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## Women's experiences when unsure about whether or not to have an abortion in the first trimester

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### ABSTRACT

Abortion during the first trimester is legal in most Western countries. However, deciding to terminate a pregnancy is a challenging process, and some women arrive at the abortion clinic still not absolutely certain. We explored the experiences of 13 pregnant Norwegian women struggling to finalize their decision, interviewing them before and after their decision. Verification of the pregnancy meant a new reality for the women. They started to consider their readiness, describing the experience as a lonely journey during which their values were challenged. A feeling of existential loneliness dominated the decision-making process and the implementation.

### ARTICLE HISTORY

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Ambivalence related to having an abortion is a common experience for a subset of women seeking an abortion (Cameron & Glasier, 2013; Foster, Gould, Taylor, & Weitz, 2012; Ralph, Foster, Kimport, Turok, & Roberts, 2017; Simmonds & Likis, 2011), but has received very little attention in the literature. The authors of this paper intend to fill this gap. We report on Norwegian women's experiences of arriving at the gynaecological outpatient clinic for an abortion, yet not fully decided. The results presented are unique and contribute to the knowledge base related to how the women's lifeworld changed when pregnant and uncertain of whether or not to have an abortion. The women's experiences can contribute to a deeper understanding of how it is to make an autonomous decision within a short timeline. Our study may stimulate an international multidisciplinary dialogue on

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pregnant women's health issues, based on participants' rich descriptions of how women in a country where abortion has been legislated for about 40 years still regard it as a "silent topic".

Women's possibilities for considering termination of pregnancy safely and legally vary. Globally, 25% of pregnancies ended in abortion in 2010–2014, meaning 56 million induced abortions each year during this period. Between 1994 and 2014, the abortion rate declined markedly in developed regions, from 46 to 27 per 1000 women of childbearing age. In contrast, it remained roughly the same in developing regions (Guttmacher Institute, 2016). Despite variations in abortion legislation, most women in Western countries are granted full or partial self-determination up until the 12th or the 20th week of pregnancy. In addition, some European countries and US states have regulations related to the provision of patient information, compulsory counseling, mandatory viewing of ultrasound images, and "reflection period" (Goenee, Donker, Picavet, & Wijzen, 2014; Guttmacher Institute, 2017).

Feelings of decisional uncertainty occur among a minority of women who consider terminating a pregnancy (Kirkman, Rowe, Hardiman, Mallett, & Rosenthal, 2009), though recently researchers in the United States revealed that the level of uncertainty in abortion decision-making is comparable to or lower than other health decisions (Ralph et al., 2017). International researchers report that between 10% and 18% of women who approached a Western clinic for an abortion were still in doubt or wanted to discuss the situation with the abortion provider (Cameron & Glasier, 2013; Foster et al., 2012; Kumar, Baraitser, Morton, & Massil, 2004; Ralph et al., 2017; Simmonds & Likis, 2011). In 2016, about 10% (1435) of the requests for abortion at Norwegian hospitals were withdrawn by the woman before the abortion was performed (Løkeland et al., 2017). The Norwegian Mother and Child Cohort Study (MOBA) that was based on responses from about 100,000 women who gave birth during the period from 1999 to 2008 showed that between 11–50%, dependent on age, decided to continue the pregnancy, even though it was not planned (Nilsen, Waldenström, Hjelmsted, Rasmussen, & Schytt, 2012).

Although the decision to have an abortion often leads to conflicting and contradictory emotions, these are usually temporary, and most women who go through with an abortion anticipate and end up feeling relieved, and do not suffer long term regret or mental health problems (Cameron, 2010; Ekstrand, Tydén, Darj, & Larsson, 2009; Kero, Högberg, & Lalos, 2004; Lie, Robson, & May, 2008; Major et al., 2009; Rocca et al., 2015). If they have mental health problems following an abortion, it tends to be because they had problems prior to the abortion (Foster, Steinberg, Roberts, Neuhaus, & Biggs, 2015), and US researchers also report that those who are denied abortions have more problems after the denial than those who get an abortion (Biggs, Upadhyay, McCulloch, & Foster, 2017; Foster et al., 2015).

However, persistent ambivalence and emotional challenges may arise and must not be neglected as such feelings may increase women's stress levels both before and after the decision (Lauzon, Roger-Achim, Achim, & Boyer, 2000). Researchers who have explored more deeply women's emotional experiences found a mixture

of positive and painful emotions, from the discovery of the pregnancy onward. These conflicting emotions may follow them throughout life (Dykes, Slade, & Haywood, 2011; Kero, Högberg, Jacobsson, & Lalos, 2001; Kero & Lalos, 2000; Major et al., 2009; Rocca et al., 2015; Trybulski, 2005). Women who were ambivalent when making the decision, who experienced coercion or pressure and lack of support, or had a history of psychiatric illness, were at greater risk for developing mental health problems after the abortion (Broen, Moum, Böttker, & Ekeberg, 2006; Cameron, 2010; Ekstrand et al., 2009; Major et al., 2009; Pereira, Pires, & Canavarro, 2017). An abortion might also be regarded as “an act of shame” and as a potentially stigmatizing event (Hanschmidt, Linde, Hilbert, Riedel-Heller, & Kersting, 2016). Cameron and Glasier (2013) conclude that compulsory counseling is in conflict with the vast majority of women who are not in doubt, but the few women who are uncertain of their decision to have an abortion should be offered counseling.

Norwegian women were in 1978 granted the right to decide whether to terminate their pregnancies up until the end of the 12th week. Induced abortions between the 13th and the 22nd week need approval by a commission. If a woman considers terminating her pregnancy, she can without any condition contact the hospital or be referred by her general practitioner (Ministry of Health and Care Services, 2000). In Norway, about 59,000 women give birth every year and 13,000 terminate a pregnancy. The abortion rate in Norway in 2016 was 11.0 per 1,000 women and 87.5% of the abortions were performed by medication alone (Løkeland et al., 2017; Statistisk sentralbyrå, 2017). Women older than 18, who are no more than nine weeks pregnant, can access medical abortion at home. The initial drugs are given in a consultation at the hospital (Helse Bergen, 2017).

Although abortion in Scandinavia during the first trimester is legal, free, and easily accessible, it remains a difficult decision and is regarded as ethically problematic by some women (Kero & Lalos, 2000; Kero et al., 2001; Kjelsvik et al., 2011). Most studies describing experiences of decision-making regarding an abortion are conducted with women who have already terminated the pregnancy. A review of 19 of these studies conducted in Western countries (Kirkman et al., 2009), showed that the reasoning preceding the women’s decision to terminate a pregnancy was complex. Less is known about the experiences of women who consider terminating a pregnancy, and are interviewed early in the pregnancy before an abortion was fully decided upon or carried out. However, two Scandinavian studies described the women’s attention to their pregnant body and their experience of both closeness and distance to the fetus. Women wanted to make an independent choice while at the same time consulting others. While some women looked forward to adult motherhood at a later date (Halldén, Christensson, & Olsson, 2005), others described a desire to make a choice that would be right for them, which might include childlessness. They hoped to receive understanding and recognition from the consultations with health personnel. This expectation was to varying degrees fulfilled (Kjelsvik et al., 2011).

The literature review indicates a gap in knowledge about the context and experience of the minority of women who are or become ambivalent about their decision when they are preparing for an abortion. In addition, Norwegian women's expectations and experiences with the health care system when considering abortion have been insufficiently explored. In order to contribute to filling the gap in the literature and thereby improving health professionals' understanding and competence when caring for ambivalent pregnant women, the aim of this study was to explore the experiences of the subset of Norwegian pregnant women, who during the decision-making process still were unsure about whether to complete or terminate pregnancy.

## Methodology and method

As we consider it important that health care providers understand their patients' experiences, we apply a phenomenological approach that is widely used in health research (Chan, Brykczynski, Malone, & Benner, 2010). Hence, this study is based on phenomenological philosophy where the starting point is the description of how human beings perceive the world, the description of the phenomena as they are lived or simply the lifeworld. But phenomenological philosophy is also the study of the meaning or the essence in these phenomena (Merleau-Ponty, 1945/2012).

Husserl was the first in the history of philosophy to give a systematic description of the human lifeworld as the world in which we live our daily lives (Spiegelberg, & Schuhmann, 1994). His work was further developed by Heidegger who described some fundamental basic structures or existentials of the human lifeworld (Heidegger, 1927/2010). Later on, the French philosopher Merleau-Ponty, to a greater extent than Husserl and Heidegger, developed the descriptions of human beings as body-subjects, meaning that the only way to experience the world is through the body (Bengtsson, 1999). Van Manen maintains that basic lifeworld structures are essential in empirical research. He emphasizes in particular lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality) as helpful guides to the phenomenological reflective inquiry process (van Manen, 1990, 2014). These existentials constitute a unity; they may be differentiated but not separated. In research they can temporarily be studied in their differentiated aspects, "while realizing that one existential always calls forth the other aspects" (van Manen, 1990, p. 105).

Based on phenomenology, this study acknowledges that knowledge always begins in the lifeworld, in the world of natural attitude of everyday life. A phenomenological attitude, however, strives toward a sensitive openness to informants' experiences and an awareness and leaving aside of the researcher's expectations and assumptions. The researcher must shift from a natural attitude to a phenomenological attitude, while striving to maintain an ability to be surprised and sensitive to the unexpected (van Manen, 1990). However, according to Gadamer (1975/1989), understanding is also always dependent on our preunderstanding. Hence,

professional background and practical experience combined with an open mind and critical reflection are crucial for acquiring new insights.

### ***Recruitment and participants***

The inclusion criteria were first trimester pregnant women aged 18 or older, who were undecided about having an abortion, at gynecological outpatient clinics in six different urban and rural districts in Norway. They had to speak and understand Norwegian. These women had been given more time for consideration than usual, due to expressed doubts about the decision to end the pregnancy. Usually they had an additional appointment within the next weeks, depending on how far their pregnancy had progressed. The women were asked to participate in the research by the nurse or medical doctor they had talked to during their consultation. Women were chosen with care in the recognition that they were in a vulnerable life situation.

Thirteen women, aged 18–36 years (average 25.6 years), were included in the study. Five went through with an abortion, six continued the pregnancy, one miscarried, and one is unknown. Nine were in a relationship with the man by whom they were pregnant and six had children. Three had earlier had a planned abortion and two had had a miscarriage. Ten women were employed; of these, one had a master's degree, four had a bachelor's degree, and five had completed high school. The last three were high school students at the time the interviews were conducted. The participants were recruited from all six outpatient clinics. In total, 26 women were asked to participate and 18 gave written consent. However, five later declined before the first interview was arranged. Reasons for declining were shortage of time, lack of childcare, or increasing nausea.

### ***Data collection and analysis***

To gain a comprehensive understanding of the women's experiences of being unsure during the decision process, we arranged for two interviews: one before and one after the women's final decision. Conducting interviews both before and after the decision made it possible to grasp changes in the women's experiences related to doubt over time.

Data collection lasted from February to December 2015. The first author conducted 23 individual in-depth interviews, lasting between 60 and 140 minutes (average 98 minutes). The first interview was conducted between the 6th and 12th week of pregnancy, and the second between one and four weeks after the final decision. Three of the 13 informants were interviewed only once. The first had started the abortion before the scheduled interview because of an overwhelming pregnancy-related nausea. A follow-up interview was not carried out with her. The other two did not have time for a second interview and contact between the participants and the first author was terminated via text messages.

An interview guide with some broad topics was prepared to assure that the same phenomenon was in focus in all interviews. In the first interview, the women were encouraged to talk as freely as possible when describing what had happened in their lives after they suspected they were pregnant. At the end of the first interview, an agreement was made to conduct the follow-up interview. The researcher sent a text message to re-establish contact. In the meantime, the first interview was transcribed and relevant issues were highlighted. Even though the guide for the second interview was individually adjusted, the opening question was related to the experience of the uncertainty: "Can you please tell me how it felt to have to make a decision?" The interviews were audiotaped and transcribed verbatim by the first author.

In analysis, we used NVivo 10/Software to organize the voluminous text material, making it easier to go back and forth between interview text, themes, and reflective notes. During the whole analysis process towards the final results, the following authors (MK, RTS, ALM, EA and EG) were involved. CC started commenting before the discussion of the findings started. Carrying out phenomenological research involves a set of data collection and analysis activities that are inseparable (van Manen, 1990). Each interview was read and reread separately by three of the authors, to capture the significant meaning of the interview as a whole. For the ten informants with whom we had a follow-up interview, the two interviews from each woman were read as a whole. Each of the authors came up with suggestions for preliminary themes based on the interview(s) from each woman and across all the women. Then, the whole research team jointly compared the preliminary themes based on interviews from each woman and across all the women. Finally, by reflecting on variations across all the preliminary themes, three final themes emerged that together constitute the essential meaning of the phenomenon of being pregnant and ambivalent in the first trimester. In this process, the four fundamental lifeworld themes, or existentials, recommended by van Manen, were helpful as guides for reflection. The reflective questions were: How were the lived body, the lived time, the lived space, and the lived relations experienced by the woman when she was uncertain? Were these lived experiences different from the time before she became pregnant?

In these processes of reflection, the art of writing and rewriting was of crucial significance (van Manen, 1990). The text was approached to capture the fundamental meaning or main significance of the interview as a whole. For the ten informants with whom we had a follow-up interview, the two analyzed interviews from each woman were synthesized. Aspects or qualities of the phenomenon "to be unsure about whether or not to have an abortion" were described as unique and preliminary themes from each of the 13 women's lived experiences. Finally, by reflecting on similarities and differences across all the preliminary themes, three final themes emerged that together constitute the essential meaning of the phenomenon of being pregnant and ambivalent in the first trimester.

## **Ethical considerations**

The Head of the involved hospital departments and the Regional Committee for Medical and Health Research Ethics (2014/1276) approved the study, which was designed in accordance with the Helsinki declaration (WMA, 2013). Participants were recruited from different areas to protect anonymity. The women received written information about the study and an invitation to participate. They gave written consent. The researcher met with the women in private meeting-rooms at the hospitals or at the university in the area where the women were recruited. A trained nurse was available after the interviews.

## **Findings**

The findings present the experiences described by the small subset of pregnant women who were unsure about whether or not to have an abortion. By verification of the pregnancy, the women were confronted with their own readiness and faced a new reality. They experienced the decision-making process as a lonely journey toward a definite conclusion during which their values were challenged. They demonstrate the various aspects of the burden the women described when having to make an independent decision within a short timeline.

### ***Confronting one's own readiness***

The pregnancy meant that the women were thrown into a reality that challenged their life projects. The women's reactions and attitudes depended upon their preparedness. When pregnant, the timing related to their age, partnerships, and awareness of support became prominent. Women's considerations and experiences might change during the limited time they had to decide whether to terminate the pregnancy and were influenced by bodily ailments and fluctuating feelings.

### ***The turmoil of the pregnant body***

Before the pregnancy, the women had thoughts about *readiness* – when and if they wanted (more) children. Some had talked about it with their partners, although they did not always agree. Only a few women had planned the pregnancy, while several described various challenges related to contraception. The expectation of controlled fertility and the shame they described when conceiving at the wrong time indicated that the women blamed themselves for having failed to protect themselves against an unwanted pregnancy. As a married woman who had discontinued hormonal contraceptives after side effects described it: “So after that, we used a condom. And it is clear that this may fail. So then, it was just simply an accident. I should really not have been here now. I do know how to protect myself.”

Suspecting a pregnancy meant awareness of bodily signs like tender breasts, dizziness, nausea, or a missed period. Most women obtained a pregnancy test as soon as the suspicion arose. Those that had an expectation of being infertile or protected

appeared to be less aware or tried to explain away the signs to themselves. Deferring the pregnancy confirmation gave a shorter time for decision-making. Even if they had verified the pregnancy by a test and the bodily signs reminded them, this new reality might feel unreal and hard to take in. Some described how they tried to keep the thoughts away, even if they were there all the time. They found thinking about the pregnancy was exhausting.

Verification of the pregnancy set women's feelings in motion and raised questions about readiness for caring for a child. They expressed their feelings as combinations of happiness, surprise, shock, despair, and self-blame. One woman said: "It was sort of a joy, but it was too early for it to happen." To some it felt more like a catastrophe. One woman in a newly established cohabitation said: "I had doubts from the beginning. From the moment I sat with a positive test in my hand, I was terrified. Suddenly my life was turned upside down – everything would change."

Verification of the pregnancy might mean being thrown into a process of reorientation. Women transitioned from an idea that it might happen to considering whether they could or would go on with the pregnancy. For those who had planned the pregnancy, it might have been a vague decision or a deeply felt desire, but when it became real, they were unsure about their readiness. Some felt happiness and anticipation despite the fact that the pregnancy was not planned. However, during the following weeks, the good feelings toward the fetus and/or the partner might change. An experience of being caught in a pregnant body with ailments for months and then being tied to the child and/or the man arose. These feelings contradicted an expectation that they would be happy for a child and be in love with the partner. The absence of good feelings might be interpreted by the women as a sign in favor of terminating the pregnancy.

Considerations related to whether the women were ready to give birth now, later, or never were affected in varying degrees by bodily changes. Bodily symptoms occurred gradually during the first weeks and were interpreted as hormones influencing feelings and the health condition. Symptoms varied and could be experienced as "not being myself." One woman in the 11th week, who for several weeks had been considering whether she was able to handle an abortion or to be a single mother of two children, said: "I think the most difficult combination is to be uncertain and filled up with hormones."

Awareness of timing and age suddenly appeared obvious and influenced what leeway they had. Some adult women referred to a personal upper age limit for being pregnant and regarded this pregnancy as their last chance. The younger women did not want to have a child before they had completed their education and had a stable relationship with a partner. This comported with their mothers' warnings. A woman described it as shameful to be a teen-age mother: "That was the mindset I had been taught: 'You must not become pregnant early and you should be done with school'."

Being pregnant made the women increasingly aware of their plans and living conditions. They considered whether their economy and living facilities were suitable and in some cases had to check if it would be possible to complete their

education, keep their jobs or realize their plans if they went on with the pregnancy. Some described all these questions as “a mess” they had in their mind and found it complicated to check out, because of limited time and feeling nauseous and exhausted.

### ***Shortage of time to decide***

Thoughts about when fertilization had happened became prominent when calculating how far into the pregnancy they might be, and thus how much time they had to make the decision. The pregnancy test could give an indication, but for some it was not trustworthy. Some did not know the timing of their last menstrual period, which was needed to calculate weeks of gestation in their pregnancy and needed an ultrasound examination. This could take time, since several women were not aware that they could contact the gynecological outpatient clinic directly. Some were shocked when the gestational age based on the ultrasound turned out to be older than expected and felt the pressure of the decision even more. One woman described her reaction to ultrasound at the outpatient clinic believing she was five weeks pregnant like this:

From the ultrasound I learned that I was 11 weeks pregnant! I was totally shocked that I had gone so far. That the baby had developed so fast. Because I thought the test I took was exact, but it was not.

The legal limit for terminating the pregnancy was described as stressful. However, despite the pregnancy ailments, most women used several weeks to decide. Some were close to the limit when they arrived at the clinic. The women described several factors that increased the stress of their experience: the time passing, the continuing uncertainty, and finally, the increasing bodily symptoms. In addition, thoughts appeared about the fetus growing. They described this as the feeling of a ticking clock or an emotional roller coaster:

Up and down all the time. It's been so intense and tiring. Tiring to be pulled one way and then the other and the same thoughts just spinning round and round. Having to think about it all the time. So tiring.

For some, the nausea increased during the first weeks. For one it reminded her of her preceding horrible pregnancies and she described not being able to stand the suffering. She went back to the hospital the next day for the pills. After the abortion, she blamed herself that she did not use more time searching for solutions.

### ***Considering available support***

The women described an improved or critical attitude toward the man by whom they were pregnant and asked themselves what he would be like as a father and a partner. This meant noticing his capacity for support, his caring qualities and willingness to let go of his own needs to cover for the needs of the mother and a potential child at a human and practical level. Even if the man wanted the pregnancy to be continued and was able to contribute financially, the women felt they were mainly responsible

for the child, and not the least, the pregnancy would depend on her. As described by one woman who feared that a third child would be too much for her to handle:

So, there are two different things. One is my own health. I have tough pregnancies. There are no good births, but that's okay. I think that that takes a certain time, nine months and now I'm done with almost two, right? But what comes next, that's it. With two children who require a lot and a small child too. And then there is all the work. This means that essentially everything falls on me; I cannot handle it again.

Several women described changed feelings for their partners and wondered if these transformed feelings, described as “not being myself,” could be explained by pregnancy hormones or the discontinuation of medication for some due to the pregnancy.

During the weeks they were struggling to make their decision, several women considered their future as a couple. Some started and some ended a relationship. For those who realized that a stable relationship would be impossible, considerations and awareness of how the partner would act as a single father and a collaborator became relevant. Some had noticed the man's interaction with the children and ex-partners he already had. These observations might contribute to concern for the future if she should become attached to him. A single mother described her considerations when the cohabitation ended in the 11th week of pregnancy: “I know that if I keep this child, I will never be done with him. However, if I have an abortion it's a relief to know I'm done with him.” If their partner would not or could not be there, the women considered on whom they could rely, should they go on with the pregnancy. Due to illness, some needed support in order to care for the children they already had. In addition to a partner, the person most frequently mentioned when considering those on whom they could rely, was their mother. This did not mean that they involved her in the decision. Some specified they did not talk with their mothers because she was known to oppose an abortion or had expressed a desire to become a grandmother.

### ***A lonely journey***

Having to decide on her own meant a tension between openness and secrecy. The women expressed a need to talk to a limited number of their close family or friends, whom they trusted and who would not disclose their condition. Disagreement with the partner or others heightened the women's feeling of loneliness. Health personnel who did not engage with them contributed to their sense of isolation. Throughout this lonely journey, they described a tension between being able to openly discuss the situation with others and at the same time not being swayed by the opinions of others.

### ***Controlling openness and secrecy***

To be pregnant and uncertain meant both a feeling of responsibility for making an independent, well-considered choice and, at the same time, an urgent need to involve significant others. The women described searching for a space for quiet contemplation. This might mean withdrawal from social life. One of the younger women described this as her “thinking-bubble”:

I did not sleep well at night and was not particularly social. Was a little more private and thought a lot and did not do much. I would be alone and listen to music and walk the dog and just be by myself a bit.

The assessments and the early pregnancy were described as a private matter, but bodily signs such as nausea and fatigue could challenge the wish for secrecy. As a woman who chose her husband and her best friend as her only interlocutors described it:

In addition to being sick all the time, you also have to hide it from your colleagues at work. For I feel, why should I mention it? When first: It's not their business and second: It is not certain that I will keep it.

When involving others, the women searched for someone they could trust and who would not judge them. The fear of being judged was to varying degrees prominent in all the women. Several, who usually had an open and trusting relationship with their mothers or sisters, for instance, considered this situation to be extraordinary and kept quiet in case they decided to have an abortion. They did not expect any understanding. However, to some, their relatives became the most important dialogue partners and supporters. In these trusting confidential discussions, some women would for the first time gain insight into family members' experiences and deliberations regarding their own past abortions. To involve significant others meant getting support and new perspectives but might also increase the burden and influence the decision. Limitless support, such as: "I'll support you whatever you chose," was given by several of the partners and others involved. This statement was perceived by some women as not very helpful when they had asked for advice or wanted to openly discuss the possibilities. It might also cause uncertainty as to what degree their partners or others involved were supportive.

In their situations of uncertainty, some women needed insight from others in similar situations. Given the wish to keep the pregnancy secret, they searched the Internet for other women's experiences. Some were disappointed at how little they found on the topic.

Even though the conversations with significant others appeared to be highly important to the women, such conversations might not help them reach a conclusion. As expressed by a woman who had planned the pregnancy with her boyfriend but became ambivalent when she became extremely tired and afflicted by nausea due to the pregnancy: "But I do not feel I have gotten any further with the few I've talked to so far. I still feel the same high level of uncertainty."

### ***The difficult silent disagreement***

The partner's attitude was at times of particular importance. To be uncertain meant to decide whether the woman should involve the partner and to what extent his attitude toward her and a possible child would be significant. Most women did involve their partner in the decision-making, although they believed that the responsibility for the final decision would be theirs alone. The woman's body had

to carry the weight of whatever she chose. However, she would listen to her partner and consider his thoughts on the situation. Some women were exposed to pressure from their partners to have an abortion and asked themselves whether it was right to have a child that might threaten their relationship as a couple. One woman described it like this: “I have thought I have to have an abortion, as he is afraid our relationship will end if we have a child.” Another woman described a value-related gap between them. While she thought of the fetus as a life, she described his attitude as follows: “Because he is like: ‘No, there is nothing there yet’.”

Other partners wanted the women to continue the pregnancy. A married woman who was still personally uncertain when she decided to continue the pregnancy at the end of the 12th week said:

I have thought about it a bit: “Does he really think that he will not bear a grudge against me if I had decided to have an abortion now?” The whole time he has said he would support any choice I make. Anyway, I have been a little uncertain about it. Whether he really does support me fully on an abortion.

Several of the women described their male partner as “resigned” and said that he felt powerless when he argued with her. Some of the men said they did not understand the woman, yet wanted to support her in what she believed was right. However, knowing that he embraced her stomach while she was pregnant, contributed to a fear that he might get attached to the fetus.

The choice women had to make negatively affected the tone of the partner relationship. Some couples became quiet. This was described as not understanding each other’s values which complicated the dialogue and attempts to reach agreement.

### *Feeling alone when meeting experts*

Encounters with health providers were important to the pregnant women and increased awareness of the providers’ attitude toward them. The lived experience meant expecting respect and a basic trust to receive good care; alongside this was a fear of the provider’s critical eye and caution about potential judgment. Several women described unmet expectations in conversations with a health provider in relation to her doubt. One woman, who had not talked to anyone but her partner, said:

I’m one who likes to figure things out on my own. But in this situation, I would have liked someone to chat with. A neutral person at the clinic who could advise me on the one or the other, or that I could talk to.

However, the feeling of shame at being caught in an unplanned pregnancy and considering termination could be a hindrance for presenting the need for counseling. As a married woman, a health professional, said:

I think you are so vulnerable that you cannot make yourself do it [ask to have a talk about doubt]. I think for my part there is some shame related to going through with an abortion.

Feelings of being ignored, abandoned, or met with an unsympathetic attitude from health personnel increased the sense of being left on one's own. One woman described her encounter with the physician like this:

When I started talking about the situation [the ambivalence], she interrupted me. I had the examination and when we came back she said: "That's more or less what you expected, isn't it? Will you sign the consent right now?"

Encounters characterized by interest, involvement, and insight into the particular woman's situation from health personnel were described as relieving some distress. Some women said they knew that health personnel could not solve their problems or give advice, but they could contribute to a feeling of being met with a nonjudgmental and open-minded caring attitude.

### ***Values in motion***

The women expressed a fundamental respect for the fetus. Although they did not think of it as an independent life, they felt resistance to removing the fetus and took precautions to protect it. The situation led them to consider the value of the unborn life against the life they were living. They questioned whether they should continue the pregnancy at any cost. They appreciated the right to self-determination at the same time as they experienced how demanding autonomy can be.

### ***Respecting a new life or assessing the value of the present life***

The women used different words to describe their imagination related to what they were carrying. Descriptions varied from a profusion of eggs and sperm, a pea or a berry, or a small body. The women believed the fetus was constantly evolving, and this increased the difficulty of terminating the pregnancy. As expressed by a woman who had two children and had had an abortion some years ago: "I feel it is a life and that I am going to take a life."

They asked themselves if the pregnancy was meant to be, and in various degrees described a sort of closeness to the fetus. This found expression in protecting the fetus by withholding teratogenic medications, starting folic acid, and refraining from smoking and alcohol. Some expressed concern that the fetus would be damaged during the gynecological examination. Awareness of the fetus was intensified when they came to the clinic and in particular by the ultrasound examination. Most women were not shown the picture on the screen. To some this was a relief, to others a disappointment. One said she secretly looked at the printout of the ultrasound image when the provider left the room. Although they had all seen pictures of fetal development in books and on the Internet, the ultrasound was described as something more trustworthy.

Concurrent with the thoughts about carrying a life, being pregnant meant making deliberations related to what would be a worthy life for the fetus, for the woman and for the family she already had. Women compared it to sitting in the

middle of a balance barbell. What mattered to the women could range from “living life in the right order” by getting married or completing an education before having children, to not being ready for responsibilities and obligations. Their assessments also included whether their own “life projects” could weigh more heavily than the fetus’ chance for a life or their partner’s wish for a child. Their relationship with their partner might have a major impact if they thought they could offer a child a good life. Several women did not expect to share childrearing responsibility with a partner. With the sole responsibility and/or pregnancy-related health problems, carrying on with the pregnancy felt insurmountable. For women in stable relationships as well, a termination of the pregnancy might be considered appropriate both due to their own health and the children they already had. One had a chronic disease progressing during pregnancy. She decided to have an abortion, and said afterward:

The thought that I had when I sat with the tablets was really: “Now I’m doing it.” I thought: “I do this for my family. I have to do this for us to function.” And I know that I must be strong, I have to be healthy for the family to work. And that was it.

The moment when they had the pill in their hand and had to make the final, irreversible decision of whether to swallow it or not was described by many women as the worst. Predicting the consequences for the future was difficult. Would they regret the termination? Some, at that moment chose not to go through with the abortion. One woman compared her feelings when sitting at the outpatient clinic with the pill in her hand to: “Standing on the edge, ready to jump.”

### *Realizing the difficulties of autonomy*

The women were unanimous in their gratitude for having been given the opportunity for choice in relation to their pregnancy. At the same time, they described it as unreal, being in this situation, considering abortion, and said they would have preferred to avoid this. Several of the informants mentioned a wish for a miscarriage that would free them from the responsibility to make a decision. Despite the fact that they felt affected by the opinions of others, they also had a strong awareness of freeing themselves from the influence of others and making an independent decision. Some of the younger women felt the pressure to have an abortion from their mothers. One of them described her final decision to go on with the pregnancy like this: “So I thought in the end that: No, it’s my life and I decide. So now I will just leave it there.”

Several had conflicting views with their partners, and this might increase their uncertainty. For the women in established relationships, making a choice in line with her conviction but in conflict with her partner’s might pose considerable challenges. “It is his child as well” was a recurring expression. The responsibility for the decision was perceived as particularly burdensome by a woman in a marriage she described as close and trusting: “I have been thinking that: ‘Boy, it’s not just my choice, we are two. You must be with me in the decision because I cannot make it alone.’”

Even if making the decision alone felt like a strain, several women described a feeling of pride at having reached an independent decision they knew was right for them. It gave them a sense of becoming stronger. As described by a woman who said she felt weak while she was uncertain but felt strengthened by independently working through the arguments so that she was able to stand up for her decision to choose abortion: “I notice how strong all this has made me.”

### *An existential choice with complex implications*

The women described a calmness attached to the sense that their final decision was correct, and a sense of relief at having made a choice in accordance with their own values. At the same time, both those who continued the pregnancy and those who had an abortion described a subsequent inner turmoil. For some it was more difficult than expected to control and keep away distressing thoughts. One woman, who terminated the pregnancy, put it like this:

I am completely at ease with the decision I have made. I know that it is impossible to undo. But at the same time, I think, sometimes, “Oh, what have I done?” It gets to me, but then again I think: “Oh, I am glad it’s done!”

Continuing the pregnancy meant for some a concern for feeling “emotionless” in preparing for the arrival of a child. This resulted in dreading or delaying informing others about the pregnancy so as not to reveal their lack of emotional involvement. The pregnancy might also provide unforeseen challenges to the relationship to the child’s father, in other relationships, and with regard to socioeconomic factors such as job, education, and housing.

Several had made their choice against their partner’s desire. For those who choose an abortion, this might result in a tacit agreement not to talk about it and to try to put it behind them. One of the women who, despite her partner’s unequivocal desire that she should have an abortion, had chosen to continue the pregnancy experienced to her relief that he changed his attitude after the choice was made. She said that their partnership had emerged stronger from the difficult times and that they both rejoiced in the future arrival of a child.

Independent of what they chose, it proved to be important to the women that the considerations of whether to terminate the pregnancy or not remained a private matter not to be talked about. They did not want others or the child they expected to know that they had considered an abortion. “Almost like feeling a bit guilty in a way. That you have been having such thoughts,” said one woman who continued the pregnancy.

## **Discussion**

This study adds to existing knowledge by revealing what characterized Norwegian women’s lifeworld experience of uncertainty when considering whether or not to terminate a pregnancy. The findings show that when the women realized they were pregnant, they were confronted with the question of whether they were *ready*

for a pregnancy or not. The confirmation of pregnancy was the beginning of a *lonely journey* where they had to make a definite and autonomous decision within a limited time frame. They had to realize that they faced an existential choice where former *values* had to be reconsidered. This situation changed their lives in many ways. To better understand the meaning of these changes we will discuss them in the light of phenomenological lifeworld philosophy, focusing on the four fundamental lifeworld existentials and relevant research.

From the moment the pregnancy was confirmed, the women started to consider their *readiness*: “Is this the right time to have a child?” and “Is my body ready for a pregnancy?” As human beings we have a temporal way of being in the world. This temporal landscape is constituted by dimensions of past, present, and future (van Manen, 1990), not in a linear sense but as a circular understanding, where events in each dimension affect each other. In their new situation, women had to rethink their previous life projects and were forced to take a stand as to their future within a short timeline. There was no longer an obvious connection between the past and the future. Most women in this study had not planned the pregnancy. Rather, they had made other plans for their near future, including projects like traveling, education, careers, and partnerships. Even though most of them did want (more) children, this could be realized later. Now, they had to face a new future in which earlier expectations and hopes had changed character.

The women’s narratives about being pregnant and unsure described a body in turmoil rather than a ready body. The experience was illustrated by the metaphor of being thrown onto a roller coaster. They compared it with a bodily journey at high speed accompanied by an awareness of having something invisible on board which they soon had to decide whether to take care of or remove.

Being pregnant is a condition that is inevitably linked to a woman’s body. Lived body (corporeality) refers to the phenomenological fact that we are always bodily in the world (van Manen, 1990). Although some women in this study attempted to keep their awareness of the pregnancy at a distance during the first weeks, an increased attention to the pregnant body became, for most of them, impossible to avoid due to ailments and fatigue. The feeling of being nauseous and exhausted is a common experience when pregnant. According to van Manen (2014) we perceive our own body with our own body. Hence, there is no way to escape this corporeality; we can never perceive the world from any other perspective than from the body. Merleau-Ponty (1945/2012), referred in Bengtsson (1999), writes that a changed body will change the perception of the world. The women described how they became aware of their changed and unpredictable bodies but were unsure whether the changes would disappear quickly or last the entire pregnancy. Pregnancy ailments affected the women’s perception of the situation. In retrospect, they wondered if the bodily changes could have influenced their assessment of the situation.

Nevertheless, bodily changes also confirmed their fertility or bodily readiness to give birth, which they all, regardless of age, described as fascinating. At the same

time, some of the women felt a bodily weakness that did not correspond with readiness but rather with despair. These complex feelings of both bodily fascination and despair were experienced as frustrating. Complex emotions in early pregnancy, including both happiness and despair, whether the pregnancy was planned or not, has been described in previous studies (Kjelsvik et al., 2011; Kirkman, Rowe, Hardiman, & Rosenthal, 2011; McIntyre, Anderson, & McDonald, 2001). These studies have all described a tension between the women's positive feelings about the pregnancy and the realities in the context of their lives as a whole, which made them consider an abortion.

Even though the women acknowledged the pregnancy to themselves, most kept it hidden from others. This bodily secret together with changed relationships, in particular with their partners, may explain the women's description of the decision process as a *lonely journey*. We always both reveal and hide something about ourselves in our physical or bodily presence (van Manen, 1990). It is possible that the women during the first weeks of the pregnancy managed to conceal their pregnancy from others, but they would probably also have revealed that something had changed. They described it as important to hide the bodily signs of their pregnancy so as not to reveal their condition. For those experiencing discomfort, this could be difficult.

Although the women managed to keep the pregnancy hidden from their social worlds, this secret may be revealed in the future. When a woman's mother or sisters were involved in her condition, they may introduce her to their own abortion experience that had been kept secret for years. This has also been reported by Canadian women who confided in significant others (McIntyre et al., 2001). Some of the women in the current study would continue this tradition of secrecy due to fear of being stigmatized. Stigma may function as a means of social control toward a poor moral record (Goffman, 1963, p. 165). We wonder how the knowledge of this topic can become part of our common knowledge, if nobody talks openly about it. Studies illuminating abortion stigma (Hanschmidt et al., 2016; Kimport, Foster, & Weitz, 2011) indicate that the women use secrecy to prevent negative judgment from friends, family, community, or society. The secrecy comes at the cost of experiencing social isolation, loneliness, or suppression of emotions.

Furthermore, the women described an experienced tension between independence and dependency. They strove to create a peaceful room for reflection for themselves. Simultaneously, they considered involving someone close they could trust and with whom they could discuss the situation without being swayed: "Relationality is the lived human relations we maintain with others in the interpersonal space we share with them" (van Manen, 1990, p. 104). Meeting others allows us to transcend ourselves by developing a space for conversation. Pregnancy changes human relationships. In spite of the expressed need for meeting others and sharing their complex situation, some women chose not to involve those close to them. Studies from legally restrictive settings show that some women even chose to not involve their spouses (Kebede, Hilden, & Middelthun, 2012; Shellenberg et al.,

2011). This seems to be less about the illegality of abortion and more about keeping it secret from other people to avoid social stigmatization (Shellenberg et al., 2011). However, all the women in the current study involved at least one person, usually the man by whom they were pregnant. As previous studies have demonstrated, the partner's attitude appeared to have a special position and became particularly important for how the woman perceived the situation (Kimport et al., 2011; Kirkman et al., 2009; Purcell, 2015; Trybulski, 2005).

Some of the pregnant women changed their feelings toward their partner and this seemed to cause existential loneliness. The future responsibility for a child made them assess their partner in a new way; they wondered whether he would accept the responsibility for raising a child, and whether he would be a good father. Even in established relationships, existential loneliness may occur. An existential loneliness, however, can only be experienced by missing relationships with others (Heidegger, 1927/2010). Contradicting views between the partners might result in silence in their partnership, a silence that continues after the final decision. As a result, the women expressed feelings of being alone in the decision-making process, during the abortion experience and after the abortion. This was also the case for some of the women who continued with the pregnancy. Existential loneliness in established partnerships when the woman was uncertain about what to do, or if the couple had contradicting views, has also been described by McIntyre et al. (2001) and Trybulski (2005).

When struggling to reach a decision, the women's conflicting *values* and the society's norms meant a threat of being judged. Individual choice and the principle of autonomy are celebrated as ideals in health care as well as in other arenas in Western society (Beauchamp & Childress, 2013; Mol, 2008). However, in real life the women had to consider the complexity of reality. Principles alone are not sufficient (Jonsen & Toulmin, 1988). The women in this study undoubtedly wanted to be autonomous in the sense of being responsible for the final decision of whether or not to terminate the pregnancy. Simultaneously, the decision was a situation they did not want, and many described a wish to be exempted from liability by a miscarriage before the time limit expired for a legal abortion.

The women's considerations related to whether or not to seek an abortion took into account their conflicting ethical principles and values. Even if the value of autonomy was dominant, it was also important for the women to protect the fetus, to respect their partner's views, to consider their family's needs, and at the same time, to adhere to the norms of society.

For those who already had children, those children's needs were balanced against the worth of the life of the unborn child. Their conflicting values are revealed by the women taking bodily precautions to protect the fetus, and at the same time making preparations for terminating the pregnancy. Even though they struggled with bodily ailments and had a corporal awareness of something growing inside them, most women gave themselves more time while they made their assessments and considered their conflicting values.

Within the partnership, the conflict of values regarding an abortion was for some due to differing assessments of the fetus. While some thought of the fetus as a life, others would, for instance, put higher value on strengthening the relationship, or prioritize the woman's health condition. Such conflicting values created a feeling of distance in the relationship and increased the woman's feeling of uncertainty and loneliness. "When I am lonely I feel a lack of intimacy, and this lack of intimacy colors my entire world," writes Kirova (2002, p. 158). The women's assessments were influenced by the partner's values and his attitudes might be decisive for her choice.

The amount of time devoted to deliberation emphasizes how much the final decision regarding abortion meant for women. This can explain why some arrived late at the clinic, still undecided. However, none of the women in this study used the opportunity to apply to the commission for a second trimester abortion (Abortloven, 1978). In contrast to the women in this study, most Norwegian women who terminate a pregnancy make their decision within the ninth week of pregnancy (Løkeland et al., 2017). This means that special attention should be given to the late arrivers who seek abortion in outpatient clinics. They might still be uncertain.

Regardless of what they chose, the final decision, and thereby the end of the time for deliberations in the decision-making process, was the hardest point for most of the women in this study. Painful feelings related to the intake of mifepristone at the clinic, and descriptions of it as an emotionally charged act, are in accordance with Swedish women's descriptions in interviews one week post home abortion (Kero, Wulff, & Lalos, 2009).

The women who were still privately trying to balance their conflicting values during the consultation at the outpatient clinic, assessed whether there was space for openness about their feelings of uncertainty. Women's shyness about disclosure led them to read and interpret nonverbal, bodily cues of the health personnel. "When we meet another person in his or her landscape or world we meet that person first of all through his or her body" (van Manen, 1990, p. 103). A kind and caring bodily attitude from health personnel created the possibility for a trusting conversation of the women's ambivalent feelings regarding the decision. In contrast, a dismissive bodily attitude made women who were still uncertain choose not to involve health personnel in their doubts regarding the decision. Not being given proper room for reflection at the outpatient clinic increased feelings of loneliness for uncertain pregnant women. "We shape space and space shapes us" (van Manen, 2014, p. 305). Lived space is shaped not only by natural and cultural objects but also by social relations. As a consequence, health personnel should be acquainted with the doubt and the loneliness women might feel when they arrive at the outpatient clinic. This requires openness to and awareness of the woman who is considering whether or not to have an abortion. The finding is in line with studies aiming to describe the women's anticipations and what they would want to discuss with their providers about pregnancy options. Most women wanted health

personnel to recognize the woman's moral conflicts in decision-making and to be treated as moral decision-makers and given emotional support (Altshuler, Ojanen-Goldsmith, Blumenthal, & Freedman, 2017; French, Steinauer, & Kimport, 2017; Rocca et al., 2015).

### **Methodological considerations**

The study was strengthened by the robust number of participants and the possibility to carry out two interviews with most of the informants. Women represented variation in age, pregnancy experiences, partnerships, educational level, geographical belonging, and were highly expressive. For the first author, being an abortion counselor for several years may be a threat to the openness required in a phenomenological study. At the same time, this experience may also increase the sensitivity to the women's situations. Throughout the research process, the first author strove to gain a new and deeper understanding of the experienced uncertainty by sustaining an open stance to the women's descriptions, and by seeking to maintain a critical doubt regarding her own understanding.

Discussion about the research interview's potential impact on the decision or whether it might increase the participant's burden – resulted in the view that the harm would be less than the benefit of being given attention and time to reflect upon the situation when interviewed by a trained counselor. The researcher's goal was not to influence the women's choice. Several of the participants stated that participation had been useful. Although a trained nurse was available to the women after the follow-up interview, no one contacted her.

### **Conclusions and implications**

The study has focused on the small subset of women who are unsure about whether or not to have an abortion when they arrive at the clinic. The experiences of these women have received little attention in prior research. The results presented are unique and contribute to the knowledge base related to how the women's lifeworld changed when pregnant and uncertain of whether or not to have an abortion. These complex changes related to the body, relations, and society happened simultaneously, and they were intertwined. Women were confronted with their own readiness related to their phase of life, their life projects, and relationships. The bodily symptoms of the pregnancy and the limited time for deciding influenced their awareness.

The women presented a tension between independence and dependency. In order to arrive at an independent decision, they strove to create space for quiet contemplation. In order to keep a possible termination of the pregnancy secret, the women limited the involvement of significant others. Those involved were to varying degrees involved in or distanced from the complex considerations. In total, this resulted in an existential loneliness for women.

When struggling to arrive at a decision, the women's conflicting values and the society's norms, which meant a threat of being judged, were prominent. Regardless of the final choice, the study participants experienced a feeling of relief and a wish to leave the previous struggle behind.

The study has contributed to deeper insight into how women experience the complex existential decision-making process when pregnant and ambivalent in the first trimester. It is important for health professionals to be aware of the loneliness described by the women, when caring for those who are still unsure when they arrive at the outpatient clinic. Individual emotional support for women who have difficulties deciding whether to terminate the pregnancy or not may be beneficial and help the women make a decision in accordance with their own values and might improve their well-being. To enable this, health care professionals must get involved and obtain time and expertise to meet the women's needs.

Findings from the study may be of interest to several professionals who consult with pregnant women who struggle to make a decision about abortion. That some women change their minds along the way may show that practical situations in real life are more complex than what may be solved by just applying abstract principles. Such insights into the women's experiences of having difficulty deciding is also an important issue in the social debate, and may be of public interest, as anybody may find themselves involved in assisting an uncertain pregnant woman. Increased knowledge about these women's experiences may also contribute to reduced abortion stigma in society.

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