting* "They just gave me the pamphlets but didn't explain it to me…I think the only time they started explainin' to me is when I told them, "I can't keep her. I can't have a baby."" -*Destiny, 15 when pregnant, adoption*
coercive/directive counseling	"She didn't really give me many, like, resources or talk to me much about, like, keeping my daughter. She just talked a lot about, like, adoption and abortion and stuff. And so, I-I don't know, I felt kinda weird, like, saying that I wanted to keep her. So, I-I don't know, I kinda stopped listening." -*Elena, 17 when pregnant, adoption*
3) Insufficient time and supportive resources	
lack of time spent	"Hm. Uh, wow. I can say, bein' as though I was in the ER, they were rushin' me. They was, like, tryin' to hurry up, do all they had to do to hurry up and get me out of there. So they only paid attention to what was on the paperwork. I can tell you that part. And my vitals. No more, no less." -*Lucy, 14 when pregnant, abortion*
lack of sufficient assistance	"It's "No, here's food stamps." There's not, um, anything else in terms of, like, housing or, like, affordable childcare or anything like that. It was just, um, yeah, I remember the [affordable housing] pamphlets, I was like, "These aren't good areas to live." I don't see why they push this on [laughter] people." -*Fei, 18 when pregnant, adoption*
4) Confidentiality concerns	
non-confidential counseling	"I was like, "I should be getting told this, like, alone," is how I felt about it, just so I can have a minute to—to process it before I decide, like, what I wanna do. 'Cause I think my initial reaction was like, "Oh, he doesn't want a baby. I really don't want one." But I was really thinking about how he felt about it. I'm like, "Oh, we'll just terminate." And that wasn't a thought-out, um, decision, either. It was kinda just split, like, drop of the hat, "Okay, yep, that's what we'll do 'cause it doesn't look like he's happy." Whereas I think if I would have, um, been told by myself, I woulda been able to think about it. And not that that ended up even being an option for us, but I don't think I would have gone to that one right away." -*Fei, 18 when pregnant, adoption*
intentional provider disclosure to parent	"When I asked her not to tell my dad and she took it upon herself-upon herself to still do that, I felt like she was just being ignorant and rude. Like, you know, this is my job. And I do this with other teen parents, so I can do that with you. Like, no, this is my situation. You can't do that." -*Elena, 16 when pregnant, parenting*
arbitrary disclosure by voicemail, insurance	"For the insurance, though, like, the-the, uh, ultrasound and stuff, like, they did come up, and…I didn't think that there was a way for me to control that…And so my mom did find out because of that." -*Grace, 16 when pregnant, miscarriage*