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# 'You Will Have These Ones!': Six Women's Experiences of Being Pressured to Make a Contraceptive Choice That Did Not Feel Right

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**Abstract:** This study aims to contribute to an understanding of women's experiences of contraceptive counselling, and of being pressured to make a contraceptive choice that did not feel right. Six women in Sweden participated in semi-structured interviews, which were analysed through interpretative phenomenological analysis. The results were organised into three themes: (1) *The normalisation process*, i.e., the ways in which the women experienced using the contraceptive were being promoted as a natural part of womanhood; (2) *Drawing the shortest straw*, i.e., the women's experiences of encountering insensitive caregivers; and (3) *Feeling like a guinea pig*, i.e., the women's sense of not being allowed to control the situation and make their own choices. In conclusion, the experience of not being respected in the healthcare system could lead to consequences not only for women's sense of self-efficacy with regard to contraceptives, but also for their willingness to engage in renewed counselling. The caregivers' communicative skills are, therefore, of prime importance.

**Keywords:** contraceptive choice; contraceptive counselling; communicative skills; self-efficacy; interpretative phenomenological analysis

## 1. Introduction

Contraceptive consultation in Sweden aims not only to promote reproductive health, but also to make women feel content and secure in their choices (Swedish Medical Product Agency 2014). International research (e.g., Dehlendorf et al. 2017), as well as midwife advisory literature (Kaplan 2009), also emphasises that caregivers should provide opportunities to discuss the client's requests, and enable the establishment of trust in the caregiver. Several studies further point to a connection between women's consistency of use and how they perceived the counselling given (Dehlendorf et al. 2013; Donnelly et al. 2014; Sköld and Larsson 2012). Caregivers could, in other words, have a very large influence on the contraceptive choice made, as well as the consistency of contraceptive use.

However, as Dehlendorf et al. (2013) note, few have studied what women value in these consultations, how the caregiver presents his or her recommendations, and how this can influence women's choice to start, continue, end, or change their contraceptive method. Belfield (2009) further emphasises the importance of the context in which the choice is made: How is the information given, perceived, and understood? How is the quality of the care and treatment perceived? These questions have not yet been studied extensively, and studies have focused even less on women's negative experiences of contraceptive consultations and the potential consequences of these experiences.

Donnelly et al. (2014) argue that it is essential to study how women are affected by low-quality consultations and counselling, especially as this may hinder their capacity to make an informed choice, which, in turn, could end in inconsistent use or ceasing contraceptive use completely. Furthermore, several studies (e.g., Donnelly et al. 2014; Higgins et al. 2016) have found that it is not unusual that

some women feel pressured to follow their caregivers' recommendations. As these experiences are relatively unexplored, this study set out to explore women's experiences of contraceptive consultations. More specifically, we focused on the experience of being pressured into making a choice that did not feel right.

## 2. Previous Research

The majority of research concerning contraception is medical, quantitative, and primarily focused on themes such as accuracy, consistency of use, patterns of contraceptive use, unintended pregnancy, attitudes toward contraceptives, and sexual behaviour (Belfield 2009). There are several factors that influence men and women's contraceptive choices, including whether or not they will use them. Some of these are education, economy, lifestyle, age, and religion (Lamvu et al. 2006). However, as mentioned above, the context in which the choice is made is also important.

Most people wish for friendly, confidential, and unprejudiced treatment from their caregivers. Patients wish to be treated with respect, being listened to and understood, and permitted to ask questions and raise concerns (Belfield 2009; Jaccard and Levitz 2013). Furthermore, studies (Dehlendorf et al. 2013; Donnelly et al. 2014) have shown that women value autonomy higher in contraceptive choice than in any other medical issues. However, the caregiver's involvement is still, to some extent, appreciated, especially concerning information about conceivable options. Thus, communication skills, such as questioning technique, the use of appropriate and accessible language, careful listening and non-verbal communication have important influences on how the consultation is perceived (Belfield 2009).

The contraceptive consultation can be viewed as a conversation in which the participants share information about lifestyle, wishes, and methods. The final choice should always be the individual woman's, because the caregiver's role is to ensure that her choice is made in a meaningful way, based on knowledge that suits her lifestyle and self-image, and, furthermore, strengthens her confidence in using her contraceptive correctly and consistently (Kaplan 2009; Jaccard and Levitz 2013). If she sees herself as a 'naturalist', then adding hormones to her body will not fit her self-image and she might, therefore, not use it correctly or consistently. It is, therefore, of note that many women in Sweden have become sceptical towards hormonal contraceptives and the associated side-effects that could affect their psychological well-being (Ekstrand 2008; Wiebe et al. 2012). The counselling could, therefore, be experienced as problematic if the caregiver disrespects the women's concerns or preferences. Moreover, De Irala et al. (2011) reported that hormonal alternatives are more often chosen on the basis of caregivers' suggestions, rather than on the women's own wishes. Donnelly et al. (2014) further found that women considered the side-effects and safety of the contraceptive to be more important than caregivers did.

As mentioned, many women fear or worry about the possible side-effects and risks of contraceptives. If such feelings are not dealt with at an early stage, there is a risk that women not only lose their trust in the caregiver, but also feel insecure about their contraceptive and how to use it correctly. Extensive research (Donnelly et al. 2014; Jaccard and Levitz 2013; Sköld and Larsson 2012) shows that this concern for, or experience of, unwanted side-effects is one of the primary reasons why women dismiss, change, or stop using a certain contraceptive. This should, therefore, be part of the consultation. However, Wätterbjörk et al. (2011) found that caregivers have different opinions on this matter, some believing that information about side-effects are unnecessary, because there is an all too great risk of discouraging women from safe options. Others, according to Dehlendorf et al. (2013), fear that it could create a so-called nocebo effect. However, they found that discussing these matters may actually have a beneficial effect on women's adherence, which is difficult to reconcile with such a nocebo effect.

Previous research (Belfield 2009; Donnelly et al. 2014; Jaccard and Levitz 2013) has shown that women do not always believe that healthcare providers possess adequate knowledge or wish the best for each individual. Donnelly et al. (2014) confirms this depiction by finding that women often receive

outdated or erroneous information about contraceptives from their caregivers. Furthermore, as both [Belfield \(2009\)](#) and [Donnelly et al. \(2014\)](#) argue, the care given is sometimes based on the caregiver's prejudices or assumptions concerning women's motivation, ability, or need. These prejudices and assumptions could be expressed through censoring, giving limited information, or by pressuring the women to make the choices that the caregiver believes to be suitable. Due to this, some women reported that they had been treated poorly, and that feelings of anger and frustrations arose from not being listened to or understood.

Together, these findings point to a number of barriers within the practice of contraceptive counselling, and shared decision making seems to be an exception rather than a rule. Indeed, [Dehlendorf et al. \(2014\)](#) identified three approaches to contraceptive counselling among caregivers (foreclosed, informed choice, and shared decision-making), and showed that as much as half of their studied caregivers used the former, foreclosed approach, wherein the practitioners gave information about methods that patients explicitly mentioned, but did not introduce other methods or partake in the final decision. Moreover, it is worth noting that when caregivers get the chance to express their own perspectives on the challenges to contraceptive counselling, they do engage in self-criticism, e.g., that they lack relevant knowledge, have negative beliefs about certain contraceptive methods, or rely too much on patients to initiate discussions. Yet, at the same time, they also point to the patients as the potential problem, e.g., that they arrive with fixed preferences, only reluctantly speak about these issues, or are all too inexperienced ([Akers et al. 2010](#)).

### 3. Method

#### 3.1. Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) tries to offer insight into how individuals interpret and ascribe meaning to their experiences ([Smith 1996](#)), and has been used in a broad spectrum of studies within health psychology (for an early review, see ([Brocki and Wearden 2004](#))). One assumption in IPA is that there is a connection between what an individual feels, thinks, and does.

IPA is, furthermore, built on an ideographic methodology, and has drawn inspiration from both phenomenology and hermeneutics ([Smith et al. 2009](#)). The search for the 'lived experience' comes from phenomenology and implies that we can only understand psychological experiences if we ask people with direct experience of the phenomenon of interest. Interpretation is a contribution from hermeneutics, and implies a focus on how an individual has come to interpret and make sense of particular experiences. As [Smith and Osborn \(2008\)](#) add, there is a so-called double hermeneutic, as the analyst also attempts to interpret and make sense of the individual's interpretation of their experiences.

#### 3.2. Participants

We recruited participants through a purpose sample with a specific criterion: Women who share experiences of being pressured by caregivers to make a contraceptive choice that did not feel right. [Smith et al. \(2009\)](#) argue that this type of homogeneous sample is well in line with the ideographic interest of the method. The sample represents a perspective rather than a population.

The participants were recruited through information sheets placed in several universities and adult education facilities in the mid-region of Sweden. A shorter version was also shared on Facebook by acquaintances of the first author. Forty-three women answered the inquiry, of which six were able to participate within the project's timeframe. [Smith et al. \(2009\)](#) recommend 3–6 participants in order to avoid the danger of being overwhelmed by the amount of data.

The participants' pseudonyms and ages are as follows: Lovisa (27), Maya (28), and Julia (30), who all first started using contraceptives around the age of 15, and Alicia (30), Elsa (30), and Olivia (31), who were between 19 and 23 at their first meeting with contraceptive caregivers. All participants had, or were about to finish, some form of higher education. Lovisa worked as an estate agent, Maya as a consultant, Alicia as an economist, and Julia within culture and media. Elsa and Olivia were currently

studying at university. They all shared the experience of being pressured to choose the caregiver's recommendation, rather than following their own wishes, both in their youth and in more recent years.

### 3.3. Procedure and Ethics

Analyses through IPA demand rich data, and the participants have been encouraged to both speak freely about their experiences and to further reflect upon, and develop, their understanding of them.

The interviews were conducted by the first author through open-ended, semi-structured questions, prepared in advance, partly to give essential focus on various thoughts and feelings, and partly to make the situation more comfortable and relaxed (Brinkmann and Kvale 2015; Smith et al. 2009; Smith and Osborn 2008). In order to test these questions, the first author conducted a pilot interview with a friend in the same age range as the participants. Thereafter, a few linguistic changes were made, and some new possible follow-up questions were added.

This pre-made guide consisted of four areas. The first area allowed the participants to share personal information about themselves. For instance, they were asked to state their age, occupation, and their current birth control method. The second area focused on the women's attitudes towards contraception before they started to use contraceptives, as well as on their expectancies and fears. Each participant was, at this point, allowed to provide her own narrative of her experiences, which provides opportunities to see what parts she takes to be important herself (Brinkmann and Kvale 2015). The third and fourth areas consisted of follow-up questions to the free narrative. More specifically, the third area focused on the participants' meetings with caregivers, how they experienced their options, and how the feeling of being pressured came about, whereas the fourth area targeted what happened afterwards, for example, focusing on the feelings that were present as they left these meetings, and how they look back on these events. Examples of questions include the following: What did you expect from the caregiver before the meeting? Was it possible for you to inform the caregiver about your preferences and fears? Why did you agree with the caregiver's suggestion? Can you describe exactly how you felt pressured by the caregiver? How did you feel when you left the meeting?

Since it is important that the participants feel comfortable during the interviews (Brinkmann and Kvale 2015; Smith et al. 2009), they were given the choice to decide where it would take place. Five women wished to meet in public, while one felt more comfortable in the privacy of her own home. The interviews, recorded with a dictaphone, lasted for an average of 72 min, and were verbatim transcribed in close succession to the interview itself.

The study was conducted in concordance with the ethical principles of research in Sweden, including informed consent, confidentiality, and usage rules (see Swedish Research Council 2011). The study did not fall under 'The ethical review act' (SFS 2003, p. 460) and, hence, did not require ethical clearance.

### 3.4. Analysis

In our analysis, we have followed the six steps presented by Smith et al. (2009). In the first step, the transcription of the first interview was read alongside the playback of the recording, with only minimal entries. Secondly, linguistic and semantic content were analysed, sentence by sentence, with a focus on what seemed important to the participant. In line with recommendations, this also included a special attention to the participants' explicit or implicit use of metaphors. Thirdly, these initial notes were transformed into codes and abstract sub-themes by constant questioning of what each note said about the participant's experience. The creation of sub-themes provided the opportunity to later compare and contrast the participants' experiences. In the fourth step, these sub-themes were placed in clusters, sorted by different connections, and turned into themes. The fifth step repeated this process through the remaining transcriptions, where the same codes and themes were used, as well as new ones being added. In the final step, all themes were grouped with their participant, to thereafter be compared with patterns between participants, including similarities and differences.

Some themes and sub-themes were re-evaluated, modified, or removed, a process that continued until distinct boundaries between themes could be drawn, while still representing the material as a whole.

#### 4. Results

There were three major themes from the analysis that were tied closely to the experience of being pressured in contraceptive consultation: The normalisation process, drawing the shortest straw, and feeling like a guinea pig. These will be presented below with the use of quotations from the transcripts to illustrate these women's experiences.

##### 4.1. The Normalisation Process

It is of note that this particular theme only concerns the women's experiences and thoughts about their first contraceptive counselling, and the general attitude about contraception at that time. In particular, they all point to a common pressure from both their close social environment and their caregivers to choose 'the pill', without seriously considering the potential consequences.

##### 4.1.1. A Rite into Adulthood

The women started using contraceptives at different ages and for different reasons. Alicia, Elsa, and Olivia felt that condoms were a safe option, because this protected them from more than just unwanted pregnancies, and, therefore, they were somewhat older when they first started to seek another contraception option. Maya was somewhat younger when she first started to use the pill, but it was because she needed this help to create a balance to her 'very bothersome' and irregular periods. Lovisa and Julia speak more strongly of another reason, but the other women do also mention it. In Julia's words:

But, from what I can remember, many friends ate the pill, and it wasn't like I, well, you were normal, and that's what you did [ . . . ] It was like something you should do. Kinda.

In this way, the participants hint of a positive view on how contraceptives, or especially the pill, can create a sense of entering womanhood, as it is described as something one should do at that age. Both Julia and Lovisa said that they felt like adults at the time, although they now, in retrospect, view themselves as still being young and naïve at the time. The pill could, thus, be viewed as a rite into the feeling of adulthood—to a new phase in life. However, it can also be interpreted to contain the wish to be like other young women and, therefore, not singled out as different. From both these points of view, meetings with caregivers can be seen as something positive, as the women sought the pill and received the pill. Nevertheless, the caregivers strongly contributed to the normalisation process of the pill, because when the participants describe these early meetings, they all emphasise that they had not been offered any other options, nor opportunities to ask about any other options. Furthermore, this normalisation process became even more apparent in later consultations when the participants, on their own initiative, wanted to speak about other options and were questioned for wishing to do so.

Another experience the women shared was that they did not initially think about how their contraceptives affected them. Julia continues:

Everyone ate the pill. And I didn't think about it then, that it could affect me. That it actually did.

Since the women viewed their usage of contraceptives as something that belonged to their gender and age, they did not reflect about how it affected their well-being, and neither did the caregivers inform them of this beforehand. It was only later that they started to feel this connection. Julia argues that, when she stopped after several years of contraceptive use, she 'felt like [herself] again'. Although most of the women do not regret using contraceptives in their youth, they wonder if the feeling of belonging and normality is really worth years of dampened happiness, decreased sex-drive, and the feeling of not being themselves without ever *understanding* why.

#### 4.1.2. The Female's Responsibility and Duty

Before the women sought contraceptive counselling, they all held different expectations and attitudes towards contraception. However, they all shared the belief that it was viewed as their responsibility and obligation, as women, to use contraceptives. Maya says:

It is the girl's obligation, unfortunately [ . . . ] because it still is, like the girl's fault if it were to be . . . yeah . . . a child that wasn't really planned for.

This obligation that Maya mentions not only concerns women's moral reputation (i.e., the risk of falling outside the norm of motherhood if they have an unplanned baby in the wrong stage of life), but also concerns their responsibility to their partners. As the quote shows, it becomes the individual woman's 'fault' if she were to become pregnant. Alicia describes exactly this responsibility shift when her current boyfriend suddenly refused to use a condom. Julia too, speaks about this shift of responsibilities, and she thinks it is sad that it seems to be the consensus among her female friends. This view is further strengthened by caregivers' perceived lack of interest in questions of non-hormonal alternatives, and that the use of condoms alone was not seen as 'safe enough' by them. In this sense, a strong bias in defence of the pill seemed to form among all parties involved.

Elsa and her boyfriend felt satisfied with the use of condoms at first, but later felt that they wanted to try something else. She felt calm and confident when she made the call to the clinic, but already on the phone, she was met with what she experienced as accusations: 'Why haven't you called before?'. She is not alone in this experience. Olivia got the feeling that she had asked for the pill five years too late:

Yeah, well, like it's something I should want as soon as I'm old enough to have sex. But it's not like that, sort of. That's not how I see it, to even have to explain that you can't get pregnant if you're not with someone—and to a midwife! That's insane.

Both Elsa and Olivia experienced it as offensive to have to give explanations as to why they had not used hormonal contraceptives before, and it can be said that they felt singled out as different and as irresponsible because they had not followed the norm and started in their teens. Typically, their partners' potential involvement in the decisions was *not* discussed, very much in line with the theme of this section. Being questioned in this first contact has affected Elsa and Olivia deeply, and they returned to this intrusion several times during the interviews.

#### 4.2. Drawing the Shortest Straw

All of the women describe meetings with caregivers who were sensitive and understanding, and who did not impose their own values on them. However, they all also speak about meetings with insensitive caregivers. According to Julia 'it kinda feels like drawing the shortest straw'. Both she and the other women realise that these 'short straws' will always be there, and that it is primarily these caregivers who have pressured them into making choices that they felt were wrong.

##### 4.2.1. The Lost Focus

All women speak of situations in which they felt that the focus of the counselling shifted away from finding an option that suited their current life circumstances, but it is most apparent in Maya's and Elsa's narratives. They both felt that the focus immediately shifted to their weight. It was not about finding a suitable solution for today, it was about how they should change their lives so that they could pass the criteria to the more optimal options. Maya says:

But it's like, it's like being back in primary school again. Where you were called 'fatso' [ . . . ] so it gets like this, the confidence isn't at its best [ . . . ] Like I'm still, I understand everything, but at the same time I go home and ruminate and get a bit sad about everything. Uh, because I feel like that's not the reason I went there, to be told that I'm overweight. You actually went there to get help.

Maya shared this experience with Elsa, and partly with Olivia, who decided to stop using the pill after rapidly having gained weight. She then sought an option better suited to her own needs. However, like with Elsa and Maya, the focus was placed on how she was supposed to act to lose the weight without switching contraceptives. Lovisa and Julia speak about this experience as well, saying that the consultation ended up as a debate rather than a professional, informative meeting. Lovisa speaks about the feelings she got when she asked to try a copper IUD instead (which the participants often understood as the most important non-hormonal alternative to the pill):

And then she got like ... she got ... she got defensive at once [ ... ] so ... and it, our conversation went sour immediately. So ... it was hardly possible to discuss and we weren't really on good terms when I left either.

Lovisa and Julia felt that the focus in their consultations was on the argumentations—it was a battle to present the better argument. They did not feel that it was about alleviating their concerns or finding a solution suitable to their wishes. Lovisa left this mentioned meeting empty handed, because she felt that they were 'still so far from each other'. The feeling that she was not 'on good terms' with her caregiver when she left further indicates that she had experienced it more as a quarrel. In other words, Lovisa did not experience this as a dialogue about the pros and cons of her desired option, but rather as a critique of herself. She states that she 'felt so criticised', and not only regarding her own wishes, but in relation to her own characteristics, as well. Lovisa said that it 'was hardly debatable' to choose a non-hormonal option, and the other women shared this feeling. Olivia describes it like it 'wasn't something I should want', and that her caregiver did not show any understanding of her wish. Julia also speaks of this feeling of being questioned when she asked for a copper IUD:

But ... then she said it like this, 'Yeah, but why don't you take the pill then?', she said. And [ ... ] although I knew what I wanted, and ... was very direct about it, she had to persuade me to something else that I didn't want. [ ... ] I think it's awful, that it's needed, that you have to explain again and again ...

Julia said that she felt frustrated during this conversation, and it is quite apparent that it was connected to both her caregiver's negative tone and that she had to repeat her arguments. This shift of focus brought with it feelings of being blamed, and some of the women hinted towards this emotion, whereas others stated it outright. Julia continues:

She was kinda, like, placing blame on me, like this, 'Do you really want this?' and 'It'll hurt to insert it' and 'Shouldn't you take the pill instead?' and so, like, [ ... ] she made me feel bothersome.

Julia said that the feeling of being blamed arose from the feeling of being bothersome, that it would be 'so much easier on everyone if [she] took the pill' instead. Her narrative shows that she experienced that her caregiver was trying to change her mind. There are also signs that she felt that her caregiver projected her own beliefs onto her, that she *should* want the birth control pill instead. This, in turn, could be viewed as a source to feeling blamed, being bothersome, because she does not produce the *right* answers. Maya too speaks of this:

And then there is that sigh, and you feel 'Oh Lord, I'm sorry I exist, but you wanna feel good too'. I get that feeling sometimes.

In Maya's statement, the sigh could be seen as morally charged, implying that she does not resemble the compliant patient, i.e., that everything would be so much easier if she were to agree with her caregiver's opinions. To Maya, this feeling is probably worsened because she returns for new consultations 'quite often', in which the focus is often directed at her weight: If she only weighed a little less, then she might be able to try something else. The way their caregivers used the blame game is something many of the participants felt diminished their own abilities.



#### 4.2.2. Treated Like a Child

Before their meetings, all of the women expected to be allowed to feel like an adult, and to make their own choices. However, this was not always the end result, and they all share the experience of not being allowed to participate in the decision making process. Maya says:

Well, they listen, but it feels like they have their ideas. So, sure, they listen to me, but it feels like it mostly goes in and out because it isn't of interest. Because it won't do anyway. What they have, on their table, that's what's gonna help.

Maya stresses that she feels like her caregivers are listening to her, but, at the same time, she states that she did not receive any answers as to why her wants and wishes are not suitable. The repetition of the phrase 'sure, they listen', followed by a 'but' indicates that she does not feel that her caregivers genuinely listened, since, when the choice is already made, there is no need to do so. The feeling of the choice already being made is reflected in all of the women's narratives. This is how Elsa describes her first meeting:

'You will have the mini pill. You will have these ones!' . . . and then she filled out the prescription, and I didn't even have time to, like, protest! She just, she was already writing on that prescription-eh-thingy [ . . . ] But it was like, there wasn't more! I couldn't protest! It wasn't possible to protest!

In Elsa's description, there is a feeling of not being allowed to contribute to the decision at all, and, like Maya, she never got any chance to discuss it. It is plainly visible that she felt surprise at how fast everything happened, as she felt that she did not even have time to assemble a protest. It also seems as if she felt suppressed by the thought that her caregiver did not even consider her consent as a requirement. This is reflected in the way she characterises her caregiver's words, 'you *will* have' and not 'you *should* have'. Olivia shares this experience and said that her caregiver 'like, didn't even care' about her side of the conversation, because she was too young to 'take the risk with non-hormonal options'. Lovisa too expresses this lack of participation:

Because . . . I kinda experienced it like she petted my head. And that I, that I wasn't allowed to make my own decision.

Lovisa's way of expressing herself indicates that she did not feel she was treated as an adult, despite being in her twenties at the time. Her illustration of receiving a pat on the head, and not being allowed to make her own decision, could be seen as resembling the parent-child relationship: The adult has the responsibility to make decisions about the child, because he or she is not yet mature enough to make the right ones. Maya's description, that her caregiver had the only solution, and Elsa's thoughts of how the decision was made for her, can also be said to reflect the parent-child relationship.

Lovisa, Julia, and Olivia speak of the same feelings after asking for copper IUDs. The only explanation they received was, as Lovisa said, 'that isn't for young girls', which further undermined their own self-images of being grown women in their twenties, with higher education, employment, and their own living arrangements. Both Lovisa and Olivia reacted strongly to being placed in the category of 'young girls', which, according to Olivia, has a completely different meaning than 'young women'. They felt stripped of their adult statuses and showed it by noting parental linguistic features. Julia says:

There were no arguments. It was the nagging. And that she, *she* sounded so firm.

That they feel treated like they are younger than they actually are can, here, be seen through the feeling that the caregiver was nagging. To describe it in this way, rather than as a discussion, further alludes to the parent-child relationship, and points to her feelings of being treated as a child. Similarly, Maya emphasises the feeling of 'being declared legally incompetent', whereas Alicia explicitly states that she was being treated as a child:



Well, ... like ... you, you know that attitude, 'yeah, yeah, but *sweetie*, let me tell you'. Kinda like you're a five-year-old who knows nothing [ ... ] when you're there alone and about to try to do something, then you want to ... be able to express yourself and be yourself. And then you get annoyed when you're treated like you don't know anything, and are five years old [ ... ] You end up at a disadvantage.

Alicia's frustration is not only directed towards her caregiver, but also towards herself because she could not maintain her adult role. She also describes it as if her caregiver 'pushed the pill' on her, although this was the only alternative she had felt uncomfortable about. Maya and Olivia speak of similar experiences in which they feel stuck in behavioural repertoires from their childhood years. Olivia explicitly said that she 'felt like a child', and described how 'the words got stuck' when she tried to present her arguments. Maya said that she became like 'little Maya again ... who is powerless' when confronted with the caregivers' ways of persuasion. Only two of the participants, Lovisa and Julia, express narratives of being able to claim back their roles as adults and remain strong in their wishes of contraception.

#### 4.2.3. Not Being Taken Seriously

Another large part of the women's narratives is the feeling of not having their fears taken seriously. Lovisa said that, even if she had acquired these fears through reading, she felt them 'too big a deal' to dismiss. However, she received no understanding of her fears in her conversation with her caregiver, who instead became defensive towards her wish for a copper IUD. In a similar way, Alicia speaks of a dismissive attitude towards her concerns, where her caregiver, instead, only emphasised the positive aspects of the pill: 'This is the safest there is on the market'. Maya too, speaks of this:

'Well, these, these aren't so bad! They won't get to your head!' Like, then there is that bit [ ... ] you're not being taken seriously.

Maya argues that her fears were dismissed, and that she was being viewed as silly for having these fears. She says that she felt 'de-prioritised' and 'not that valuable a human' when her concerns were not being taken seriously. Maya's descriptions fit Olivia's experiences as well, who states that she felt that she 'wasn't allowed to be afraid'.

Another aspect of not being taken seriously is the feeling of being patronised, a word which implies condescending treatment and of getting the feeling that others believed them to be stupid. Elsa describes a conversation on the phone:

'No, it's impossible. It can't be like that!' Like, it was like 'yeah ... but ... ' It was almost as if she was telling me that 'you don't feel the way you do', 'what you feel is wrong' [ ... ] And then I realise that I'm quite upset when I hung up.

Elsa's feeling of being upset can be interpreted as coming from having her feelings dismissed with an 'it's impossible', despite these feelings being genuine. Her reaction to being met with a 'what you feel is wrong' further shows that she felt patronised. This could, in turn, lead to other emotions, as Lovisa states:

But I, I felt more and more stupid. And, you question yourself [ ... ], your decision.

It is visible in Lovisa's earlier descriptions that she felt patronised when she had to say no to the pill over and over again, and she was told that her arguments were 'incorrect', despite feeling that she had read about the relevant issues in detail. This made her doubt herself, even if she still refused to start to use the pill again. She asked herself if she was just being 'silly', and questioned her course of action. Moreover, to question a caregiver is difficult, as Maya explains:

I kinda think that a doctor, or mid-wife or whatever, a gynaecologist, they should really be right so I can't argue with them. Then there is, if ordinary people try to argue or something

with a doctor then you'd probably get a scolding back! So, that is the feeling I have. So that's why you don't dare to argue with someone who knows. Or should know . . .

This line of thought is apparent in all women's narratives. They view the healthcare system as an authority, because, as Olivia expresses, 'it should help you feel well, not make you feel worse'. At the same time they all express thoughts about their caregiver as being 'educated' which also adds to the feeling of being at a disadvantage. They should 'know what they talk about', as Julia phrased it, or 'they must have greater knowledge than us', as Elsa expressed it.

#### 4.3. Feeling Like a Guinea Pig

The term 'guinea pig' has many strong connotations, and it is used by several of the women when they describe their feeling of having used contraceptives for many years. To many, the term 'guinea pig' refers to a powerless animal used in experimental testing, with no right to end its participation and no understanding of why and what is happening. Julia says:

I feel like this, that my body has been some kind of test-thing. Like, I have felt like a guinea pig for about fifteen years.

In similar ways Maya describes herself as feeling like a laboratory *rabbit* and Olivia like a *test-object*. They use these terms instead of the Swedish equivalent for human beings in research (*försöksperson*), where the emphasis is on the fact that we are not animals, but people with our human rights intact. The use of these metaphors shows that they felt that a part of their humanity had been lost in their meetings with caregivers. It might be the sense of being powerless that reflects the use of these metaphors, but the fact that the participants have spent up to fifteen years trying to find a suitable option can also play a role. Nevertheless, these explanations, along with inconsiderate attitudes from caregivers, might strengthen the feeling of being treated as guinea pigs.

Similar to Julia, Olivia said that her 'body was in their hands' and that she felt 'forced to hope for the best'. They both seem to make a distinction between themselves and their bodies, and describe themselves as lacking agency. Moreover, all women felt that the counselling often gets reduced to a quickly typed prescription. Maya says:

When you come, asking for help, you only get a prescription without any explanation. 'Try these, it might be great'. [ . . . ] So, you kinda get tired [ . . . ] you don't get the help you sort of wanted. Any kind of support, for that matter . . .

Maya speaks the strongest of her feeling of being a guinea pig. As seen above, she felt invisible: She had expected advice and support, but she felt that she only received a prescription with the slogan 'try these, it might be great!'. In agreement with the metaphor, she also expresses a frustration about the caregivers' attitudes, 'try it!', without any accompanying explanations.

Although Alicia, Elsa, and Lovisa do not explicitly describe themselves as guinea pigs, they still have experiences thereof. They, like the others, feel dismissed from the decision-making process, and their fears are not being taken seriously, which can be linked to the guinea pig metaphor, along with the sense of being denied information. After nearly nine years with the same contraceptive, Alicia experienced something that is still very vivid in her memory:

But, what she told me then, and that wasn't even brought up when I had my first meeting, which made me feel devastated inside, was that she asked me if I had predispositions for . . . uh . . . breast cancer [ . . . ] The horror if I had chosen something else! What would have happened then? [ . . . ] I was relieved to know that I had the right sort, but at the same time I got really concerned, why hadn't she brought it up back then?

Alicia dreads what could have happened if she had used a potentially dangerous alternative, without ever knowing about the risk. Words like 'devastated' and 'horror' show how close to danger

she felt. She also states that, if she had been given the other option, the one her caregiver originally wanted her to have, she would have 'felt like a guinea pig'. Thus, even though she has *not* felt like a guinea pig, the thought is not far off.

There is another emotion that all women had experienced, which Alicia puts into words: The feeling of 'being option-less', without choice. In hindsight, she cannot say if she would have chosen differently, but her experience of her choice would have been different. She states that having more information about how the contraceptives could affect her both physically and psychologically could have made her feel 'safer'. She describes her first three years as 'a hell', partly because she had not been aware of why her body reacted as it did. That these were 'very normal' reactions was the kind of information she would have liked to have been told in advance, not three years later.

All participants mentioned that they would have preferred to have been told more about the side-effects of the various options, and also about how those options worked to prevent pregnancies. For instance, Olivia, although not against abortion in general, had long since decided that she would never end a life created in her own body. Her major concern before meeting with a caregiver, and the reason she waited for so long, was based on the misconception that there were some options that prevented pregnancies in similar ways to an abortion. In the meetings, she always made it clear that whatever option she finally picked, it was not allowed to prevent pregnancy by 'causing miscarriages'. She later felt 'cheated' when she learnt that two of the contraceptives she had used could, in her opinion, have actually caused an abortion by preventing a fertilised egg from attaching to her womb. She expressed that this knowledge, although misconceived as an abortion, would have been crucial to her decisions about contraceptives, and that her caregiver should have provided this information. To her, this event not only meant that she had been misled into violating her own moral code, but also made her lose faith in the healthcare system.

Another experience the women shared was the feeling of not being allowed to switch or stop using their current contraceptives, which also ties in to the guinea pig metaphor. Elsa says:

I wasn't allowed to switch when I called about it [ . . . ] you almost get spooked about it. Because you think that . . . No, it isn't okay that caregivers, like, forces you to something you sort of feel in your body is wrong.

Elsa said that she had, for several months, felt worse and worse and, in the end, it was 'unbearable', not only to the people around her, but 'to [herself] as well'. It is understandable that a caregiver might want to know the reasons as to why she wished to switch to another form of contraception, but Elsa's strongest memory of the event was that they did not believe her reasons, and that she was, therefore, not allowed to either switch or stop. Not being allowed to decide over their own participation is the strongest association to the guinea pig metaphor, because, as a human participant in science, you are always entitled to opt out.

## 5. Discussion

In this study, the participants expressed several ways in which they had felt pressured by their caregivers into making a choice that did not feel right. This feeling was strengthened by the pressure the women already felt before their meetings, pressure stemming from themselves, from cultural norms, and/or from their boyfriends' refusal of condoms. It becomes the individual woman's responsibility to her partner, and to her society, instead of her own right, to decide on contraceptive use. All of the participants spoke of these emotions, and similar findings has been reported in earlier studies, as well all around the globe (e.g., [Brown 2015](#); [Brunner Huber and Ersek 2011](#)).

As mentioned earlier, recommendations from the [Swedish Medical Product Agency \(2014\)](#) state that highly-effective options should be prioritised. However, how these recommendations are conveyed to the women seeking contraceptive counselling, and how they may perceive them, have to be taken into consideration. It is obvious that when the participants of this study encountered these recommendations in use, they were experienced as predetermined choices, i.e., not choices at all.

A clue as to why the problem arises in the first place might be found in the fact that the participants describe themselves as 'young and naïve' at the time of the first consultations. As inexperienced patients, they were certainly vulnerable to the power asymmetry that often exists in medical settings (Pilnick and Dingwall 2011). Yet, only two participants depict themselves as eventually reclaiming a more adult or equal position in later consultations. This shows the strength of the institutional position and discourse. Although the participants certainly dare to speak up about their experiences in meeting with friends or an interested researcher, they do not necessarily do this in medical encounters. Caregivers with a more authoritative style can, therefore, easily get the impression of effectuating a series of smooth meetings, and this can, thus, lead them to repeat previously-used practices.

In particular, the apparent predetermined treatment was encountered when the women asked for non-hormonal alternatives, which their caregivers dismissed in favour of more highly-effective options (although the copper-IUD is included in these). Thus, the present study confirms Ekstrand's (2008) finding that women often sense that it is given beforehand that they should use some sort of hormonal contraception. This is unfortunate because women often experience various problems with such alternatives, as revealed in the present as well as other studies (e.g., Van Kammen and Oudshoorn 2002). Moreover, it hinders women from making informed choices in collaboration with their caregivers. As mentioned earlier, Dehlendorf et al. (2014) identified three approaches to contraceptive counselling among caregivers: Foreclosed, informed choice, and shared decision making. Through our study of a particular subgroup of displeased women, we would like to add a fourth one: An enforced approach. It is our belief that such an approach not only risks making the encounters ineffective, but may also prevent women from developing a sense of self-efficacy in relation to contraceptives and contraceptive counselling.

All participants spoke of being subjected to different forms of influence (persuasion, nagging, sighs, moralisation, blame, etc.) by their caregivers. Receiving such reactions to their actions and wishes can lead to changes in their expectations of further counselling. Previous studies (Dehlendorf et al. 2013; Donnelly et al. 2014; Jaccard and Levitz 2013) have taken note of the problematic situation women are put in when they do not view their caregivers as accommodating, and, as the present study has shown, there may be many negative consequences. It could, for example, lead to an experience of being unable to make a meaningful choice, and, thus, result in the choice of not returning for further consultations. It could also imply a weakened motivation to use a contraception method that requires a caregiver's involvement. Considering that contraceptive understanding is a powerful determinant of contraceptive use (Carter et al. 2012), it is particularly unfortunate if caregivers contribute to making women less prone to return for renewed consultation.

It is of particular concern that the women make use of a guinea pig metaphor when they speak of their sense of lack of control. They desire information and knowledge, not only about their options in general, but also about how it could come to affect them, why they should use a certain alternative, or why they are advised against another. They wish to be treated as mature adults, capable of making good decisions, regardless of their age, but fear repeats of their previous negative experiences. Moreover, as others (Belfield 2009; Donnelly et al. 2014; Jaccard and Levitz 2013) have argued, the participants also felt that their caregivers were rather unprofessional, and that they were more focused on getting to the end of the meeting than on their clients' well-being. They describe being bereft of their own agency, and fighting against this would, indeed, demand a strong sense of self-efficacy.

The experiences of not being seen or heard place emphasis on how important it is for caregivers to have good communication skills (Belfield 2009) and to avoid making assumptions about which contraceptives or methods are most suitable, instead, listening to women's requests and wishes. It is reasonable to assume that caregivers' treatment of their patients influences not only the latter's sense of agency and self-efficacy, but also their experiences of using different methods of contraception and, thus, their expectations regarding further use. The results of this study can, therefore, be of importance to healthcare professionals working with contraceptive counselling, because it provides insight into how they can be viewed by their patients, and what consequences this could cause for the women that

are treated. It is of importance that one knows how one is perceived, whether or not the conveyed picture is regarded as true or not. This could also provide a better understanding of women's reactions during consultations, and, thus, provide opportunities to both create a more trustworthy relationship between caregivers and their patients and to repair potential breaches of trust.

A few limitations of this research should be mentioned. First, it is crucial to remember that the participants of the study were a small sample of women who were selected because of their negative experiences of contraceptive counselling. Naturally, we do not have any reason to question practitioners, in general. Second, on a few occasions the participants also brought up positive experiences, which we, however, did not focus on. Thus, contraceptive counselling is perhaps rarely a black or white matter. Third, the findings of the study may not be applicable to other settings, particularly those with different medical or cultural traditions. It would be interesting to see further phenomenological studies of such alternative settings. Moreover, quantitative surveys of women's experiences of contraceptive counselling, perhaps with a cross-cultural design, would also be welcome.

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