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Determinants of Abortion in the Tehran Metropolis Based on the Lived Experiences of Tehranian Women

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A B S T R A C T

This study was conducted with the aim of examining abortion in the Tehran metropolitan area using a grounded theory methodology. Purposeful and snowball sampling methods were employed, and semi-structured interviews were conducted with 33 women residing in Tehran who had undergone at least one induced abortion in a medical office under the supervision of a specialist physician between 2021 and 2025. Data analysis based on Strauss and Corbin's interpretive analytical approach revealed three distinct pregnancy patterns among participants. In the first group, the main categories included alcohol and drug use and engagement in high-risk sexual relationships (causal conditions); dysfunction of the family institution and delegitimization of traditional lifeworld norms (contextual conditions); social control over women's bodies and fertility and incompatibility of lifestyles (intervening conditions); the feasibility of safe abortion and the normalization or moral neutralization of abortion (interactional strategies); and physical and psychological consequences (outcomes). The core category was identified as "reproductive autonomy in the absence of socially legitimate relationships." In the second group, the principal categories included the existence of extramarital relationships (causal condition); marital dysfunction, long-term suppression of sexual and emotional needs, husbands' extramarital relationships, and perceived positive functions of extramarital relationships (contextual conditions); barriers to divorce (intervening condition); interaction with peer social networks, transformation of women's attitudinal and behavioral systems, and resistance to traditional and religious socialization (interactional strategies); and physical and psychological consequences (outcomes). The core category was "redefinition of feminine roles in response to marital and social constraints." In the third group, the main categories consisted of convergence toward discourses of voluntary childlessness or low fertility (causal condition); hardships of childbearing, economic difficulties, women's employment, and respondents' idealistic expectations regarding childrearing (contextual conditions); non-supportive social environments, marital life circumstances, and women's social networks (intervening conditions); changes in fertility behavior and transformations in women's attitudes toward childbearing (interactional strategies); and physical and psychological consequences (outcomes). The core category was "rationalization of fertility within the framework of modern life."

Keywords: *Unintended pregnancy; Induced abortion in Tehran (Iran); Second demographic transition in Tehran (Iran); Extramarital relationships; Family transformations.*

1. Introduction

The phenomenon of abortion has long occupied a central position in sociological, demographic, and public health debates because it intersects with issues of reproductive autonomy, gender relations, demographic change, moral regulation, and institutional governance. Across societies, abortion is not merely a medical event but a socially embedded practice shaped by cultural norms, structural constraints, family dynamics, and transformations in values surrounding sexuality, marriage, and fertility. Contemporary sociological analyses increasingly conceptualize abortion as part of broader processes of reproductive decision-making occurring within changing social structures rather than as an isolated individual act (1, 2). In this perspective, abortion reflects tensions between personal agency and normative expectations, where women negotiate reproductive choices within legal, moral, economic, and relational contexts.

Globally, unintended pregnancy remains one of the most important antecedents of induced abortion. Empirical studies demonstrate that unintended pregnancies arise from a complex interaction between contraceptive behavior, relationship dynamics, socioeconomic status, and access to reproductive health services (3, 4). Even in societies with relatively widespread contraceptive availability, inconsistent use, gendered power relations, and inadequate sexual negotiation continue to produce unintended fertility outcomes. Research shows that unintended pregnancy is not evenly distributed across populations but is associated with structural inequalities, educational differences, and variations in reproductive knowledge (5). Consequently, abortion becomes a strategy through which individuals attempt to restore control over disrupted life trajectories.

From a public health standpoint, abortion also constitutes a major global concern due to its relationship with maternal morbidity and mortality. International evidence indicates that unsafe abortion remains a significant contributor to preventable maternal deaths worldwide, particularly in settings characterized by legal restriction or limited access to safe medical services (6, 7). These findings have shifted scholarly attention from moral debates toward understanding the social determinants that shape abortion practices, emphasizing that legal prohibition alone does not eliminate abortion but instead influences its safety conditions and social visibility.

Within the Iranian context, abortion has increasingly attracted sociological inquiry as fertility behavior, gender norms, and family structures undergo rapid transformation. Earlier demographic research identified substantial levels of induced abortion despite restrictive legal and cultural frameworks, highlighting the roles of contraceptive failure, religiosity, and reproductive intentions (8). Subsequent empirical evidence from Tehran confirmed that intentional abortion occurs across diverse social groups and is closely linked to changing reproductive aspirations, economic uncertainty, and shifting marital dynamics (9). Qualitative investigations further reveal that women's decisions regarding abortion are embedded in lived experiences involving stigma, secrecy, relational conflict, and perceptions of future life opportunities (10, 11).

Recent studies conducted after policy shifts toward pronatalism in Iran indicate that structural pressures—such as economic instability, employment insecurity, and restricted reproductive services—continue to influence abortion practices, sometimes increasing reliance on unsafe procedures (12). These findings demonstrate that reproductive behavior cannot be understood independently of macro-level policy environments and socioeconomic transformations. Sociological analyses therefore emphasize abortion as a negotiated response to conflicting institutional expectations: pronatalist discourse on one side and lived realities of modern urban life on the other (1, 13).

At the theoretical level, explanations of abortion must be situated within broader demographic and cultural change, particularly the framework of the Second Demographic Transition. Classic demographic theorists argue that advanced modernization processes generate profound shifts in family formation, fertility preferences, and value systems, including the rise of individual autonomy, gender equality aspirations, and alternative life-course trajectories (14, 15). Later refinements of the theory emphasize declining centrality of marriage, postponement of childbearing, increased acceptance of nontraditional relationships, and the prioritization of self-realization over traditional familial obligations (16-18). Within this framework, abortion becomes one mechanism through which individuals align fertility outcomes with emerging lifestyle preferences.

The cultural dimension of demographic change has been further elaborated by modernization theory, which posits

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that economic development and educational expansion promote a transition from survival values toward self-expression values emphasizing autonomy, personal fulfillment, and individual rights (19). Such cultural transformations reshape attitudes toward sexuality, motherhood, and reproductive responsibility. In urban contexts undergoing rapid modernization, women increasingly perceive fertility decisions as part of identity construction rather than solely as social obligations. Sociological research in Iran similarly documents changing attitudes toward family size, delayed marriage, and selective childbearing, reflecting ongoing demographic transition processes (20, 21).

Importantly, abortion decisions are deeply intertwined with gender relations and power structures. Feminist sociological perspectives highlight how reproductive autonomy is constrained by patriarchal norms, unequal sexual negotiation, and moral surveillance over women's bodies. Studies examining opposition to abortion show that internalized gender ideologies and moral worldviews significantly shape societal attitudes toward women's reproductive choices (22). At the same time, legal and institutional frameworks governing abortion influence how women experience agency or vulnerability within reproductive decision-making processes (23). These insights underscore that abortion is simultaneously a personal decision and a socially regulated phenomenon.

In Iran, sociological scholarship has increasingly focused on women's subjective experiences of abortion, demonstrating that decisions often emerge from cumulative pressures rather than singular events. Women negotiate between fear and choice, balancing moral concerns, relational expectations, economic constraints, and aspirations for personal stability (2). Earlier conceptual discussions described intentional abortion as a socially sensitive practice shaped by secrecy, stigma, and moral ambivalence, yet persistently present within society (24). More recent analyses show that abortion decisions frequently reflect attempts to reconcile modern lifestyles with enduring cultural and religious norms (1, 10).

Moreover, abortion cannot be separated from broader transformations in family institutions. Declining fertility intentions, increasing marital instability, and diversification of intimate relationships contribute to new reproductive dilemmas. Sociological studies demonstrate that unintended pregnancy may arise not only among unmarried women but also within marriages experiencing emotional dissatisfaction, economic strain, or shifting gender expectations (3, 5). These dynamics indicate that abortion reflects evolving meanings of marriage, sexuality, and parenthood in contemporary societies.

Medical and reproductive health literature also highlights that abortion experiences are linked to psychological, relational, and bodily consequences, reinforcing the need for contextualized sociological understanding rather than purely biomedical interpretations (25). By situating abortion within women's lived experiences, researchers can better capture how structural conditions, cultural narratives, and interpersonal relationships shape reproductive outcomes.

Despite growing scholarship, significant gaps remain in understanding how diverse pathways toward abortion emerge within large metropolitan contexts characterized by rapid cultural change. Tehran, as Iran's largest urban center, represents a particularly important setting for examining abortion because it concentrates demographic transition processes, social heterogeneity, changing gender norms, and evolving reproductive aspirations. Previous studies have largely focused either on demographic indicators or isolated experiential accounts, leaving insufficient integration between macro-level social change theories and micro-level lived experiences (12, 13). A grounded sociological analysis capable of linking structural conditions, interpersonal interactions, and individual agency is therefore necessary.

Accordingly, this study seeks to analyze the determinants of abortion in the Tehran metropolis through the lived experiences of women by employing a grounded theory approach in order to identify the causal conditions, contextual factors, interactional strategies, and consequences shaping abortion decision-making among Tehranian women.

2. Methods and Materials

In this study, the grounded theory method, as one of the qualitative research approaches, was employed. Data were collected through semi-structured interviews, and data analysis was conducted based on Strauss and Corbin's interpretive analytical method {Strauss & Corbin, 1998}. According to this approach, after each interview was

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conducted, the audio file was transcribed verbatim, and the transcript was confirmed by the interviewee. Subsequently, the processes of open coding, axial coding, and selective coding were initiated.

During open coding, interview transcripts were examined line by line and segmented, and each line was assigned a concept based on the researcher's interpretation. In the axial coding stage, concepts capable of forming relational networks were categorized into broader conceptual groupings, leading to the formation of initial categories. During selective coding, these categories were integrated according to shared characteristics and transformed into major themes, which were connected within a paradigmatic model centered around the core category.

Sampling initially followed a purposive sampling strategy; however, due to the limited number of eligible participants willing to be interviewed, snowball sampling was subsequently employed. Interviews continued until theoretical saturation was achieved. The study participants consisted of 33 women residing in Tehran who had experienced at least one induced abortion performed by a specialist obstetrician–gynecologist between 2021 and 2025. Interview locations were selected according to participants' preferences, and the average duration of the first interview was approximately four hours. Fourteen participants requested a second interview, and seven participants requested a third interview. To enhance the credibility of the findings, intercoder agreement was applied using coders who were not members of the research team.

3. Findings and Results

The general characteristics of the respondents are presented in Table 1.

Table 1

General Characteristics of Respondents

Interview No.	Year of Birth	Marital Status	Education	Employment Status
1	2003	Married	Diploma	Unemployed
2	2001	Single	Associate Student	Irregular Income
3	2000	Single	Bachelor's Student	Employed
4	1998	Married	Bachelor's Degree	Employed
5	1998	Single	Bachelor's Student	Irregular Income
6	1997	Single	Diploma	Employed
7	1997	Single (Separated)	Bachelor's Student	Irregular Income
8	1996	Married	Bachelor's Degree	Unemployed
9	1995	Married	Associate Degree	Employed
10	1995	Single	Bachelor's Degree	Unemployed
11	1995	Single (Separated)	Master's Student	Employed
12	1993	Married	Diploma	Unemployed
13	1993	Married	Master's Degree	Employed
14	1992	Married	Bachelor's Degree	Employed
15	1992	Single	Diploma	Unemployed
16	1991	Married	Bachelor's Degree	Employed
17	1990	Single	Bachelor's Degree	Employed
18	1989	Single	Master's Degree	Unemployed
19	1989	Married	Master's Degree	Employed
20	1989	Married	Associate Degree	Employed
21	1988	Married	Master's Degree	Employed
22	1987	Single (Separated)	Doctoral Student	Irregular Income
23	1986	Single	Bachelor's Degree	Employed
24	1986	Married	Diploma	Employed
25	1984	Married	Bachelor's Degree	Unemployed
26	1983	Single (Separated)	Master's Degree	Irregular Income
27	1983	Married	Associate Degree	Employed
28	1982	Married	Master's Degree	Unemployed
29	1981	Single (Separated)	Master's Student	Employed
30	1980	Married	Bachelor's Degree	Employed
31	1979	Married	Doctoral Degree	Unemployed
32	1977	Single	Master's Degree	Employed
33	1975	Married	Bachelor's Degree	Employed

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Among the 33 participants, 18 individuals (54.5%) were married and 15 individuals (45.5%) were single. Regarding educational attainment, 5 participants (15%) held a diploma, 4 participants (12%) held or were studying at the associate level, 13 participants (39.5%) held or were studying for a bachelor's degree, 9 participants (27.5%) held or were studying for a master's degree, and 2 participants (6%) held or were studying for a doctoral degree. Concerning employment status, 19 respondents (57.5%) were employed, 9 participants (27.5%) were unemployed, and 5 participants (15%) reported irregular income.

The findings indicate that abortion experiences among respondents followed three distinct pregnancy patterns, or, in other words, three different pregnancy narratives.

Group One: Women who were not in legally recognized marriages.

Group Two: Married women who experienced unintended pregnancy as a result of an extramarital relationship.

Group Three: Married women who did not intend to have children.

The following tables present the subcategories derived from the analysis of 33 interviews conducted with the three aforementioned groups. Subcategories that demonstrated the capacity to be organized into broader analytical clusters were classified under the column of main categories and subsequently contributed to the formation of the core category.

Group One: This group consists of 15 respondents who were not in legally recognized marriages at the time of the interview. Ten respondents had never married, and five were separated or divorced.

Table 2

Concepts and Categories Derived in Group One (Core Category: Reproductive Autonomy in the Absence of Socially Legitimate Relationships)

Subcategories	Main Categories (Propositions)
Non-normative sexual relations, multiple sexual partners, transactional sexual relationships, sexual partner irresponsibility at the moment of unintended pregnancy, inconsistent use of contraceptive methods, absence of sexual negotiation and power inequality, lack of sexual knowledge and education	High-risk sexual relationships
Use of alcohol and drugs in family/friend gatherings, pleasure associated with alcohol consumption, escape from psychological pressure and reduction of anxiety and depression, increased sexual desire, facilitation of emotionally detached sexual relations, pressure from sexual partners or peers, accessibility and affordability of alcohol, addiction	Alcohol and drug consumption
Parental divorce (legal/emotional), parents' extramarital or non-normative relationships, instability among children of divorce, excessive freedom or extreme parental control, parental inability to communicate effectively with daughters, lack of understanding of unmarried women's needs, fear of stigma and family rejection, reduced intimacy among family members, emotional disintegration of family support, parental violence, parental busyness, parental conflict, parental irresponsibility, family economic problems, addiction within the family	Dysfunction of the family institution
Fear of disclosure of sexual relations or pregnancy within family, kinship, workplace, university, or social networks; social and moral stigma toward pregnancy among single women; shame associated with pregnancy; lack of familial and social support; criminalization or religious prohibition of pregnancy outside marriage	Social control over women's bodies and fertility
Rejection of parental lifestyles, weakening of parental authority, rejection of tradition and religion, decline of religious norms, declining importance of social norms, individualism, value transformation, mothers' desire for daughters' alternative lifestyles, conflict between traditional beliefs and contemporary lifestyles, present-oriented living, normative family pressure on daughters' emotional relationships, absence of protective legal frameworks for women, intense religious tensions	Delegitimization of traditional lifeworlds
Nonrecognition of daughters' sexual needs by parents, transformation of marriage patterns, acceptance of emotional and sexual relations outside marriage, contradictions between parental beliefs and practices, conflict between modern lifestyles and existing legal–social regulations, generational and cognitive gaps with parents, divergence between individual and collective views regarding religion and custom, conflict over personal and sexual freedom, influence of social media in representing modern lifestyles, increased female participation in public spheres	Lifestyle incompatibility
Certainty in the decision to terminate pregnancy, declining importance of illegality or religious prohibition of abortion, previous abortion experiences among relatives or friends, absence of regret, experience of safe abortion	Moral neutralization of abortion
Financial capacity of the woman or sexual partner, support from partner or peers, access to a trusted specialist physician (directly or via intermediaries)	Feasibility of safe abortion
Psychological consequences: concealment of pregnancy, self-care during physical and psychological complications, anxiety, fear, attempts to forget pregnancy and abortion experiences, emotional instability, irritability, crying, reduced sexual desire, fear of sexual relations, fear of subsequent pregnancy, sleep disturbances, depression, negative attitudes toward men resulting from mutually pleasurable sexual relations and abortion experienced as gendered suffering; Physical consequences: bleeding, fever, dizziness, nausea, pain, physical weakness, menstrual irregularities	Consequences of abortion

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Group Two: This group includes eight married respondents whose pregnancies resulted from extramarital relationships. Two respondents had one child, while the remaining participants were childless.

Table 3

Concepts and Categories Derived in Group Two (Core Category: Redefinition of Feminine Roles in Response to Marital and Social Constraints)

Subcategories	Main Categories (Propositions)
Initially appropriate but emotionally terminated marriage, perceived wrong marriage, revenge toward husband, resentment toward spouse, sexual/emotional variety-seeking, perceived right to experience love, inclination toward non-committed relationships, seduction by men	Existence of extramarital relationships
Dissatisfaction with marital life, emotional stagnation, poor quality of love, monotony of married life, implicit divorce agreements, lack of communication skills, major personality differences, divergent future goals, absence of shared leisure or purpose, routine life, lack of attraction to spouse, psychological strain, inability to tolerate spouse or in-laws, marital exhaustion, fear of lost life opportunities, constant conflict, forced continuation of marriage, emotional indifference, inability to resolve family conflicts, financial exploitation of women, financial difficulties, childlessness, preference for permanent childlessness	Dysfunction of marital life
Absence of sexual relations with spouse, neglect of women's sexual pleasure, traditional views of sexuality, dissatisfaction with marital sexual relations, repetitive and low-quality sexual encounters, loneliness, feelings of neglect, humiliation, worthlessness, diminished attractiveness, negative self-evaluation	Long-term suppression of sexual and emotional needs
Husbands' infidelity, deception, absence from home, addiction to alcohol or drugs, distrust toward husbands	Husbands' extramarital relationships
Moral neutralization of extramarital relationships and abortion, desacralization of motherhood, marital fidelity, romantic love, and exclusive sexuality, weakening family influence in couples' lives, perceived inefficacy of religious teachings	Resistance to traditional and religious socialization
Religion perceived as restriction, marriage and motherhood perceived as permanent confinement, nihilistic views toward motherhood, prioritization of individual quality of life, employment as empowerment, financial capacity enabling abortion	Transformation of women's attitudinal and behavioral systems
Individual barriers (fear of divorce, concerns about divorced status); structural barriers (presence of children, spouse's opposition, parental reactions, legal restrictions, distrust in judicial institutions, occupational consequences of divorce, societal attitudes toward divorced women)	Barriers to divorce
Feelings of vitality, perceived attractiveness, intense sexual pleasure, improved quality and frequency of intimacy, experience of new emotions, emotional affection, pleasure derived from desirability, fulfillment of communicative needs, attraction of secrecy, perceived personal courage, emotional affection, increased self-confidence, discovery of a new self, occupation of leisure time, forgetting an unsuccessful marriage	Positive functions of extramarital relationships
Normalization of extramarital relations and abortion in society, awareness of similar experiences among peers and relatives, normalization through social media, films, and television series, avoidance of judgmental individuals, externalization of responsibility and blaming husbands	Interaction with peer social networks
Physical consequences: bleeding, fever, dizziness, nausea, pain, physical weakness, menstrual disorders, reduced sexual desire, fear of sexual relations; Psychological consequences: anxiety regarding disclosure of unintended pregnancy, preservation of family order and marital continuity, loneliness, negative emotions, sleep disturbances; Other consequences: symbolic rupture of the idealized image of pregnancy	Consequences of abortion

Group Three: This group includes nine married respondents. Four participants had one child, two had two children, and three were childless.

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Table 4

Concepts and Categories Derived in Group Three (Core Category: Rationalization of Fertility Within the Framework of Modern Life)

Subcategories	Main Categories (Propositions)
Couples' agreement on permanent childlessness, postponement of childbearing, sufficiency of one or two children	Convergence toward childlessness, single-child, or low-fertility discourse
Insufficient household income, prioritization of women's employment and independence, employment prioritized over motherhood, job insecurity, contractual employment, fear of job loss, lack of institutional support for working mothers	Women's employment
Desacralization of motherhood, prioritizing self-development over childrearing, allocation of resources to education, leisure, and personal advancement, perceived burdens of motherhood exceeding pleasures, relativization of the "ideal mother," separation of marriage from childbearing, acceptance of childfree womanhood, reduced influence of religious beliefs concerning fertility and abortion, diminishing parental influence in couples' lives	Transformation of women's attitudes toward childbearing
Uncertainty regarding marital continuity, gap between ideal and lived marital life, male irresponsibility, limited paternal participation in childcare, lack of understanding of working mothers' conditions, perceived negative impact of children on marital quality, male impatience, unequal childcare burden on women, difficult experiences with previous children	Non-supportive marital environment
Physical burdens (body image concerns, health risks, pregnancy and childbirth complications, breastfeeding difficulties, prenatal/postpartum depression), demanding nature of motherhood, lack of personal time, forced sacrifice of personal goals and leisure, conflict between motherhood and other social roles, educational challenges and costs, incompatibility between childbearing and migration, higher education, career advancement, travel aspirations, restrictions on freedom, reduced marital welfare	Hardships of childbearing
Financial costs of children (pregnancy, childbirth, infancy expenses), perception of children as lifelong financial responsibility, insufficient living standards including housing limitations and lack of adequate transportation	Economic constraints
Economic instability, healthcare problems, environmental challenges (air pollution, traffic congestion, electricity shortages, water scarcity), gender inequalities, perceived insecurity for women, patriarchal structures, unjust laws, psychological insecurity caused by political and social conditions, concern for children's safety during civil unrest, media and social discourse favoring lower fertility, negative societal attitudes toward having multiple children	Non-supportive societal environment
Husband's reluctance toward childbearing, lack of support from maternal or in-law caregivers, family encouragement of childlessness or smaller families, ridicule by colleagues or relatives regarding multiple children, jealousy or resistance among existing children	Non-supportive social network environment
Distinction between infertility and voluntary childlessness, acceptance of childlessness or single-child norms, acceptance of abortion-related guilt, absence of gender preference, parental age considerations, fulfillment of parental identity through existing children	Transformation of fertility behavior
Perceived lack of physical or psychological readiness for childbirth, concentration of family resources on existing children, postponement of childbearing until economic stability, home ownership, employment security, sufficient travel and savings, post-migration childbearing plans, perceived inadequacy in parenting capacity, declining physical and psychological energy	Idealization of childbearing conditions
Physical consequences: bleeding, pain, fever, chills, headaches, abdominal pain, infection, menstrual irregularity; Psychological consequences: fear of subsequent pregnancy, fear of infertility, reduced sexual desire, feelings of suffering and regret, grief over fetal loss, satisfaction with preventing an unwanted birth; Other consequences: acceptance of the risks of permanent childlessness or single-child status	Consequences of abortion

In Strauss and Corbin's systematic grounded theory approach, after open and axial coding, a stage known as the paradigmatic model—or the systematic causal–strategic framework—is developed. This model is drawn to understand how the central phenomenon occurs and to identify the interaction among influencing factors, strategies, and consequences. In essence, the paradigmatic model provides a conceptual framework for analyzing the relationships among major and minor categories and organizes the processes of social action and interaction surrounding the phenomenon within a causal and structural context.

In Strauss and Corbin's systematic model, concepts and categories that answer the questions of why and how are treated as causal conditions; concepts related to the individual and their circumstances are treated as contextual conditions; and concepts and categories that influence the individual but are not readily alterable through the individual's will—namely, those in which the individual is effectively situated—are placed under intervening conditions. The combination of these factors gives rise to the

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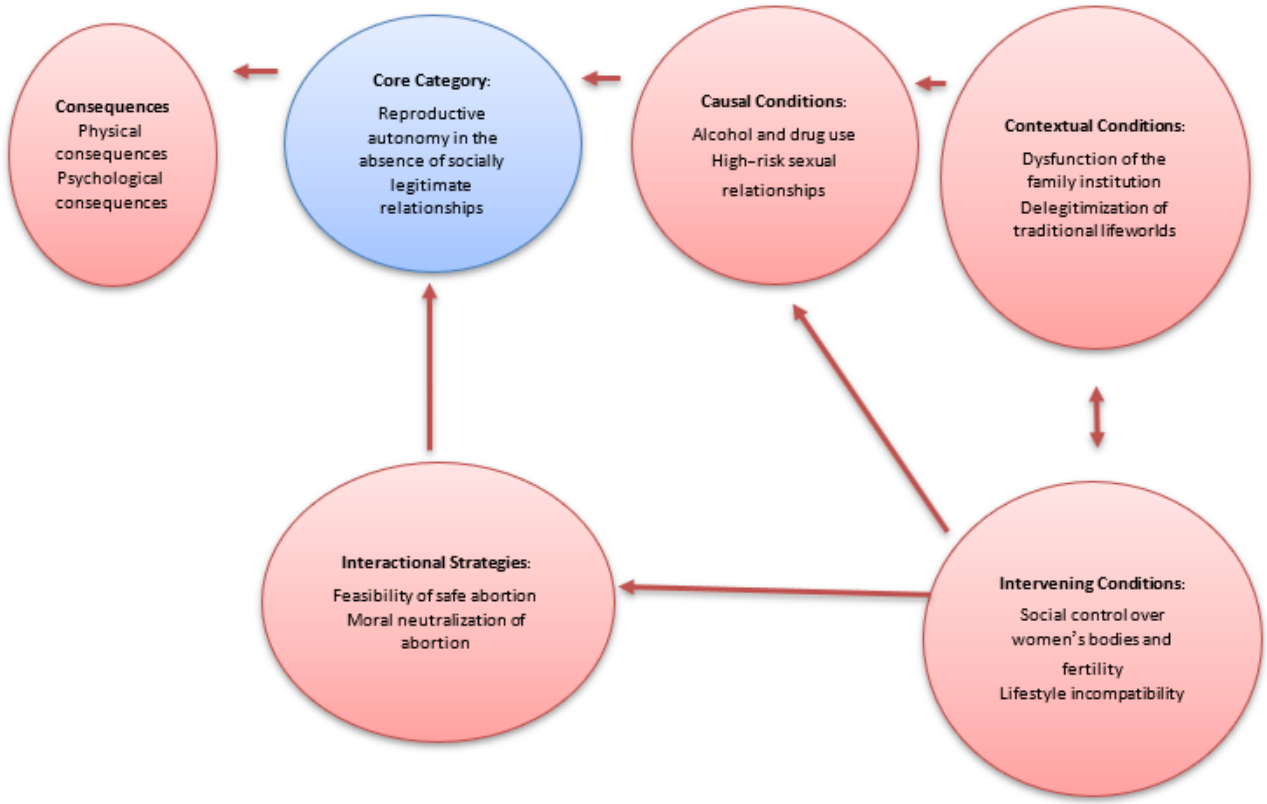
core category. After the emergence of the core category, the paradigmatic section of strategies (action–interaction) is specified, and finally the consequences resulting from these strategies are categorized.

In what follows, the paradigmatic model drawn for each group is presented separately.

Group One: Based on the concepts and categories extracted from 15 interviews with women who were single in terms of marital status, alcohol and drug use and the presence of high-risk sexual relationships were identified as causal conditions; dysfunction of the family institution and delegitimization of traditional lifeworlds were identified as contextual conditions; social control over women's bodies and fertility and the existence of lifestyle incompatibility were identified as intervening conditions; and the feasibility of safe abortion and the moral neutralization of abortion were identified as interactional strategies. As shown in the figure below, these categories converge around the core category, "reproductive autonomy in the absence of socially legitimate relationships," which yields physical and psychological consequences for the actors.

Figure 1

Paradigmatic Model in Group One



Group Two: In this group, the existence of an extramarital relationship (causal condition) constitutes the trigger of unintended pregnancy and the primary reason underlying the respondents' decision to undergo an abortion. Dysfunctional marital life, long-term suppression of sexual and emotional needs, husbands' extramarital relationships, and the perceived positive functions of extramarital relationships (contextual conditions), alongside barriers to divorce (intervening condition), created the enabling context and facilitated the formation of extramarital relationships among respondents. The core category generated by the study is "redefinition of feminine roles in response to marital and social constraints," which is characterized by interactions and actions such as engagement with peer social networks, transformation of women's attitudinal and behavioral systems, and resistance to traditional and religious socialization, and which entails physical and non-physical consequences for the actors.

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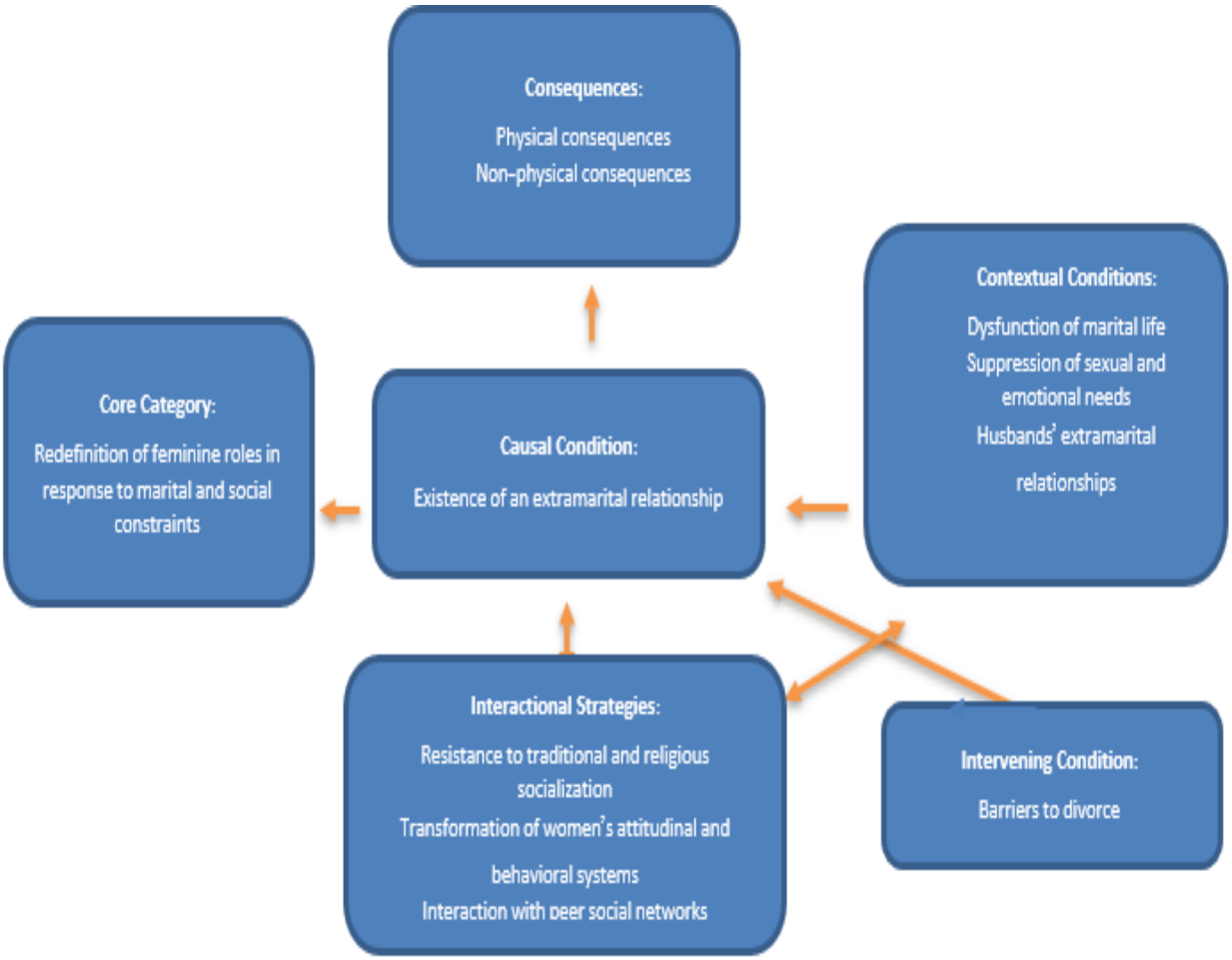
Figure 2

Paradigmatic Model in Group Two



Group Three: The primary reason for respondents' decision to undergo abortion in Group Three is their convergence toward a discourse of permanent childlessness/low fertility (causal condition). The hardships of childbearing, economic difficulties, women's employment, and respondents' idealism regarding childrearing (contextual conditions), together with non-supportive societal conditions, marital life, and women's social networks (intervening conditions), are influential in the formation of the discourse of permanent childlessness/low fertility. The central category generated by the study is "rationalization of fertility within the framework of modern life," which is recognized through interactions and actions such as changes in fertility behavior and changes in women's attitudinal system toward childbearing, and which leads to the physical and psychological consequences experienced by the actors.

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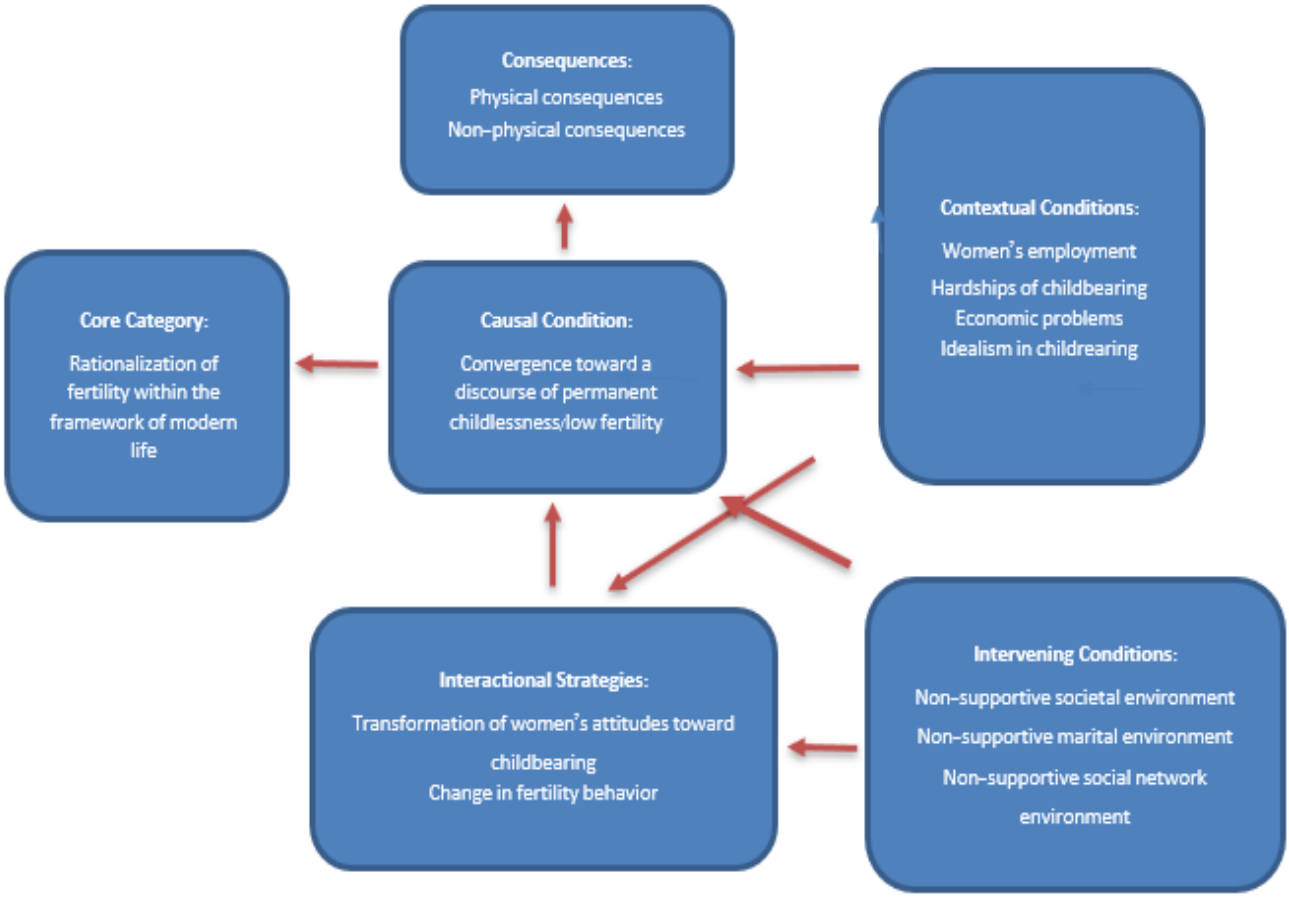
Figure 3

Paradigmatic Model in Group Three



4. Discussion

The present study sought to explain the determinants of abortion in the Tehran metropolis through women's lived experiences using a grounded theory approach. The findings revealed three distinct pregnancy narratives: abortions among women outside legally recognized marriage, abortions resulting from extramarital relationships among married women, and abortions associated with deliberate low-fertility or childfree orientations among married women. These patterns collectively demonstrate that abortion in contemporary Tehran cannot be interpreted solely as a medical or moral phenomenon but must instead be understood as a socially structured reproductive strategy emerging at the intersection of demographic transition, gender relations, and modernization processes.

The first pattern, characterized by abortion among unmarried women, highlights the growing divergence between traditional normative frameworks and lived social realities. Participants' narratives emphasized high-risk sexual relationships, alcohol and substance use, weakened family support systems, and strong social surveillance over female sexuality. These findings align with sociological analyses indicating that unintended pregnancy frequently occurs within contexts of limited sexual communication, inconsistent contraceptive use, and unequal gender power relations (3, 4). The persistence of stigma surrounding premarital sexuality intensifies women's vulnerability, transforming abortion into a mechanism for restoring social legitimacy rather than merely terminating a pregnancy. Earlier qualitative research in Tehran similarly demonstrates that fear of social exposure and family rejection plays a decisive role in abortion decision-making among unmarried women (10, 11).

At a broader theoretical level, the first group's experiences reflect value transformations described by

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modernization and postmodernization theories. Increasing individualism, weakening authority of traditional institutions, and the prioritization of personal autonomy over collective norms correspond to the cultural shifts identified in modernization theory (19). The erosion of traditional life scripts—particularly regarding marriage and sexuality—creates a mismatch between institutional expectations and everyday practices. Within the framework of the Second Demographic Transition, such tensions are interpreted as outcomes of changing fertility ideals, delayed marriage, and diversification of intimate relationships (14, 15). The core category identified for this group, reproductive autonomy in the absence of socially legitimate relationships, therefore represents a localized manifestation of global demographic change.

The second pregnancy narrative, involving married women experiencing unintended pregnancy through extramarital relationships, reveals a different configuration of social determinants. Here, abortion emerged not primarily from premarital vulnerability but from marital dissatisfaction, emotional deprivation, and prolonged suppression of sexual and affective needs. These findings resonate with research demonstrating that unintended pregnancy can occur even within marriage when relational quality declines or emotional intimacy erodes (5). Participants' accounts suggest that extramarital relationships functioned as compensatory mechanisms addressing unmet psychological and sexual needs, a phenomenon previously identified in Iranian qualitative studies examining abortion experiences among married women (13).

The study further shows that barriers to divorce—including legal restrictions, social stigma toward divorced women, and economic dependence—played a crucial intervening role. In such circumstances, abortion became part of a broader strategy for managing contradictory social expectations: maintaining marital stability while pursuing emotional fulfillment elsewhere. The resulting core category, redefinition of feminine roles in response to marital and social constraints, reflects an ongoing renegotiation of gender identity within modern urban contexts. Sociological research indicates that women increasingly reinterpret traditional roles of wifehood and motherhood under conditions of expanding education, employment participation, and exposure to alternative lifestyles (20). The normalization of extramarital relationships within peer networks and media environments further supports this transformation, illustrating how social learning processes reshape moral boundaries surrounding sexuality and reproduction (22).

Importantly, the findings suggest that abortion decisions in this group were not impulsive but embedded in long-term relational trajectories. Participants framed abortion as a means of preserving social order, avoiding scandal, and maintaining family continuity. This observation echoes sociological analyses emphasizing that abortion often serves as a mechanism for negotiating competing social roles rather than rejecting motherhood outright (2). Thus, abortion operates simultaneously as an act of agency and an adaptation to structural constraints.

The third pregnancy narrative identified in this study reflects perhaps the most profound sociological transformation: the rationalization of fertility within the framework of modern life. Women in this group consciously embraced low fertility or voluntary childlessness, viewing childbearing as a decision requiring economic stability, emotional readiness, and lifestyle compatibility. This finding strongly corresponds with demographic theories of the Second Demographic Transition, which emphasize declining fertility aspirations, postponement of parenthood, and prioritization of self-realization (16-18). Participants' narratives demonstrate that fertility decisions increasingly follow cost–benefit rationality rather than normative obligation.

Economic insecurity, employment pressures, and perceived inadequacy of institutional support for working mothers emerged as major contextual conditions shaping abortion decisions. Previous research has similarly identified economic uncertainty and employment instability as central drivers of fertility decline and abortion decisions in urban societies (1, 12). Women's increasing participation in education and labor markets alters opportunity structures, making motherhood a carefully calculated project rather than an inevitable life stage. These results also correspond with studies indicating that unintended pregnancy outcomes are closely linked to socioeconomic expectations and life-course planning (20).

Another significant finding concerns the transformation of cultural meanings attached to motherhood. Participants

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challenged traditional notions that equate feminine identity with childbearing, instead emphasizing personal development, marital quality, and psychological well-being. Such shifts illustrate the cultural dimension of demographic transition described by Lesthaeghe and van de Kaa, in which individual autonomy and self-expression replace normative fertility expectations (14, 15). Similar attitudinal changes have been documented in Iranian society, where fertility decline is closely associated with changing gender ideologies and evolving family aspirations (21).

Across all three groups, abortion appears as a socially situated response to structural contradictions rather than a uniform phenomenon. Whether motivated by stigma management, marital negotiation, or rational fertility planning, women's decisions were shaped by interacting causal, contextual, and intervening conditions. This confirms prior scholarship demonstrating that abortion decisions emerge from cumulative social pressures rather than single determinants (1, 9). The findings also reinforce global evidence that restrictive social environments do not eliminate abortion but instead influence its meanings, pathways, and perceived legitimacy (7).

The study further contributes to understanding how pronatalist policy environments interact with lived realities. Despite institutional encouragement of higher fertility, participants' narratives revealed persistent economic anxiety, social insecurity, and shifting cultural values that reduce willingness to bear children. Such tensions between policy discourse and everyday life have been highlighted in recent qualitative research documenting continued abortion practices under pronatalist regimes (12). From a sociological perspective, this indicates that demographic behavior responds more strongly to structural conditions and cultural transformations than to normative policy messaging alone.

5. Conclusion

Finally, the physical and psychological consequences reported by participants underscore the embodied dimension of abortion experiences. While abortion served as a strategy for restoring agency or stability, it also involved emotional ambivalence, anxiety, and health concerns. These findings are consistent with broader reproductive health literature emphasizing that abortion experiences must be understood within social and relational contexts rather than reduced to biomedical outcomes (6, 25). The coexistence of relief and distress among participants illustrates the complex emotional terrain surrounding reproductive decision-making in transitional societies.

The present study is subject to several limitations. First, the qualitative design and purposive sampling strategy limit generalizability to the wider population of women in Tehran or Iran. Second, due to the sensitive nature of abortion, participants may have engaged in selective disclosure or self-censorship despite assurances of confidentiality. Third, the study relied on retrospective accounts, which may be influenced by memory reconstruction or post-hoc rationalization of decisions. Additionally, the sample was restricted to women who accessed abortion services under medical supervision, potentially excluding experiences of clandestine or highly unsafe abortions.

Future studies could employ mixed-method or longitudinal designs to examine how abortion decision-making evolves across women's life courses. Comparative research between metropolitan and non-metropolitan settings would help clarify the role of urbanization in shaping reproductive choices. Further investigation into male partners' perspectives, family dynamics, and institutional actors such as healthcare providers could deepen understanding of relational dimensions influencing abortion decisions. Quantitative studies examining the interaction between demographic transition indicators and reproductive attitudes would also contribute to theoretical development in the sociology of fertility and family change.

Policy makers and practitioners should recognize abortion as embedded within broader social realities rather than as an isolated behavioral issue. Expanding comprehensive sexual education, strengthening counseling services, and improving access to reliable reproductive health information may reduce unintended pregnancies. Supporting women's employment security, childcare infrastructure, and family-friendly workplace policies could address structural pressures influencing fertility decisions. Finally, reducing stigma and promoting confidential, respectful healthcare environments may improve women's physical and psychological well-being when confronting complex reproductive choices.

Authors' Contributions

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All authors contributed equally to the conception and design of the study, data collection and analysis, interpretation of the results, and drafting of the manuscript. Each author approved the final version of the manuscript for submission.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethics Considerations

The study placed a high emphasis on ethical considerations. Informed consent obtained from all participants, ensuring they are fully aware of the nature of the study and their role in it. Confidentiality strictly maintained, with data anonymized to protect individual privacy. The study adhered to the ethical guidelines for research with human subjects as outlined in the Declaration of Helsinki.

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