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## Article title

*Beyond autonomy and care – experiences of ambivalent abortion seekers*

## Authors

Marianne Kjelsvik<sup>a,b</sup>, Ragnhild J. Tveit Sekse<sup>c,d</sup>, Asgjerd Litleré Moi<sup>e</sup>, Elin M. Aasen<sup>b</sup>, Per Nortvedt<sup>f</sup>, Eva Gjengedal<sup>a</sup>

<sup>a</sup> Department of Global Public Health and Primary Care, University of Bergen, Bergen, Norway; <sup>b</sup> Department of Health Sciences in Aalesund, Norwegian University of Science and Technology (NTNU), Aalesund, Norway; <sup>c</sup> Department of Obstetrics and Gynaecology, Haukeland University Hospital, Bergen, Norway; <sup>d</sup> Department of Clinical Science, University of Bergen, Norway; <sup>e</sup> Department of Health and Caring Sciences, Western Norway University of Applied Sciences (HVL), Bergen, Norway; <sup>f</sup> Centre for Medical Ethics, University of Oslo, Norway

## Corresponding author info

Marianne Kjelsvik, [makj@ntnu.no](mailto:makj@ntnu.no), +4791371857

Address: Department of Health Sciences in Aalesund, Norwegian University of Science and Technology (NTNU), Box 1517, N-6025 Aalesund, Norway

## Abstract

### Background

While being prepared for abortions, some women experience decisional ambivalence during their encounters with health personnel at the hospital. Women's experiences with these encounters have rarely been examined.

### Objective

The objective of this study was to explore ambivalent abortion-seeking women's experiences of their encounters with health personnel.

## Research design

The data were collected in individual interviews and analysed with dialogical narrative analyses.

## Participants and research context

Thirteen women (aged 18-36 years), who were uncertain of whether to terminate their pregnancies during the first trimester, were interviewed before and after they made their decisions. The participants were recruited at six Norwegian outpatient clinics.

## Ethical considerations

Approval was granted by the Regional Committee for Medical and Health Research Ethics.

## Findings

The ambivalent pregnant women sought to make autonomous decisions while simultaneously involving their closest confidants and health personnel in the process.

The following three types of narratives of women's experiences with encounters with health personnel were identified: the respected women, the identified women and the abandoned women.

## Discussion

The findings are discussed in terms of the ambivalent pregnant woman's autonomous responsibility in considering an abortion and how her autonomy can be enabled or impaired during encounters with health personnel.

## Conclusion and implication

Although the women considered themselves autonomous and responsible for their final decisions, they wished health personnel were involved in their situations.

The health personnel contributed by enabling or disabling the possibility of decision-making in accordance with the women's values. The findings indicate that health personnel who care for women considering abortions must be trained in dialogical competence.

## Keywords

Ethics of care, choice, first trimester pregnancy, women's reproductive health, decision-making

## Introduction and background

Legalizing and facilitating safe and effective abortions has been a global concern for the last decades. The focus of this process has been on defending women's access to abortion and improving technical aspects, such as medical vs. surgical abortion. Less attention has been placed on what constitutes caring for women in a consultation for abortion preparation <sup>1,2</sup>.

Meetings with women who seek abortions are part of the daily practices of Norwegian gynaecological units. To prepare for and start an abortion, women are dependent on assistance from healthcare personnel. However, approximately 10 % of the requests for abortions in Norway are cancelled after the woman has been prepared at the gynaecological unit <sup>3</sup>. This coincides with western studies showing that during the preparation process, 10 to 18 % of abortion-seeking women experience ambivalence about the decision of whether to have an abortion <sup>4-7</sup>. Moreover, women who are ambivalent when making the decision have been shown to be at greater risk for developing mental health problems after the abortion <sup>8-10</sup>. Inspired by Merriam-Webster's definition <sup>11</sup>, ambivalent women, may in this context mean that the women simultaneously have contradictory attitudes and/or feelings and are continuously uncertain about the decision they should make.

The World Health Organization (WHO) guidelines recommend ensuring the woman's autonomy, including informed and voluntary consent, when preparing a woman for an abortion. Health personnel are asked to be sensitive to the woman's needs and perspectives and should offer counselling if needed <sup>12</sup>.

During the last 40 years, Norwegian women have had legal access to free and self-defined abortions during the first trimester. In Norway, preparations for and initiation of abortions occur at gynaecological units in governmental hospitals by nurses and medical doctors, i.e., persons designated health personnel in this paper. Usually, no personnel specifically trained on counselling is available on site. The government recommends ambivalent pregnant women to contact trained staff off site for counselling <sup>13</sup>. For women in rural districts, online and telephone support is available, while women in larger cities are additionally offered face-to-face consultations <sup>14</sup>. Health personnel in gynaecological units is obligated to provide information about the nature and medical effects of the abortion procedure and ensure the provision of information about societal assistance once a pregnancy is completed <sup>15</sup>. In 2017, most abortions in Norway were performed with medication (88,6 %) <sup>3</sup>.

Most studies describing experiences of decision-making regarding abortions have involved women who had already terminated their pregnancies. A review of 19 of these studies conducted in Western countries <sup>16</sup> showed that women sought to make independent choices while simultaneously consulting others. These findings have been confirmed in Scandinavian studies involving women who were considering their decisions to terminate their pregnancies <sup>17-19</sup>.

The counselling needs of women seeking induced abortion services differ, and some women require more intensive psychosocial counselling than other women, who only require basic information regarding the procedure <sup>20, 21</sup>. Although the approach of health personnel towards addressing women's physical needs has been described as good and professional, women with unmet counselling needs have expressed dissatisfaction due to a lack of acknowledgement of their emotional and existential needs. <sup>2, 21, 22</sup> Moreover, in a recent survey from the UK, the findings revealed that nearly a quarter of women did not know that counselling was available <sup>20</sup>.

Women who had experienced support from health personnel in the decision-making process reported that they were listened to, that their decisional authority was affirmed and that the health personnel recognized the women's many difficulties. <sup>17-19, 23, 24</sup>

Similar to other Western countries, <sup>1, 2</sup> abortions performed in Norway are safe, and the process is effective. This permits a shift in focus towards improving other aspects of the quality of care, guided by a patient's values and understanding. There seems to be a lack of knowledge on the experiences of ambivalent pregnant women in particular and their expectations when encountering health personnel in gynaecological units.

This study is part of a larger project. In the first study of this project, we explored the experiences of a subset of Norwegian pregnant women who, during the abortion-seeking process, were ambivalent about whether to complete or terminate their pregnancies. In the second study, health personnel from gynaecological units were interviewed. The results of the first study indicated that the expectations that women had of the encounters with gynaecological health personnel were met, but only to some degree <sup>19</sup>. On the other hand, health personnel described ethical dilemmas in their encounters with women who had not fully decided when preparing for the abortion. The dilemmas were about revealing, handling and being involved in the woman's potential uncertainty, without influencing her decisions <sup>25</sup>.

Because knowledge of women's experiences is essential for the quality of care, this study aimed to explore more in depth the women's stories about their abortion preparation consultations.

## Methodology and methods

The narrative approach emerged as a natural choice due to the stages and chronology typical of ambivalent women's experiences with encounters with health personnel. Narrative inquiry increases our understanding of human lives through the lens of a person's own story, honouring the lived experience as a source of important knowledge and understanding <sup>26</sup>.

### Setting and participants

The participants were recruited at six different outpatient clinics in Southern Norway, based on the following criteria: pregnant women in their first trimester who were aged 18 or older, ambivalent about whether to terminate the pregnancy, able to understand and speak Norwegian.

Women who were perceived as ambivalent during the consultation were informed about the study and asked to participate. If a woman consented, the researcher contacted the woman and made appointments for interviews.

Before recruitment started, informational meetings with the health personnel were arranged at all six hospitals. For ethical reasons, the researcher requested for women who were considered exhausted or overloaded to not be recruited. Due to their geographical locations, ages and life situations, the women represented a range of experiences with ambivalence about whether to terminate pregnancies.

In total, twenty-six women were invited, and eighteen consented to participate. However, before the first interview was conducted, five declined, resulting in the participation of 13 women.

The participants were aged between 18 and 36 (average 25.6 years). Nine of the participants were in a relationship with the man with whom they had become pregnant, six had children, three had previously gone through a planned abortion, and two had experienced a miscarriage. At the time the interviews were conducted, most of the women were employed, whereas three were students.

### Ethical considerations

The Regional Committee for Medical and Health Research Ethics (2014/1276) approved the study. It was designed in accordance with the Helsinki declaration<sup>27</sup>. The participants were informed both orally and in writing about the study, its purpose, that participation was voluntary, and that they could withdraw from the study at any time without explanation. Each participant provided her written consent. The narratives presented in this paper are anonymized, and the names have been changed.

### Data collection

The study design involved two interviews with each woman. Twenty-three in-depth interviews with 13 women were conducted in 2015. The first interview occurred a few days after each woman had been to the outpatient clinic to prepare for an abortion. Follow-up interviews were conducted with ten of the women after they had decided on whether to terminate or proceed with their pregnancies. For personal reasons, three of the informants were not interviewed twice. Typically, the follow-up interview took place between two and four weeks after passing the twelfth week limit. Five had gone through with an abortion, six had decided to continue the pregnancy, one had a miscarriage, and the outcome of one is unknown. The interviews were conducted by the first author, were based on an interview guide and lasted between 60 and 140 minutes (average 98 minutes).

### Dialogical narrative analysis

Based on the interviews from the first study<sup>19</sup>, we had rich narratives of the women's general experiences and specific experiences with their encounters with health personnel. To obtain a deeper understanding of the women's experiences with these encounters, we chose to re-analyse their descriptions by using a "dialogical narrative analysis" as presented by Frank<sup>28, 29</sup>. In accordance with this method, we reread the 13 stories based on the 23 interviews and searched for descriptions of how each woman spoke about her meeting with health personnel, what she disclosed, what constituted the content of her story, and what occurred during the meeting.

Brief summaries describing what was at stake for each woman were formulated. Furthermore, the narratives were systematically analysed by examining potentially coinciding features. A matrix with colour codes and a mind map with key words related to each individual woman's story were helpful in this activity.

Frank recommends identifying the core narratives upon which most specific stories depend. A typology is a collection of different types of stories<sup>29</sup>. Three typologies or core narratives reflecting the similarities and variations across all thirteen women's experiences, were identified<sup>29</sup>. These stories were valuable for understanding the experience of the encounters with health personnel from the women's perspective. According to Frank, it is important to consider that the types in a typology are *narratives* rather than people as follows: "Each person's story can remain unique while being representative in that uniqueness"<sup>28</sup>.

## Three stories of encounters with health personnel

The narratives presented describe what was at stake for the women when they met health personnel in the hospital and had to decide whether to terminate the pregnancy.

An overall finding was the women's wishes to make autonomous decisions, although they had involved some of their closest confidants in the decision-making process.

However, several major similarities and differences were revealed, mainly concerning the women's awareness and communication of ambivalence. Some women indicated that they felt ambivalent once they arrived at the hospital, while the other women arrived with the goal of undoubtedly terminating their pregnancies but became ambivalent during their consultations with health personnel. Moreover, their descriptions of how and whether their needs in terms of their uncertainty were met by the health personnel varied.

The following three types of experiences were identified: the respected women, the identified women, and the abandoned women. Although all 13 women could be placed in one of the three typologies, we chose to present one story within each typology.

## The respected women - ambivalence addressed by health personnel

*Lene had planned her pregnancy but became doubtful as to whether or not she was ready. The health personnel perceived her doubts and recommended that she take more time to consider her decision.*

Similar to most participants in this study, Lene was in a stable relationship, had a safe job and was at an age where couples often plan to have children. Her partner wished to become a father, and Lene both wanted and did not want the pregnancy to proceed. Even before the pregnancy was confirmed, she cared for the foetus by abstaining from alcohol and taking folic acid supplements.

What was at stake for Lene was that she was uncertain of whether she was ready to give up her freedom and 'be tied to a child'. Some days she felt calm and ready to go on with the pregnancy, but doubt and turbulent feelings frequently recurred. During the weeks of consideration, Lene confided only to those who were the closest to her regarding her feelings of doubt. The consultation at the hospital was part of Lene's decision-making process: 'I ordered the consultation because I thought, "Maybe I'll decide that day when I'm sitting there". And I also thought, "I can always feel conflicted until I take the first pill. There will be time to reflect until then"'.

In the encounter with health personnel, Lene hoped for the possibility to talk about her uncertainty: "I needed to talk about my thoughts". Similar to many of the stories, the nurse gave Lene the opportunity to share her thoughts by asking, 'Have you decided to have an abortion?' Lene replied:

'I am not really decided', I was crying, and she saw that I doubted. She realized I was not sure. The nurse explained, "You can talk to people, and you have a few days to decide", and said, "We can wait, and if you want to, you can come and get the pill on Monday morning, and if not, you will continue the pregnancy".'

For Lene, it was a relief to not have to make the final decision that day. She felt met by the nurse and appreciated that the nurse showed interest in and dedication to her: 'She saw that I was in doubt, she understood it when she saw me'. Similar to most participants who may fit into this typology, Lene had an experience of being treated with respect and acknowledgement given the complexity of the situation. She appreciated being listened to and given more time.

## The identified women – ambivalence not fully addressed by health personnel

*When asked the question, "Are you sure?", Kine realized that she was not. Health personnel prevented her from taking the pill, advised her to spend more time thinking, and left her to herself.*

Similar to some of the other young participants, Kine planned to further her studies and had an unclarified relationship with the man with whom she had become pregnant. Her first thought when the pregnancy was confirmed was to terminate it: 'When I first figured it out, I did not think it could go fast enough. Because I would not think about it and wanted as few people as possible to know about it. I just wanted to get out of it'. A few days after the pregnancy was confirmed, Kine attended an outpatient clinic for a medical abortion.

What was at stake for Kine was that it was too early in life to become a mother. The idea of not letting anything prevent her from 'completing an education before children' dominated her other thoughts, she explained. However, just before taking of the initial medication, she was asked: 'Are you sure?' Then, something happened, and she described the following:

'The feeling of reality came while I sat at the clinic. Because before this happened, I'd just thought, "Do not think about it. There is only a small pea inside, and it is just cell division that is going on, with no life inside of it. It deserves nothing". But, when I was sitting there, ready to take the pills, the healthcare person asked, "Are you sure?", and then, I began to cry, but I did not understand why. And then, I could not do it. And that was when I felt properly, I think, that I actually had something living inside me, which is mine and it does not feel right to take it away'.

The health personnel reassured her that she had sufficient time and that she could contact the outpatient clinic again if she wanted to terminate the pregnancy. It was an overwhelming situation for her. Kine wanted but was not able to present her need for a dialogue about her uncertainty: 'So, if they had investigated a little more...because it's a bit below the surface. I would have liked them to give me the possibility to talk about my doubt'. The other women whose ambivalence were identified also presented such a need for a dialogue.

## The abandoned women – ambivalence not addressed by health personnel

*Anna was met in her ambivalence in the preparation at the outpatient clinic but was overlooked when she hesitated at the crucial moment when the termination was to be initiated.*

Anna was in a stable relationship. She had children, and she was employed. Anna was unsure of whether she was healthy enough to undergo a new pregnancy while simultaneously caring for her family. Her partner wanted them to have another child.

What was at stake for Anna was the following: Should she terminate her pregnancy to pay attention to her own or her family's health or continue the pregnancy? Similar to most women in this study, Anna postponed contacting the outpatient clinic because of ambivalence regarding whether to terminate the pregnancy. However, during the first consultation at the hospital, Anna was met and given time to talk about both the challenges associated with her health and the risks a pregnancy could entail. Anna experienced being taken seriously, had time to talk about her ambivalence and was given more time to think. After the first encounter at the outpatient clinic, similar to several other women, she started hoping for a miscarriage to avoid making a choice. Nevertheless, the miscarriage did not happen. Time passed, and she had to decide.

Anna still felt ambivalent when she arrived at the hospital to initiate the abortion. She received no response to her signals about uncertainty in the crucial moment:

‘The health care provider went through what would happen and asked if I had any questions. Then, I said, "I am sitting here, doubting and do not know what to do."

Then, the provider responded by saying, "Yes, but here are the tablets." And then I just thought, "No, there's no room for anything else"’.

Anna described herself as inexperienced, while she considered the health personnel to be experienced. She expected that they would talk to her about the choice of an abortion. What Anna experienced as the worst aspect of the encounter was the lack of commitment from the provider. Anna described that she felt like she was on a production line. Not condemned but abandoned and left to herself, she had missed the opportunity for a dialogue:

‘Just that I can say, "I am in doubt, and I am uncertain; I do not want this", and someone says, "Go home and think about it!" (...) I just wanted someone to talk to me. I could have cleared my mind because it is quite scary. You make a serious choice. In addition, you stand there alone. I was not cared for. Not at all. However, none of them forced me to make a choice. Absolutely no one.’

## Discussion

The findings of this study are related to the autonomous responsibility of ambivalent pregnant women considering an abortion and how their autonomy can be enabled or impaired during interactions and relationships in encounters with health personnel. The following discussion focuses on the women’s experienced tension between freedom and responsibility and between autonomy and dependency and how health personnel can balance this difficult terrain.

### *Freedom and responsibility*

The women did not express doubt about their wishes to make autonomous decisions on whether to terminate their pregnancies. Nevertheless, during their encounters with health personnel, they also hoped to be treated in a caring way. Despite knowing that they were free to choose, they experienced the choice as conditional. They felt responsible for making an independent and a right choice, and the process was described as complex and complicated. The freedom to choose may be a challenge and commits responsibility to the woman as emphasized by existential philosophy. Sartre<sup>30</sup> even says that we are condemned to freedom as follows: ‘That man being condemned to be free, carries the weight of the whole world on his shoulders; he is responsible for the world and for himself as a way of being’<sup>30</sup>. This rather radical view of freedom is placed in a professional care context by Mol:<sup>31</sup> Giving the patient the choice also gives her the responsibility, as well as the guilt p. Accordingly, the responsibility to choose may be considered an existential burden.

The women in this study had to decide their future within a short period. In this context, making a choice was described as a tough and lonely responsibility. In existentialist terms, the women were “thrown back upon themselves”. They came to the hospital with their complex dilemmas and had to decide. Like descriptions by other western women who considered abortions<sup>1,2</sup>, the women in this study expressed moral conflicts in which they assessed what

would weigh heaviest, such as whether their own health, their partnership, their freedom or their ability to have an education should be worth more than a life with a child. The women lived through these concerns in different ways. More than a few wished, like Anna, to be exempted from the choice with a miscarriage.

### *Autonomy and dependency*

The women's considerations were described as internal dialogues with themselves. However, all of the women involved some of their closest confidants, which could mean having support but could also further complicate the decision-making process. Whether the women in this study were fully autonomous is worth discussing. According to Beauchamp and Childress's definition of autonomy, two conditions are essential for autonomy to be present: agency (capacity for intentional action) and liberty (independence from controlling influences)<sup>32</sup>. However, these authors indicate that disagreement exists over the meaning of these two conditions and whether additional conditions are required. Nevertheless, all women in this study had agency, including the capacity to conduct an abortion or complete the pregnancy. However, the narratives revealed how they felt autonomous to different degrees. Other people did not control these women, but they were also not completely independent. They sought to make independent choices but wished for health professionals to have a caring attitude and be engaged and involved in their decision-making processes. This is in accordance with a study of young Swedish women, who reported appreciating the interest from healthcare professionals. The support during their decision-making processes contrasted the pressure some of them felt from those nearest to them and from social norms<sup>24</sup>. A caring attitude from healthcare professionals could provide a larger space for reflection and dialogue than that provided by other sources, such as pressure from family and social and religious norms. According to the relational autonomy theory, decision-making is not just a matter of choice but must be seen in social and situational contexts. Support and resources provided by careers may be required to enable autonomous decision-making<sup>33</sup>. This notion is consistent with Martinsen and Delmar, who elaborated some ethical challenges in caring with relevance to autonomy<sup>34, 35</sup>. Martinsen describes how the degeneration of care can be maintained through the principle of patient independence. In our study, when the health personnel's only focus was to provide a choice without being attentive or open to listening to the woman's experience of her whole situation, including the context of the decision-making process, autonomy could contribute to a rejecting attitude<sup>34</sup>. A rejecting attitude reflects a conquering and domineering way of thinking, which can destroy the other by rendering her world narrow,

dark, tedious, and menacing. However, a receptive attitude, such as that experienced by Lene, who was one of the women who felt respected by the health personnel, may expand the other's room for action by widening the other's world and making that world light, diverse, and safe<sup>35</sup>. Lene was given an opportunity to be open about her doubt and to open up her space for action in a manner that expanded her leeway.

From Anna's narrative, her anticipation of being seen and listened to according to her doubt was apparent in the interplay with the health personnel in the first encounter at the hospital. However, when she became ambivalent during the second consultation, the caregiver did not respond to her appeal, and she experienced being abandoned. Such rejections of responsibility for women being prepared for abortions have also been reported in previous research in which US health professionals emphasized the woman's autonomy and, therefore, did not become involved<sup>36,37</sup>. In another report, nurses in gynaecological units did not consider ambivalent women their patients if they had not fully decided<sup>38</sup>. Additionally, Italian nurses have reported ethical dilemmas in supporting ambivalent women being prepared for abortions. These nurses claimed exemption from responsibility with the notion that "This is not my choice"<sup>39</sup>.

#### *Involving without influencing autonomous women*

Norwegian health personnel have reported that respecting autonomy while caring for women being prepared for abortions is challenging<sup>25</sup>. The health personnel felt responsible for determining whether a woman was ambivalent once she arrived at the clinic to be prepared for an abortion. However, they described the experience as an ethical dilemma, namely, how to reveal the uncertainty without influencing the autonomy of the woman's decision. The question is whether revealing if a woman has fully decided is permissible within the health personnel's ideals of being non-judgemental and non-influential. In Kine's experience, she realized her uncertainty when asked the question, "Are you sure?"

Did health personnel, for better or for worse, influence her autonomy? How does such involvement by health personnel interact with autonomy? The question of whether Kine was certain contributed to her postponement of the decision. She later reflected that the decision of the health personnel to investigate whether she was fully decided and recommend that she take some time to consider her choice was correct. Kine's positive evaluation of being

identified as ambivalent has been confirmed by women who have wished for healthcare professionals to appear to be generally compassionate and open to what they sought to choose and show them respect as whole persons <sup>1, 40</sup>.

As described by health personnel caring for women seeking abortions, not influencing or upsetting the women to prevent the decision-making processes from being more difficult is highly challenging <sup>25, 41-44</sup>. However, as evident in Anna's narrative, the decision to not become involved may also be perceived as problematic and result in feelings of being abandoned. An important ethical question here pertains to moral sensitivity. How do health personnel identify the women who want to be guided and the ones who want to remain fully autonomous in their choices? What is the appropriate behaviour for health personnel in situations of such discretionary uncertainty, especially within a very short time frame? In particular, knowing the right to do in advance is a continuous challenge to moral discretion overall.

In addition to informing the abortion-seeking women about the technical and practical arrangements that are preliminary to abortions, Norwegian health personnel are obliged to provide advice or inform patients about other places where counselling can be obtained <sup>15</sup>. However, the Norwegian legal regulations <sup>15, 45</sup> and guidelines <sup>46</sup> do not provide detailed descriptions about what to do when women are ambivalent of whether to have abortions. The regulations are generalized, being about responsibility for support and counselling, and do not emphasize the importance of being sensitive to women who might be ambivalent. Thus, whether the woman herself is responsible for presenting a need for counselling or whether the responsibility lies with the health personnel remains unclear. According to these regulations, Lene, who was one of the respected women, seems to be "an ideal" autonomous patient. She is conscious about her doubt, and she is able to express her expectations to the healthcare provider.

### *Responsibility for autonomous women*

We can ask whether Norwegian health personnel have any ethical or professional responsibility for revealing uncertainty when a woman being prepared for an abortion does not express a need for counselling. Respect for autonomy, as a norm of respecting and supporting autonomous decisions is one of the four moral principles of biomedical ethics. <sup>32</sup>. Legally, Norwegian regulations may contribute to an understanding that women should decide entirely on their own, without any kind of interference. However, a caring attitude

requires taking interest in the woman and her experience of the situation<sup>34</sup>. A strict principle-based approach might be insensitive or blind to what motivates us to act properly and the importance of appropriate moral perception<sup>47</sup>. The danger is that only the principle of the woman's autonomy and her self-determination are in focus. According to Martinsen, trust is built not by acting strictly according to rules but by daring to get involved<sup>34</sup>. As in Anna's and Kine's narratives, the ambivalent women may feel rejected rather than autonomous if health personnel refuse to do more than inform them about their options, denying dialogue about their choices.

A relational caring ethical approach is consistent with Martinsen's theory<sup>34</sup> and challenges the concept of nondirectiveness. This enhances the outcome of counselling because the health personnel then recognize their patients' struggles.

The various expectations and experiences of women being ambivalent have proved to be challenging for health personnel in abortion care. In addition, health personnel have described a lack of both training, counselling and support for themselves when caring for ambivalent women<sup>25, 38, 39, 41, 42, 44, 48-50</sup>. With a caring approach, health personnel should meet women with moral sensitivity, which demands time, presence, dialogical competence and engagement.

To support health personnel's demand for qualification and training in dialogical competence, the Norwegian guidelines<sup>46</sup> should be extended to the WHO guidelines that recommend ensuring women's autonomy and sensitivity to women's needs and offering counselling if needed<sup>12</sup>.

### Methodological considerations

Data were assessed as rich, based on content and depth. The interviews were conducted when the women were engaged in their decision-making processes and shortly thereafter, when their memories of their encounters with health personnel were fresh. After conducting 23 interviews, we recognized some important topics. Although the data cannot be considered exhaustive, we believe that the study provides increased insight into how encounters may be experienced. The follow up interview allowed the women to reflect upon their experiences after having made their decisions and the researcher to obtain clarification regarding the first interview.

Notably, this study included only informants that health personnel revealed were ambivalent. The experiences of women who were prepared for abortions and were not revealed as being ambivalent when encountering health personnel were not examined in this study.

## Conclusion: Implications for practice and suggestions for further research

The women described an inescapable responsibility when they had to choose whether or not to terminate their pregnancies. The decision-making process for the ambivalent women was described as complex. Although they considered themselves autonomous and undoubtedly responsible for the final decision, they described a relational dependence on their health providers comprising trust and hope that health personnel would be involved in their situations.

The health personnel contributed to enabling or disabling the possibility for decision-making in accordance with the women's values. These findings indicate that health personnel who care for women considering abortions must be trained and guided in dialogical competence.

The guidelines should emphasize the importance of being sensitive to women who might be ambivalent. More research is needed to develop training programmes and guidelines for health professionals.

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