

## ORIGINAL ARTICLE

# Walking on a tightrope—Caring for ambivalent women considering abortions in the first trimester

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## Abstract

**Aims and objectives:** To improve the understanding and competence of health personnel when caring for ambivalent pregnant women, the aim of this study was to explore the experiences of encountering women who are unsure whether to complete or terminate pregnancy.

**Background:** Feelings of ambivalence are present in a significant number of women preparing for abortions and may challenge the provision of health care. Health personnel have reported an ideal to be nonjudgemental and supportive. Insufficient attention has been directed to the experiences of health personnel who prepare women for abortions in gynaecological units.

**Design:** Qualitative design with a hermeneutic-phenomenological approach.

**Methods:** Focus group interviews were conducted with health personnel from four gynaecological outpatient clinics and wards in Norway ( $n = 20$ ).

**Results:** The health personnel felt responsible for contributing to patient well-being. This demanded focused attention towards all women being prepared for abortions and meant a consciousness and balancing act towards revealing, handling and being involved in the woman's potential unsureness without influencing her decision. When involved, the health personnel risked being confronted with their own vulnerabilities and values.

**Conclusions:** The health personnel tried to balance their care and support without influencing the woman's decision. Although they viewed the women as fully autonomous and responsible, they became personally involved, to varying degrees, in the uncertainty and were faced with their own vulnerabilities and values. They lacked a possibility for immediate debriefing and regular counselling after complicated consultations.

**Relevance to clinical practice:** Knowledge of the experiences of health personnel can provide input for professional development at gynaecological departments. These findings contribute to discussions about what information should be given and whether the woman's feelings should be discussed in preparation for an abortion. The ability of health personnel to discuss subjects related to ethically challenging encounters with women who are considering abortions should be established,

namely, professional education and workshops at the national level and small groups with counselling and case study discussions at hospitals.

#### KEYWORDS

caring, decision-making, focus groups, nurse practitioners, nurse-patient relationship, phenomenology, qualitative study, registered nurses, reproductive health, women's health

## 1 | INTRODUCTION

Women in most of the Western World have access to and have a legal right to make an autonomous decision regarding whether to terminate a pregnancy in the first trimester. Although abortions do not usually have negative mental health consequences in women, those who are ambivalent are at higher risk of poor psychological outcomes than those who are nonambivalent (Broen, Moum, Bødtker, & Ekeberg, 2006; Cameron, 2010; Hoggart, 2015; Major et al., 2009; Pereira, Pires, & Canavarro, 2017). Women might have complex lives that affect their decision-making in early pregnancy, and despite the legality of abortion, the decision may be questioned and/or regarded as ethically problematic (Kero, 2014; Kimport & Weitz, 2015). When a woman is considering terminating a pregnancy, she is usually dependent on health personnel to set the pregnancy length and obtain treatment. According to previous research, approximately 10%–18% of women are still unsure when they arrive at the hospital for preparations for abortions (Cameron & Glasier, 2013; Foster, Gould, Taylor, & Weitz, 2012; Ralph, Foster, Kimport, Turok, & Roberts, 2017; Simmonds & Likis, 2011). In Norway, the number of annual requests for abortions is approximately 14,000, and nearly 10% of these requests are withdrawn before the abortion is performed (Løkeland et al., 2018). The services provided by health personnel for unsure women are central to the quality of abortion care.

In the last 30 years, medical abortion has increasingly replaced surgical methods of abortion worldwide (Swica, Raghavan, Bracken, Dabash, & Winikoff, 2011). This shift has meant that more responsibility for the abortion procedure is handed over from medical doctors to the nurses in both outpatient clinics and hospital wards (Gallagher, Porock, & Edgley, 2010; Lindström, Wulff, Dahlgren, & Lalos, 2011; Lipp & Fothergill, 2009). Over the last few years, there has also been a third shift, whereby home abortions have been introduced. The relocation of abortions from the hospital to the home has meant that the responsibility for the implementation of the abortion has shifted from the nurse to the woman (Purcell, Cameron, Lawton, Glasier, & Harden, 2017).

The termination of a pregnancy in Norway is free in all government hospitals; there is no mandatory counselling or compulsory waiting time (AbortionAct, 1978; Helsedirektoratet, 2018). There are social workers at the hospitals, but usually, they are not specialised in option counselling. The Norwegian government supports an option counselling service for those who are unsure ([www.amathea.no](http://www.amathea.no)) and welfare programmes for those who decide to continue the pregnancy (Helsedirektoratet, 2018; NAV, 2018). Norwegian women have the legal right to decide whether to terminate their pregnancies up until the end of the 12th week (AbortionAct, 1978). Medical abortion was introduced in Norway in 1998 (Løkeland, Bjorge, Iversen, Akerkar, & Bjorge, 2017). In 2017, most abortions in Norway were performed before the ninth week of pregnancy (81.2%). Of all completed abortions, 12,187 (95.7%) were performed in the first trimester, and 88.6% were medical (Løkeland, 2018). The most commonly used drugs for medical abortion in Norway are mifepristone and misoprostol, delivered in a two-dose fashion at the hospital. The initial abortion medication is taken with supervision (Helsedirektoratet, 2017). Women older than 18, who are no more than nine weeks pregnant, are eligible for performing medical abortions at home (Helsedirektoratet, 2018).

### What does this paper contribute to the wider global clinical community?

- This study can benefit nursing practice and education by contributing to discussions about what information should be given to woman in preparation for an abortion.
- The study highlights the need for healthcare personnel to be debriefed and receive counselling after complicated consultations.

## 2 | BACKGROUND

Health personnel working at abortion clinics in the United States (Gould, Perrucci, Barar, Sinkford, & Foster, 2012; Wolkomir & Powers, 2007) and the United Kingdom (Lipp & Fothergill, 2009; Nicholson, Slade, & Fletcher, 2010) have reported that it is not a matter of course for a woman's decision to be absolute when she arrives at the clinic. Health personnel have learned that the decision to terminate a pregnancy might be challenging and that some women may change their minds (Lipp & Fothergill, 2009; Nicholson et al., 2010; Wolkomir & Powers, 2007). According to Nicholson et al. (2010), nurses described that identifying the women who are unsure is difficult. In a number of Western studies, health personnel have reported that they felt obligated to ensure that the woman was well informed

and that the choice was based on the woman's own opinion (Galagher et al., 2010; Gould et al., 2012; Lipp & Fothergill, 2009; Nicholson et al., 2010; Ralph et al., 2017; Wolkomir & Powers, 2007). Some abortion clinics in the United States use a questionnaire to identify those who need guidance (Joffe, 2013; Ralph et al., 2017). In the encounters with women being prepared for abortions, health personnel present an ideal of hiding their own feelings with the goal of being nonjudgemental and supportive (Martin, Hassinger, Debbink, & Harris, 2017; Purcell et al., 2017; Yang, Che, Hsieh, & Wu, 2016). In a Swedish study, midwives have described value conflicts when their own professional and personal values were challenged when facing women preparing for abortions (Hallden, Lundgren, & Christensson, 2011). Scottish health personnel reported that value conflicts related to abortion work increased with the duration of pregnancy (Purcell et al., 2017). None of the studies examined specifically investigated encounters with ambivalent women. Nevertheless, two studies noted that health personnel found the experience of an unsure woman arriving to be challenging and time-consuming (Mauri & Squillace, 2017; Wolkomir & Powers, 2007).

There seems to be a gap in the research related to how health personnel experience and handle consultations when women arrive to terminate a pregnancy and turn out to be unsure about their decisions. To improve the understanding and competence of health personnel when caring for ambivalent pregnant women, the aim of this study was to explore the experiences of health personnel in meeting women who were unsure whether to complete or terminate pregnancies.

### 3 | METHODOLOGY AND METHODS

The study took a hermeneutic-phenomenological approach (van Manen, 1990), based on philosophical traditions (Husserl, Heidegger, Merleau-Ponty) and adapted to empirical research by several authors (Galvin & Todres, 2013; Giorgi, 2009; van Manen, 1990).

Husserl, who aimed to capture experience in its primordial essence, introduced phenomenological philosophy. One of the key terms he developed was the notion of the lifeworld, which refers to an experienced everyday world of meaning. The lifeworld concept has further been developed by Heidegger in that phenomenology is concerned with what gives itself and that there is a mutual connection between human beings and the world (Bengtsson, 1999; Heidegger, 1927/2010). Examples on fundamental structures constituting the human lifeworld are the lived body, lived relations, lived time, and lived space. These intertwined dimensions (existentials) in the lifeworld are crucial for understanding human beings in general and, consequently, in also understanding patients.

Galvin and Todres (2013) have developed a caring model, namely, lifeworld-led care, based on phenomenological philosophy. In this model, an insight into the lifeworld perspective is essential for understanding the patient and implies a desire to contribute to well-being. To achieve well-being, there must be room for freedom, including agency and vulnerability. Well-being is regarded as vitality

and includes both the possibility of movement and the possibility of rest. Human freedom is situated, which means it is limited by several conditions, such as death, bodily weaknesses, and changes in time, space, culture and language. These are vulnerable conditions we as human beings are not separated from. In lifeworld-led care, we must take into account all of these dimensions if the other should feel recognised (Galvin & Todres, 2013).

Galvin and Todres (2013) refer to Gadamer (1975/1989) in their understanding of experience as an interaction in a situation with other people and things. The experience that one understands is neither fully one's own nor is it another's alone. Yet, we attend very closely to the experimental world that the other's word expressions open up. "To understand is then to understand both something of this unique individual and the shared intersubjective horizons within which any unique experience occurs," writes Galvin and Todres (2013, pp. 161–162). Merleau-Ponty (1945/2012, p. 370) elaborates how we perceive each other: "It is precisely my body that perceives the other's body and finds there is something of a miraculous extension of its own intentions, a familiar manner of handling the world."

The interesting and important question for phenomenologists is to open up what we assume we already know (Vagle, 2016). The basic phenomenological question is "What is this experience like?" This question allows us the possibility to wonder about the meaning of a certain moment of lived life (van Manen, 2017, p. 811).

#### 3.1 | Participants and recruitment

To obtain knowledge on health personnel experiences, invitations to participate in a focus group were sent to the head nurse at each gynaecological unit included. Moreover, information about the study was presented in meetings at the gynaecological units by the first author. The head nurses recruited a purposeful sample by including nurses and medical doctors with experiences in meeting with ambivalent women in the first trimester of their pregnancies at both gynaecological outpatient clinics and/or wards.

Twenty-two health personnel consented, but two medical doctors were prevented from joining the study due to work-related obligations. From one of the hospitals with a small gynaecological unit, only one nurse was asked. She joined the group at the hospital in the neighbouring town. In total, 19 registered nurses and one medical doctor from four urban and rural hospitals in southern Norway participated in the focus groups. The participants were all female, aged 24–60 years (average: 44 years). The average experience of these personnel in a gynaecological unit was 11 years and ranged from 3 months to 33 years. When the interview occurred, the medical doctor was employed at a gynaecological unit, 12 of the nurses were employed at an outpatient clinic, and seven were employed at a ward.

Nurses and physicians have different tasks when meeting women who prepare for an abortion at Norwegian hospitals. The nurses meet with the patients before and after the consultation with the doctor. However, one of the outpatient clinics included in this study had introduced a new sharing of responsibilities. The nurses had

been delegated the responsibility for the whole procedure, including the ultrasound examination. The doctors were consulted only when extraordinary situations occurred.

### 3.2 | Design and data collection

The point of departure for this study is the findings from individual in-depth interviews with women who were ambivalent when preparing for an abortion. We gained insight into the women's lifeworld from their consultations with healthcare providers. The women described a basic trust, but also unmet expectations in relation to their doubt (Kjelsvik et al., 2018). On the basis of these findings, we designed a study incorporating focus group interviews with health personnel to gain insight into their experiences from encounters with ambivalent abortion seekers.

Three focus group interviews with 6–8 participants were conducted in sheltered meeting rooms in the hospitals during December 2016. Each interview lasted for approximately 100 min. The purpose of the discussions in the focus groups was to gain insight into topics in which the participants had specific knowledge, namely, caring for unsure women, and to facilitate natural and easy conversation between the participants without much interference from the researcher (Krueger & Casey, 2015).

The focus group interviews were facilitated by hearing each of the informant's individual voices. The participants were also encouraged to interact by reflecting on and sharing their experiences that enriched and complemented each other. During the interviews, the health personnel provided rich descriptions and presented an open and sharing attitude. They inspired and stimulated each other to deepen their experiences and both confronted and challenged one another. This resulted in new perspectives we had not predicted (Bradbury-Jones, Sambrook, & Irvine, 2009). The first author moderated the interviews. The comoderator (EG) took notes and observed the interactions among the group. The interviews were based on an interview guide (Table 1).

### 3.3 | Data analysis

Before the analysis, the overall impression from the interviews was discussed among the research team. All the digitally recorded interviews were then transcribed verbatim and anonymised by the first author. Transcripts were read independently by each member of the research team and then discussed to compare interpretations and identify preliminary themes. When each interview was analysed, the

**TABLE 1** Interview guide

The questions prepared in the interview guide were as follows
How do you recognise or detect unsureness when encountering a woman preparing for a first trimester abortion?
How do you handle unsureness and how do you experience these encounters?
Are there challenges?

preliminary themes from each of the three interviews were synthesised. During the whole process, the data were interpreted further to gain a deeper knowledge of the health personnel experiences. The analysis ended in three final themes. During the analysis process, questions to obtain the meaning of the data (Table 2) were guided by recommendations from van Manen (2017). NVivo 11 software was used to facilitate data management.

The interpretations based on these questions became crucial in the overall understanding of the data. Phenomenological analysis presumes appropriate phenomenological questions and experimental material upon which the reflection can be conducted (van Manen, 2014, p. 297). In this process, the lifeworld existentials were part of the reflections. During the whole process, the research team met and discussed regularly.

### 3.4 | Ethical considerations

The study was designed in accordance with the Helsinki declaration (WMA, 2013). Research approvals were obtained from the heads of the involved hospital departments and the Regional Committee for Medical and Health Research Ethics (2014/1276). The health personnel received written information about the study and an invitation to participate. All of the participants provided written consent. The participants were requested to keep the group conversation confidential. To ensure anonymity during publication, the citing of quotations is related to the group, not the individual participant.

## 4 | RESULTS

The health personnel felt responsible for contributing to patient well-being. This demanded focused attention towards all women being prepared for abortion and meant a consciousness and a balancing act related to the themes of revealing, handling and becoming involved in the women's potential unsureness without influencing their decisions. When involved, the health personnel risked being confronted with their own vulnerabilities and values. All of these themes were coherent and overlapping, even though they are presented separately below.

**TABLE 2** Questions to obtain the meaning of the data

Examples of questions that were asked to obtain the meaning of the data
What is support like based on the experiences of the health personnel?
What makes this situation a unique human experience for the health personnel?
What is it like to be a health personnel meeting a woman who is struggling to decide whether to have an abortion?
How does a conversation with a fully decided woman differ from an encounter with an undecided woman?

#### 4.1 | To reveal uncertainty, focused attention is necessary

The health personnel had a focused attention towards all women being prepared to terminate a pregnancy in the first trimester. They described the women as vulnerable, easily influenced and potentially ambivalent towards the decision. They felt responsible for revealing a potential uncertainty despite viewing the women as autonomous and given the legal right to decide. The concern was explained by the definitiveness of the procedure and limited time frame to decide. One of the most experienced nurses summarised her concern as “They really have to be fully decided when they swallow that tablet” (F2).

Even though the informants often prepared several patients in one day for an abortion, they wanted to provide each woman with the feeling of being treated with respect and dignity and not like “a thing on a conveyor belt.” To different degrees, they tried to become emotionally involved during the consultation by gaining knowledge of the woman's experience of her own situation. They realised that uncertainty might have different appearances: “The unsureness is so diversely expressed” (F3).

The health personnel differentiated between gaining insights into an open or an underlying uncertainty. The open uncertainty was unproblematic to discover as the women then spoke about their doubt regarding whether to have an abortion. Revealing an underlying uncertainty, however, presupposed attention: “It's constantly about our sensitivity” (F1). Frequently, this meant being aware of both what the woman said and how she appeared. When the woman's verbal and body language did not correspond, the health personnel became attentive and relied on their intuition to gain further insight. Through the interpretation of the woman's body language, they described being touched themselves; they noticed whether the woman gave the impression of being uncomfortable, had an evasive posture, spoke in a stifled voice or was tearful or making eye contact was difficult. A nurse described her observations as “Some mislead us that they are certain, but then their body is really uncertain” (F1). The health personnel tried to clarify whether their intuition was correct by asking the woman direct or indirect questions. When asking directly, they emphasised being friendly and sought a balance in tone to avoid appearing interrogative. They were aware that some of the women did not want to involve them in a possible doubt and that asking directly might influence the woman and contribute to shame or uncertainty for her. An example of questioning in a pleasant way is the following:

‘So, you want an abortion?’—It's important for me that my questioning not make them feel like ‘Oh, I'm doing something wrong or have to consider it again. Should I feel unsure?’ No, I want them to feel supported in their decision. (F3)

Others were sceptical towards direct questions and confined themselves to indirectly revealing uncertainty by asking if the

woman had questions or needed more information. Some had changed their practice after becoming more qualified and had been more direct when asking “Are you unsure about whether to have an abortion?” (F1).

When performing the preparations for pregnancy termination, the health personnel understood both their own and the woman's situation as temporarily stressful. They had limited “clock time” for each consultation and usually concluded it by delivering the initial medications for the abortion. They knew the women often experienced body ailments such as nausea and dizziness, complicated relationships and a limited time for decision-making due to their gestational time and legal regulations. In addition, they had an awareness that the women might become ambivalent during the consultation.

The moment when the initial medication was swallowed was defined by the health personnel as the decisive moment for the woman with no possibility of withdrawal. The nurses described the medication handover as their responsibility. Due to the concern of whether the woman was ready to start the abortion, they assessed each woman strictly. They checked whether she was informed, whether she had understood the definitive effect of the medication and whether she felt ready to start the termination process. One described her moral responsibility as “It is heartless to just leave the pill on the table” (F1). The interpretation of the woman's attitude meant continuing or interrupting the procedure. If a woman hesitated to take the medication, the health personnel tried to determine whether the reluctance was due to uncertainty or whether starting the abortion process was simply too demanding: “Even those who are fully decided often shed some tears. It is hard to take the pill” (F3). When handing over the medication, the health personnel's considerations were influenced by earlier encounters, namely, memories of those who regretted the decision and in desperation had tried to vomit the medication. On the other hand, they had witnessed women who were sad about carrying out an abortion, although had decided to do it because it was considered to be the best solution.

#### 4.2 | To handle uncertainty—a balancing act

When a woman's unsureness of whether to terminate a pregnancy was revealed, the health personnel described various feelings of responsibility to handle the ambivalence during the consultation. The process of talking with an unsure woman was expressed as a balancing act between being actively involved and holding back. The health personnel wanted to show that they cared and convey an understanding of the challenges without influencing the woman's choice: “It is demanding to be in such a situation. You have to be involved and, at the same time, not influence” (F2). However, the time to talk about the woman's complex feelings and life situations was limited. The health personnel sensed there was tension between the need to talk face-to-face with the woman and an obligation to not delay the schedule.

Women preparing for an abortion were portrayed as a grateful, although quiet and invisible group. The health personnel knew that

the woman's thoughts on abortion might be a secret that needed to be hidden from family and friends. Two nurses reflected "We know that the considerations of abortion are not an open theme," "No, not even at home" (F3). This secrecy indicated that those who were unsure called for special attention from the health personnel.

During the consultations, it was important for the health personnel to appear as neutral as possible to the woman's choice: "Throughout the years, I have been conscious of my neutrality, to maintain a non-judgmental attitude" (F2). This meant that in the conversations, the health personnel emphasised openness towards the individual's narrative and support of the woman's thoughts and considerations. Furthermore, they took a position on how to provide the information related to the preparations for and performance of the abortion. At times, because of the diversity of the women, knowing how to adapt the information was challenging. They did not want to frighten anyone, but at the same time, they felt a commitment to being realistic and preparing the woman for what to expect due to pain, bleeding or other discomforts.

When they spoke with the woman about the choice and what it meant for her to terminate or continue the pregnancy, they continuously considered both their own and the woman's language. Some emphasised the use of the same words as the woman. However, sometimes, they reworded the woman's descriptions. If a woman said "My child," the informants indicated that the dialogue could be like this: "I say to the woman, as the doctors do, 'We do not use this term. We use the terms "embryo," "fetus," or "pregnancy product" when the pregnancy is early'" (F2). The health personnel discussed whether they wrapped the information up too much in the consultations. An example might be whether they should inform the woman about multiple pregnancy. Moreover, how to respond in an honest and considerate way when the woman asked questions related to the ultrasound image was discussed: "When they ask: 'Does the heart beat?' We cannot lie? We must say 'Yes, the heart beats'" (F1).

If the unsure women asked for permission to view the ultrasound image, the health personnel usually refused them. They wanted to be caring by protecting them from the sight and feared that the image could affect them and complicate the decision. At the same time, the health personnel discussed with each other and sometimes with the women if the health personnel were entitled to hold this information back. Some indicated that they said to the women that the ultrasound information was only for documentation for the professionals.

When the health personnel identified unsureness during the consultation, they modified the routines to allow for a less stressful decision-making process. These women were usually not given a new appointment. Instead, the unsure woman's documents were placed in "the waiting pile." Within the legal limit, the woman could, on her own initiative, return to the hospital.

During the consultations, the health personnel could be met by expectations from the uncertain woman for assistance in decision-making: "Many ask what we would do [in their situation]. They have expectations of being able to decide" (F2). To be supportive and

contribute to the decision-making process, the health personnel advised the women to take more time, write down their arguments or talk with someone trustworthy. Some of the caregivers had developed their conversational skills. Instead of advising, they more actively listened and allowed the woman to tell her story.

If a woman showed herself to be uncertain and hesitated to swallow the pill, even though she had decided to start the abortion, the health personnel described withdrawing the medication as an ethical duty. They described this as a temporary decision they took on behalf of the woman. She could return and obtain the medication later, but at that exact moment, the health personnel decided they would not provide it: "I do not give a tablet to anyone who is sitting here stiff and crying and who really does not want it; maybe someone else thinks she must take it. In this case, I say, 'No, I do not want to give you this tablet. We will spend more time considering this'" (F2).

Most of the health personnel had gained experience from several occasions with unsure women. They had learned that their intuitions of women being unsure and in need of a conversation about their uncertainty or to be given more time to consider the decision had been correct; some women had decided to go on with the pregnancy. Several of the health professionals expressed that they could feel happiness on behalf of the woman when this occurred.

If a woman finally chose to start the abortion, the healthcare personnel supported her by comforting her if she needed comfort. They advised her to remind herself of the arguments upon which she had based the decision. Some of the health personnel remarked that they tried to identify with the woman and encouraged her not to bother herself in the future with thoughts about whether she could have managed to keep the baby.

#### 4.3 | To become personally involved in uncertainty—confrontation with one's own vulnerabilities and values

The health personnel communicated agreement regarding the woman's sole responsibility for the decision. However, they found the encounters with the unsure women and their often-unsolvable dilemmas challenging. Their involvement meant a risk of being affected and overwhelmed. Even though the health personnel mastered the practical and technical procedures, they lacked skills and competence in handling the emotional and moral challenges. As expressed by one of the nurses at an expert level: "Although the personnel are skilled, one encounters new experiences and must consider 'How should I handle this?'" (F1).

Their involvement in the woman's life and considerations could lead to a need for debriefing: "You meet someone who awakens your compassion and you simply need to discuss or describe the encounter with someone else or just get the emotions out" (F1). No units offered debriefing or counselling for the staff. Usually, the health personnel simply had to suppress their thoughts and go on or seek support from their colleagues in between consultations. Women applying for abortion accounted for a large proportion of

the patients at the gynaecological units. However, the health personnel had to constantly adjust when taking care of patients having different reproductive health problems. The lack of space or time for debriefing or formal guidance contributed to the informants' feelings of being left to themselves: "In a way, we are our own psychologists. Of course, we are talking together. However, as I experience it, there are many thoughts after such a day [having consulted several ambivalent pregnant women]" (F1).

Occasionally, the values and knowledge of the health personnel came into conflict with the woman's choice. This could occur when a woman was considering an abortion solely because of the pressure of others but against her own will or if a woman decided to terminate the pregnancy despite a stable marriage with good finances and, according to the assessments of the health personnel, the ability to take care of a child. In contrast, the health personnel felt worried if a woman chose to go on with the pregnancy despite a lack of caring abilities for the child(ren) she already had. In such situations, it became important for the health personnel to emphasise for themselves that the choice had to be based on the woman's values and that her decision was not the responsibility of the health personnel: "There are thousands of reasons. They are theirs, not mine" (F3).

Although the health personnel were usually able to care for the uncertain woman, they sometimes felt unable to contribute further and had to ask a colleague to take over, as when a woman returned to the hospital several times, still ambivalent and undecided. Regularly, the health personnel considered some women's circumstances to be too complicated for them to handle at the gynaecological unit. Neither their competence nor their limited time frame was sufficient. Due to their engagement with the individual women, the health personnel observed that allowing each woman to be able to make an autonomous decision within her time frame was important. For this reason, they frequently referred the ambivalent women to the social services at the hospital or to the professional counsellors at the national guidance service.

They described the possibility for professional development for nurses at the gynaecological units as limited. Several personnel hoped for a national professional forum to be established where they could share experiences and develop the gynaecological field. As expressed by one, "We have a desire to establish a gynecological nurse association for all hospitals to have a place to share and develop experiences because there is nothing for professionals working with abortion" (F2).

## 5 | DISCUSSION

This study provides new insight regarding the experiences and understanding of health personnel when encountering unsure women who are considering terminating a pregnancy in the first trimester. The care of these women demanded focused attention from the health personnel. They felt responsible to reveal and handle a potential decision-related uncertainty to support the woman's aim for health and well-being in the future. This task showed itself to be

a balancing act between getting involved and holding back. The personal involvement in the women's complex lives and dilemmas was challenging. Supporting and caring for the women required an awareness to not influence their decision and could result in confrontations with the vulnerabilities and values of the health personnel. Their struggles to achieve such a balance towards the women's decision may be understood and interpreted in the light of the model of lifeworld-led care (Galvin & Todres, 2013). In line with this model, the health personnel were aware of how the existential dimensions were intertwined. They wanted to act by being open to the patients' conditions and recognising both their freedom of choice and vulnerability. Subsequently, the possibility for vitality, movement and peace was addressed.

From the moment the health personnel at the gynaecological unit met a woman who came to terminate a pregnancy, the health personnel focused their attention towards her bodily presence. Despite their view of the woman as autonomous and free to decide, they had an awareness of the woman's vulnerability and felt responsible for revealing and handling a potential unsureness. This required an openness towards the living body. Such a response corresponds to the involvement of the health personnel in the face-to-face relations reported in earlier studies (Gallagher et al., 2010; Lipp, 2008; Nicholson et al., 2010; Purcell et al., 2017). This interaction entailed that the health personnel attempt to interpret whether the woman was fully decided as they observed her body while listening to her story. This openness to the woman's lived body was a form of touching and being touched. The phenomenology of eye contact is not only to see but also to touch and meet the other (van Manen, 2017), which may be crucial in understanding the meaning of the woman's story. Depending on the appearance of the woman, the personnel interpreted her decisional attitude. Usually, they relied on their own intuition. According to Galvin and Todres (2013, p. 18): "Our insiderness reveals the human body as tiredness, pain hunger, loss of function, excitement, vitality and other experiences of the human body's being-in-the-world." Nevertheless, the interpretation of the woman's bodily appearance by health personnel can be complicated.

Although the health professionals, due to suspicion at times, asked directly about the woman's unsureness, direct questioning was not always performed. The choice to not ask directly whether a woman was certain was justified by the responsibility that the health personnel felt to not contribute to doubt or turmoil in the women who had fully decided to have an abortion. As a result, most of the health personnel described being careful and reserved in their open investigation of potential unsureness. This led to a risk of overlooking a potential decisional ambivalence in women preparing for an abortion. However, due to their reflections after earlier encounters, some of the more experienced nurses had found an alternative course of action. They strived to show an open attitude by asking more directly whether the woman was unsure. Such an open attitude can support a patient's well-being despite their challenging condition. This is consistent with the recommendations from Perrucci (2012, p. 21) that suggest inviting dialogue with those coming for

abortions with an open-ended question: “What was it like for you to make the decision to have an abortion?” This gives the woman the possibility to respond that it was either “easy” or “hard.” According to Perrucci (2012, p. 117), those who are not sure about their decision will generally be offered the opportunity to reveal their ambivalence when asked this question. This is also consistent with lifeworld-led care that is characterised by openness and bodily presence from the health personnel (Galvin & Todres, 2013).

The process of individualising health personnel involvement was challenging because several different patients were seen over the course of the day. Although they had similar dilemmas, their ages, partnerships, possibilities and values varied. Moreover, the health personnel knew the woman's time for deciding was limited and that either terminating or continuing a pregnancy is a definitive decision. As human beings, we have a temporal way of being in the world. This temporal setting is constituted by dimensions of the past, present and future, where events in each dimension affect each other (van Manen, 1990). Often, the personnel found the women to be unsure at the end of the consultation just before the intake of the medication that would start the abortion. Revealing and handling uncertainty was expressed as a momentary opportunity, namely, now or never (van Manen, 2017). During the limited “clock time” of the health personnel to consult with the woman, they attempted to obtain an idea of the woman's thoughts about the choice that might influence her partial unknown future and *personal journey*. According to Galvin and Todres (2013), a dehumanising practice may develop when individuals are oppressed by sameness, routine and repetitive activity. One can discuss whether there is space for unreseness related to decision assessments and counselling at the gynaecological units. These findings are in accordance with the time-efficient manner that limited the opportunities of Scottish health personnel to engage with the woman's emotional needs in decision-making (Purcell et al., 2017). The findings also correspond with the experience of Italian health personnel who found that the psychological aspect of caring for women undergoing abortion was time-consuming, in contrast to the physical procedures (Mauri & Squillace, 2017). This gives the impression of systems adapted for patients as consumers with freedom to choose a treatment. The limited time frames are not in accordance with the fact that frequently, the women being prepared for abortion were considered to be vulnerable in having inner turmoil due to their decision-making process.

For the health personnel, it was important to recognise the situation of the individual woman as a starting point of care. This is in accordance with a humanising care approach that actively facilitates patient participation. If agency is taken away, one's sense of personhood may be diminished, resulting in an excessive emphasis on attitudes and practices that render the person passive in relation to her condition and treatment (Galvin & Todres, 2013). Keeping the women responsible for their choices and actions was part of strengthening their agency and thereby the possibility of freedom. During the consultations, some of the health personnel involved themselves by providing advice related to how the woman could handle the unreseness. Others provided the woman space for

reflection in that they consciously remained silent and actively listened to the women. Some personnel had learned that often, it was not their words that meant anything but rather the silence that gave the woman the opportunity to reflect on her situation. The ability to adapt the conversation to the individual woman was described to be a skill the health personnel continuously tried to develop. This kind of knowledge has more to do with thoughtfulness and tact than with rules, techniques and external competencies (van Manen, 2017). The experience of illness as changing and a nonlinear condition that is understood differently by different patients at different times is in accordance with the ideas of the British philosopher Havi Carel. She elaborates that vulnerability requires a flexible response (2009). The diversity of the woman's needs required that the caregivers possess a broad repertoire of understanding and communication skills. However, as the health personnel had expressed earlier (Wolkomir & Powers, 2007), even skilled caregivers sometimes failed to contribute to clarification for the ambivalent women.

When the health personnel described their responsibility to become involved in the woman's feelings of uncertainty, one of the reasons was the recognition of the woman's loneliness in the situation, due to stigma and a lack of trusted interlocutors. To be human is to be in community, and our uniqueness exists in relationships. “Togetherness and uniqueness imply one another and make meaningful the central human experiences of both aloneness and intimacy” (Galvin & Todres, 2013, p. 14). However, according to some studies from the United States, it is not a matter of course that caregivers emphasise emotional care and involve themselves in their patients' considerations (Gould et al., 2012; McLemore, Kools, & Levi, 2015; Perrucci, 2012). Some focus more on holding back due to the principle of a woman's autonomy and do not believe that they are obliged to explore the woman's feelings about or reasons for abortion (Gould et al., 2012; Perrucci, 2012). However, McLemore et al. (2015) found that several registered nurses did not identify women considering abortion as their patients until they had made their decision. Even if the health personnel in this study held up the principle of the woman's autonomy, they felt responsible for contributing to clarification and thereby well-being. With a caring approach, they gained insight into the woman's complex dilemmas and possible solutions. This is in accordance with a lifeworld-led care approach, where it is important for a caregiver to support a person's own strategies to increase health and well-being and to ensure that the person feels that her needs are more ‘deeply met’ (Galvin & Todres, 2013).

However, at some points, one could discuss whether the health personnel acted against their own principles of not influencing the woman's choice and for upholding her possibility for making an autonomous decision. One example may be when the personnel tried to balance their own and the woman's word choices and consciously held back information related to the foetus. In other situations, the caregivers “took over” and interrupted the woman during the intake of the initial abortion medication and sent her home for further consideration. In these situations, they claimed to understand the consequences for the woman and her future better than she did



herself based on their competence and earlier experiences. At the same time, they feared complicating the decision-making process.

In some situations, adhering strictly to the principle of autonomy may inflict a vulnerable woman more harm than good. A lifeworld-led care approach acknowledges different levels of expertise and understanding between patients and professionals (Galvin & Todres, 2013). One can assert that the health personnel reduced the woman's agency and contributed to passivity when they actively intervened. In caring for the unsure woman, respecting both the woman's freedom and vulnerabilities on her personal journey when she struggled towards a decision of whether to terminate the pregnancy was important to the health personnel. They endeavoured to think that the woman was able to choose and that she would move towards a decision if she were simply provided with specific information or more time to reflect. This is in accordance with reports from earlier studies in which health personnel encouraged their patients to take more time if they were unsure (Gould et al., 2012; Wolkomir & Powers, 2007). Health personnel have also described being conscious of their word choices because they did not want to influence the woman or appear judgemental (Gallagher et al., 2010; Lipp & Fothergill, 2009). Ultrasound workers from the United States reported that they never denied patients the opportunity to view the scan if desired. They had learned that showing the image did not influence the women who had decided to have abortions but could influence the women who were uncertain (Kimport & Weitz, 2015).

The health personnel described the meetings with the women being prepared for abortions as encounters with a quiet and invisible group of women and as encounters that engaged the health personnel; however, the existential demands of these women could be tough to address. The personnel wanted to contribute towards clarification for the unsure women and achieved a conversation. However, these personnel lacked training and support to meet both the woman's and their own vulnerabilities. This challenge could make emotionally coping with the woman's existential issues and dilemmas difficult. There is a vulnerability that arises out of the experience of the vulnerability of others. According to Carel (2009, p. 218), vulnerability is a gate to creativity and flourishing, and this type of vulnerability may require more recognition by the professional.

The legal regulations offer the woman the right to an autonomous decision (AbortionAct, 1978), but, at the same time, the woman is dependent upon the health personnel to fulfil it. In encountering the unsure woman, the health personnel are affected by the woman, and her appeal to involvement needed to be addressed. Situations where health personnel met with vulnerable women in their daily work cut deeply into the existential aspects of their human existence. According to Carel (2009), such intense situations place health personnel in a unique position of vulnerability themselves. This may lead to the experience of emotional and physical fatigue. Not recognising the health personnel as vulnerable may come at a cost to both themselves and to patients and their families. Carel (2009) concludes that the difficulty and uniqueness of these situations are often insufficiently recognised within the professional's training, practice and culture. Emotional loads and a lack of training and support for health

professionals at gynaecological units have also been pointed out previously (Gallagher et al., 2010; Harris, Debbink, Martin, & Hassinger, 2011; Lindström et al., 2011; Lipp & Fothergill, 2009; Martin et al., 2017; Mauri & Squillace, 2017; McLemore et al., 2015; Nicholson et al., 2010; Yang et al., 2016). It seems obvious that systematic education, the possibility for debriefing and counselling should be established. Hopefully, this could contribute to better care for the unsure woman and to preventing burnout for caregivers.

## 5.1 | Strengths and limitations

The strength of this study is the new insight into the experiences of health professionals who care for unsure women preparing for abortions. Little has been known about caring for this particular group of women. Most informants were nurses with extensive experience in meeting ambivalent pregnant women in gynaecological departments and outpatient clinics. The inclusion criteria had no lower limit for job experience from gynaecological departments. Still, only three of the informants had less than one year of experience. One weakness of the study was that no experienced gynaecologists participated. However, the study results are valuable because the practice investigated has increasingly been transferred to nurses.

The group interviews were all characterised by informants who were experienced, interested, direct, honest, committed to the subject and willing to contribute. The fact that some participants told about demanding situations helped open up the discussions in the groups.

Webb and Kevern (2001), referred to in Bradbury-Jones et al. (2009), criticised the use of focus groups in nursing research, concluding that focus groups and phenomenology are incompatible. However, based on our own experiences and the phenomenological literature (Bradbury-Jones et al., 2009), we argue that individual's lived experiences can be preserved within a group context and that focus groups are congruent with phenomenological research. Bradbury-Jones et al. (2009) extended this argument further by proposing that group interviews in phenomenology are actually beneficial because they stimulate discussion, may open up new perspectives and could provide a greater understanding of the phenomenon under study.

This is also our experience. The group discussions contributed to rich descriptions of the participants' knowledge, knowledge that is based on both private and professional experiences. It became clear that familiar bodily expressions appeared to be important for understanding the pregnant women.

## 6 | CONCLUSION

This study demonstrated that the health personnel felt responsible for revealing uncertainty by directing focused attention to the individual women arriving for abortions. They were aware of the possible complexity of this choice and of the limited time to decide. The findings also show that the health personnel felt responsible for the woman's immediate and future well-being and tried to balance their care and support without influencing the woman's choice. Although

they viewed the women as fully autonomous and responsible, they became personally involved, to varying degrees, in the uncertainty and confronted their own vulnerabilities and values. The health personnel needed a possibility for immediate debriefing and regular counselling after complicated consultations. They hoped for workshops including education and fellowships with other gynaecological professionals related to care for ambivalent pregnant women.

## 7 | RELEVANCE TO CLINICAL PRACTICE

Knowledge of the experiences of health personnel can provide input for professional development at gynaecological departments. These findings contribute to discussions about what information is to be given and whether the woman's feelings are to be discussed in preparation for abortion. The ability of health personnel to discuss subjects related to ethically challenging encounters with women who are considering abortions should be established, namely, through professional education and workshops at the national level and small groups that include counselling and case study discussions at hospitals.

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## CONFLICT OF INTEREST

The authors declare that they have no conflict of interests.

## AUTHOR CONTRIBUTIONS

Study design: MK, EG, RTS, EA; data collection: MK, EG; data analysis: MK, RTS, ALM, EA, EG; manuscript writing: MK; and critical revisions to the manuscript: RTS, ALM, EA, EG.

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