The Hui Process:

A framework for counsellors to explore abortion decision-making

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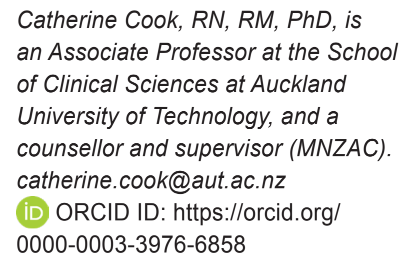

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Abstract

Abortion-specific counselling practices can fail to attend to clients' self-knowledge and lived experience. The intention of this article is to discuss the scope of counselling in relation to a decision about accessing an abortion, and to trouble frameworks that seek to fragment women's and pregnant persons' lives into pre- and post-abortion counselling segments. When stories cannot be told in a space that is free from judgement – or worse, when they cannot be told at all – silencing is inevitable. The context of this exploration is a regional publicly funded community-based sexual and reproductive health service in Aotearoa New Zealand. To explore the role of the counselling conversation throughout a person's decision-making, the Indigenous framework the Hui Process is integrated. The relationship-building principles of te ao Māori (the Māori world) in the Hui Process complement a narrative approach to companioning. Both narrative therapy and the Hui Process support cohesive approaches to offering a safe space in which people can be heard.

Key words: abortion; pregnancy; midwifery; Hui Process; Aotearoa New Zealand; Māori; narrative practice

Hannah, C., Kutia, S., Manea, T., & Cook, C. (2022). The Hui Process: A framework for counsellors to explore abortion decision-making. *International Journal of Narrative Therapy and Community Work*, (1), 67–76. https://doi.org/10.4320/HXLA8166
Author pronouns: she/her for all authors

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Introduction

Since March 2020, no-cost abortion on demand has been a right in Aotearoa New Zealand until 20 weeks gestation. This shift in legislation has repositioned abortion as a health issue, and service providers are now challenged to respond appropriately. Counselling is no longer a requirement, and the national services focus on physical care. The authors' concern is that the current discourse reduces abortion to being seen as equivalent to any other minor clinical procedure. The authors' preferred approach is to uphold the right to abortion, and to refrain from imposing meaning on this decision. This includes not erasing the possible significance of the decision for the person seeking an abortion. We see abortion decision counselling as addressing our clients' whole lives, rather than focusing on a single and fragmented episode.

In order to be helpful to those considering abortion, counselling skills are paramount. Narrative therapy has offered us ways of weaving counselling and midwifery practices together in this context. Narrative therapy draws from social constructionist ideas that critique universal truths and examine the ways that language shapes how people are positioned and how they make sense of their world. The cultural and gendered stories that circulate about fertility create considerable metaphorical noise that makes it very hard for people to hear their own choices and preferences. Our approach to therapy is to companion the people that consult with us, taking time to create 'spaciousness' through curiosity and questioning to enable people to hear their own expertise about their lives (Frank, 2018).

The collaboration of the co-authors-informs this paper. Chris Hannah identifies as Pākehā (of European settler descent). She was born in Aotearoa New Zealand and is a midwife and counsellor. Tiziana Manea identifies as a manuhiri/first generation immigrant of Italian culture and language and is a midwife and counsellor. Catherine Cook identifies as Pākehā. She was born in England, and has a long history of research in women's health and pregnancy, including working as a cultural ally with Māori colleagues (see for example Cook, et al., 2018; Cook, et al., 2014). The shared work of these authors has been deeply informed by the guidance of Suesanne Kutia, Te Aitanga a Hauiti te Iwi, a kuia (woman of status within her culture) who has shared tikanga wisdom (customary values and practices) and local knowledge that support the work. Suesanne's direction has enabled the development of a sustainable service caring for people considering an abortion. The relational work described within this article takes place in an area of Aotearoa where most of the population are tangata whenua (people of the land), and where there is the highest level of deprivation in the country. The collective commitment of the authors is to culturally competent abortion care in which women and pregnant persons are at the centre (Hannah, Cook, & Manea, 2019). Narrative therapy informs and supports the authors' work for social justice, and this is complemented by the Hui Process framework (Lacey et al., 2011).

The abortion decision-making counselling context

In the context of discourses surrounding abortion, 'counselling has the potential to replicate oppressive practices of the wider culture' (Crocket, 2013, p. 462). Our intention is to resist this potential by witnessing and honouring the stories that women and pregnant persons share with us in a space free of judgement.

Narrative therapy supports the idea that people's lives are multi-storied and have multiple possibilities. Freedman (2014, p. 21) has highlighted how therapy often is seen not as a place to tell and retell a story, but as a place where a third party will 'determine "the real" problem'. Taking a witnessing position, Chris and Tiziana engage in practices of listening, and in the retelling, the person may hear their own story for the first time. Tentative exploration can offer the person an opportunity to discover other aspects of life that are important to their story, helping them to develop meaning-making that reflects their values and hopes. A person presenting with an unintended pregnancy is seen as bringing with them an untold story rather than an isolated problem to be solved.

We hope that abortion decision-making counselling will shift from models prescribing pre-and post-abortion sessions, like bookends to a clinical procedure, to conversations about clients' wider lives: lives too often marginalised; lives with a past and a future; intricate lives. It is the authors' intention to speak of abortion *and* counselling as a journey; a continuum rather than fragments. The effects of the outcome are part of the journey. Preparing for the journey, storying and witnessing, exploring the person's meaning-making and the hopes and values that support them in the decision-making, are part of the preparation and may connect with other important issues in their life (Joffe, 2013, p. 60). The journey begins before the person attends the clinic. We provide clients with the opportunity to describe their experience in

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a holistic way, without having to separate out the clinical, social, relational and spiritual parts of their experience in dialogue with different practitioners.

Pregnancy is a period of liminality; of being between one state of being and another. This transitional process is typically presented as beginning with a pregnancy test or with the social acknowledgment of a pregnancy. The normative expectation is that this liminal stage will end in childbirth, with associated physiological and social rituals that mark the beginning of a new state of being (Purcell et al., 2017). Abortion stories disrupt the normative progression of pregnancy. Dominant societal norms often narrow the scope of people's lives, and when lives do not fit within that narrow scope, self-blame is only a small step away, creating a sense of dis-ease. The invitation to silence is ever present when a pregnancy does not follow the prescribed trajectory. What happens when important stories of our lives cannot be told or acknowledged?

> We need to tell someone else a story that describes our experience because the process of creating a story also creates the memory structure that will contain the gist of the story for the rest of our lives. Talking is remembering. (Schank, 1990, p. 115)

In the telling of the story, 'a future is also being created, and that future carries a distinct responsibility' (Frank, 2013, p. 61). In Chris's and Tiziana's experience as counsellors and midwives, the counselling conversation offers a space for an abortion story to be told; for loss to be acknowledged; for a possible future to be reimagined. The telling of a story allows the re-drawing of paths leading to new destinations (Frank, 2013). In the unfolding of the conversation, the before and after join rather than separating.

The Hui Process

Catherine's research team, including Terryann Clark, Ngā Puhi, studied Māori accounts of culturally safe care. They identified that clinical consultations that included a gynaecological examination were more culturally safe for Māori patients when practitioners' engagement mirrored the Hui Process (Cook et al., 2014).

The Hui Process (Lacey et al., 2011) was developed to teach medical students how to integrate the relationship-building principles of te ao Māori (the Māori world view) into their consultations to improve health outcomes for Māori. The Hui Process incorporates a communication framework with communicative steps that resonate with Māori. This framework provides a partial yet important move towards culturally competent practice, which in turn contributes to reducing health inequities (Lacey et al., 2011). The process described by Lacey and colleagues (2011) includes four key stages:

- mihi (initial greeting and engagement)
- whakawhanaungatanga (making a connection, primarily through shared relationships with people and land)
- kaupapa (attending to the main purpose of the encounter)
- poroporoaki (concluding the encounter).

The Hui Process is particularly appropriate when discussing topics that are tapu (sacred and set apart from everyday aspects of life) or connected to sexuality, fertility and whakapapa (genealogy). Adopting the sentiment that 'what is good for Māori is good for everyone' (Bishop, 2014), the Hui Process is used to guide connection with all of our clients. Attending to the steps of the Hui Process means that dialogue does not begin with what the person has brought to discuss, which might be sensitive to speak about; instead, connection is established first and threaded through the entire meeting. This approach aligns with narrative therapy's refusal to define a person by the problem they present with (medical or personal), and its attention to alternative storylines of life that may emerge during a conversation.

In conversation, Suesanne put into words the whakawhanaungatanga (process of enabling relationships) and manaakitanga (kindness, hospitality) that are part of the Hui Process, and which are manifested in actions rather than abstract concepts:

> You [as non-Māori] care for what the women are going through. You listen from start to finish and in the aftercare – they're not just forgotten. Culturally safe, yes – one hundred per cent. An example is the water – to be able to be able to sprinkle the water, and the karakia [ritual], they connect us to whānau, to being Māori.
>
> Getting them to trust – to trust us … a lot of our women are not versed in tikanga here, and that was the last thing on their minds when they accessed the service. Having a Māori face to

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move the service into a more nonjudgemental space, a comfortable space is important. I've been called auntie, nanny – I've looked after the babies while they were here, as whānau do.

For the time that the women are there, we are their family; I take the place of their mums if they can't be there. It's not just going in holding their hand; when they cry, I cry. We feel what they feel for that moment, showing no judgement on why they're there and they know that. We take them home afterwards [if women do not have transport], ringing them up later to see if they're alright. Homelife was shit for most of them, men in jail, they couldn't cope at times. So having the service locally is a benefit for our women.

The Hui Process as companioning

As counsellors and midwives, Chris and Tiziana commence the Hui Process with the mihi, welcoming the person and whoever they bring as support people. The connection continues to develop beyond the initial mihi. The connection developed at the whakawhanaungatanga stage is essential to ensure the person feels supported, heard, safe and cared for. The process of whakawhanaungatanga enables Chris and Tiziana to locate themselves in the mahi in a judgement-free space. They invite the person to occupy that space with them: 'implicit to whakawhanaungatanga, is the embodiment of genuine interest, concern, and hence obligation towards the patient' (Parry et al., 2014, p. 260)

Kaupapa follows, attending to the main purpose of the encounter. Themes explored include what has brought the person to the clinic; how they made their way there; the thoughts that accompanied them; how they juggled their time to get there; difficulties in making an appointment; and any geographical barriers. The dialogue often highlights resilience and courage in the face of adversity, stigma and normative judgement.

The social norms that position abortion as a deviant practice (Hoggart, 2017) in turn feed stigma and silence. Abortion stigma compounds secrecy (Cockrill & Hessini, 2014). Cockrill (2014) offers some useful ideas on what the opposite of stigma may look like: *connection* and *integration*. The Hui Process provides opportunity for this connection and integration; for the person to speak about their experience. The story unfolds: how they found out about the pregnancy; their body knowledges; their actions. For example, taking a test is not a simple action, but rather a series of steps and considerations: buying the test; managing the cost; when, where and with whom to do it; how to prepare for the result. For some, the moment they understand their fertility as a reality is a shock. In this collaborative effort of attending to the kaupapa, we are encouraged by Johnella Bird's suggestion to privilege discovery: 'I believe the person I'm travelling with knows more about this journey than they appreciate and in the journeying they will discover what is it that they now know' (Bird, 2003).

This collaborative journey positions counsellors as supporting persons in exploring their knowledges: how they manage difficult decisions and the history of decision-making in their life. This dialogue involves pausing, revisiting and exploring options. The collaboration includes considering what may change and the possible effects of these changes. Relationships, self-care and resilience are explored. The conversation is not split between 'pre- and post-' abortion, but rather entails supporting the person to have a sense of continuity in their relationship to self. Weaving their life experiences, values and hopes into the decision-making about an abortion creates a sense of continuity. The connection between making the best decision in the given circumstances and taking care of oneself following the decision are part of the same journey as a whole person, not a fragmented body-mind pre- and post-abortion experience.

Our position is that the provision of abortion counselling conversations addresses the persons' concerns, whatever they may be. Part of the mahi (work) is addressing dissonance, exploring ambivalence: not ignoring what is said, not ignoring what is observed. This involves 'making the "silent habits" of thoughts visible and thus more difficult to continue with' (Davies et al., 2006, p. 89). Those considering an abortion occasionally open the conversation with an expression like 'I don't believe in abortion'. They are carrying a huge burden with them. Exploring what it is that they believe in can help to deconstruct what they are faced with and how they might reconcile what they believe with the challenging decision they are making. Through seeking to provide a space sheltered from normative judgement, we align ourselves with the poststructuralist invitation to 'assist people to stop measuring their lives according to what certain social norms say life *should* be about [and to] consider how stories of our lives shape our lives and how therapy might enable the rich description of preferred stories of identity' (Thomas, 2020, p. 87). In the face of societal,

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cultural and internalised stigma, self-protective secrecy (Cockrill & Hessini, 2014), normative assumptions (Purcell et al., 2017), and ideas about deviance and moral transgression (Hoggart, 2017), the conversation cannot afford to ignore what is observed, what might have been discarded or discounted. This conversation may be the only opportunity the person is offered to be heard, to explore what is important to them: their preferred ways of being. Weingarten suggested that 'story is the antidote to silence' (2016, p. 207).

For Chris and Tiziana, practice comes from a position that people presenting with an unintended pregnancy must not have their lives diminished by moral judgement or indifference to their dilemma. It is our hope that counselling will offer the possibilities of the stories of their lives to support them. If stories cannot be told and memories cannot be created, then meaning cannot be made. Disenfranchised grief (Doka, 1999) must be acknowledged. Disenfranchised grief emerges from a loss that cannot be openly acknowledged or publicly mourned. In honouring the loss in an abortion, there is recognition of the values that have brought the person to make this difficult decision. Life extends beyond the problem, and by honouring the loss, opportunity and plans may become visible and clearer, and this may become a catalyst for change and personal growth (Neimeyer, 2004).

Abortion decision-making counselling is about people's lives. We believe it is the role of counsellors to support the person in finding what they need so that they can be resourced to continue their journey unscathed:

> The significance of telling a story and having another human being listen closely to it should not be underestimated. If the client has previously experienced exclusion and denial of voice, it is most important that the power of the counsellor be concentrated towards legitimation of that voice. (Winslade et al., 1997, p. 66)

A poroporoaki concludes the encounter. This ending offers an opportunity to review what has been said: captured words providing a testimony of the person being heard; the focus on what matters to the person. In closing the hui, Chris and Tiziana recap collaboratively: is there anything that needs to be said that has not been said or asked? The intent is to strengthen the connection, and to support the sense of possibility and hope that arises in the process of decision-making. Weingarten (2010, p. 7) has suggested that 'no one gives or provides hope to another, but rather one creates the conversational space for hope to arise from the forms of conversation one shares'. The counsellor carries the responsibility to provide that space, and to do this, we draw from the Hui Process to shape each subsequent meeting.

A story of practice

The following story of practice highlights dialogue that positions the person as courageous and as a moral agent in coming to a decision to have an abortion. The transcript also shows the wide-ranging kaupapa (discussion) in which a practitioner with both counselling and clinical skills drew together the hopes the woman had for her life and the foetus she would no longer carry, and identifies her support network, which extended to her mother who had recently died. The pragmatic and the spiritual were woven seamlessly into the conversation. Keita (a pseudonym) had been coming to our sexual and reproductive health clinic intermittently for about 10 years; not so often in recent years, but enough that there was an established relationship of trust with staff. On this occasion, she came with a four-month-old baby in his capsule, the youngest of her four children. He sat at our feet as we caught up. Keita is tangata whenua with whānau (extended family) living nearby. The recent death of her mother had been hard. Her partner, Jimmy, is a logger: off to work before daylight, home late to wash, eat, sleep and repeat the next day. Parenting fell solely to Keita who looked tired and was tearful.

Chris: What do the tears mean, Keita?

Keita: I have to do this [have an abortion], and it's all my fault.

Chris: It seems like you have been working through what you need to do. Can you share that with me?

Keita: It's about my life, I have to do this.

Chris: Are you talking about your life as a mum or is it about more than this, do you think?

Keita: For the children, for my mental health, for everything. I can't do another baby [crying].

Chris: This is a hard space for you – your love for your whānau is very strong in what you are saying. There seems so little space for you to care for yourself. Have you shared where things are at with someone else?

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Keita: Yes, Jimmy is sad too, but he knows we can't do it, and my sister – she's with me all the way. They both know this is the safest option for me.

Chris: There is a lot of taking care in what you are saying, Keita, a lot of love and consideration. If Mum were here with you now, what do you think she would be saying to you, Keita?

Keita: [There is a pause and more tears] Mum would want me to look after what I've got, take better care of myself and she'd want me to look after this baby [the foetus] properly too, even if I can't have it.

Chris: Do you have some ideas about how you might look after yourself a bit more?

Keita: Yeah, I'd like to have a bit of time out, a bit more control over what happens for me. I'd like not to be scared of having sex [due to fear of pregnancy], and to be getting a bit more sleep.

Chris: So I'm thinking reliable contraception would be something we could help you with, like the Mirena [an intrauterine device]. Have you heard about these?

Keita: Yeah, my sister's got one. She says it's choice [excellent]. Her periods are lighter, and she hasn't been worried about getting pregnant for years. I was going to get one, but I just didn't get on to it because I got busy.

Chris: Are the older three children in school and kōhanga [Māori immersion preschool]?

Keita: The two big ones are, but I haven't gotten on to organising for the third one. He could go – that would mean it was just me and baby for a few hours each day. Maybe I could have a sleep.

Chris: That sounds like a useful thing to get organised – give you a bit of calm in your busy life. I also heard you talk about 'looking after the pregnancy'. Do you have a plan for the care of your taonga [the treasured foetus]?

Keita: I want to bury the baby at Mum's feet, so she can take care of it for me.

Chris: Who will help you do this?

Keita: Jimmy and I will do it this weekend.

At this point, Chris offered an ipo, a burial pot for this purpose. Clinic staff commissioned these specifically to help women return their taonga (the treasured foetus) to the whenua (land). The sight of the pot soothed Keita a little. We planned for the abortion procedure to take place in two days hence. It would include the fitting of a

Burial ipo
Artist: Seymour May

Mirena intrauterine contraceptive. Keita planned to come alone as Jimmy would have to work. Her sister would care for the children but needed to be at work at 4pm.

On the day of the procedure, Chris provided Keita with support. To ensure the safety of the foetus's wairua (spirit), the window was left open so the spirit could fly. There was water for ritual cleansing and karakia (prayers to honour the loss). Keita was calm throughout the short process, which is conducted with conscious sedation. The Mirena was fitted at the same time. Keita slept for an hour or so afterwards, and then dressed to return home to the children with her taonga carefully packaged in its ipo. Keita reassured Chris that there was takeaway arranged for dinner as she kissed Chris goodbye.

Conclusion

This article shows how the integration of narrative therapy, with its social justice agenda, and the Hui Process framework can create opportunities for pregnant women and persons to be listened to deeply and to listen to themselves. We consider that providing this space for exploration involves an ethic of care, ensuring that the stigma and silence that surrounds abortion does not deny people the opportunity to contemplate this decision with supportive companionship. Drawing from the Hui Process ensures that the conversation is not solely a dialogue about abortion, but is rather an opportunity to situate this decision in the wider context of the person's life. The authors feel an obligation to speak up for the right to a counselling conversation that acknowledges the difficulties of managing fertility, that allows the expression of grief, that bears witness to resilience, and that enables people to voice their hopes about their future.

Concept guiding practice	Actions, comments, questions	Additional points, what to listen for
Manaakitanga Hospitality, kindness, generosity, support The process of showing respect and care for others	Introductions: meeting the woman/pregnant person as a whole person before discussion of abortion begins. This step may only take few minutes. It involves the counsellor sharing a bit about themselves and how they might be helpful. An essential step to forming rapport and humanising the conversation/consultation.	Notice the woman's/pregnant person's demeanour and body language. Are they at ease or tense? The counsellor's noticing may help them notice that they are being cared for.
Mihi Initial greeting and engagement	*Are there pressing needs?* e.g., time constraints, kids to pick up, lunch hour from work, school, somebody waiting.	Through attending to the needs, what is important to the person is made visible.
Whakawhanaungatanga Making a connection	*Who has come with you?* Include others in the introductions. Explore the connections: sisters, cousins, friends, partners. Ensure toys are available. Check ages of children. Be mindful of what is said in their presence.	Acknowledging who is important to them. What is important in their relationships Safety: will they be able to speak freely? Is there coercion? Can I ask questions in ways that will not exacerbate their vulnerability when they leave the clinic? Seize or create an opportunity to ask about safety when alone with the person.
Kaupapa Attending to the main purpose of the encounter The person and the presenting problem; the unfolding of their story	Opening the conversation, listening to the story unfold. *What brings you here today?* *How are you feeling today?* *I understand that you are pregnant…* *I have received a referral…* *Would it be okay to talk about what brought you here today?* *Are there hopes or fears about our meeting?* Check that it is okay to ask some questions. Explain the purpose of the questions: not to judge nor to influence the decision, but to offer an opportunity to revisit how or whether they have come to a decision. Inviting the person to voice their thoughts, concerns and hopes. *How did you find out you're pregnant?* *Did you have to buy the test?* (Wonder about or acknowledge their courage in buying a test kit at the supermarket or the pharmacy, money spent when on limited resources)	Noticing how the person refers to the pregnancy: 'it' or 'the baby' or carefully avoiding naming it. Using the person's language (rather than a 'correct' medical expression) is important. It validates how they express *their* experience. This helps to make the collaborative position visible. Making the person's actions visible: resilience, self-knowledge, courage in taking action, who stands with them. Listening to the ways they describe the embodiment of pregnancy – 'I just knew' or 'I felt sick' – opens spaces for invisible knowledges the person holds about their body. *'I missed a period'* may allow for a later conversation about fertility awareness, what is/isn't available to them, barriers or fears.

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Kaupapa (cont.)	*Were you alone when you took the test?* *When and where did you take the test?* *How did you prepare for the result?* *What was your reaction when you saw the test was positive?* *Who did you tell?* *What did you do next?* *What prompted you to act?* These questions often lead to how the person came to make the appointment. The counsellor becomes a witness to the journey so far. Focusing on *their* story, reconnecting with what happened and what is available to them to make meaning of the situation (thoughts, feelings, hopes, bodily knowledges, fears). The intention of the questions is to allow space for the person to voice experiences in their own words.	These enquiries open the conversation about self-awareness, resourcefulness, the important people in their life, hopes and coping strategies. Values connected with actions: self-care, 'getting it sorted', the courage required to make the appointment. Their values may emerge in the unfolding of the story, their initial bodily reaction.
Decision-making The person *and* the presenting problem, the unfolding of their story	*What helped you to make the decision?* *What might help you to make a decision?* Exploring effects of decision; revisiting important points that formed the basis for the decision. Connecting words with emotions. Remembering other experiences in life that may be of help in guiding them. Other perspectives, and tentatively |exploring possibilities: *What would happen if…?* *What might happen if…?* Revisit, pause. *Have you thought about how you might feel after the abortion?*	Exploring the history of decision-making in the person's life: tentative questions on self knowledges, what has helped them in the past, what has not been helpful in the past. Speaking the unspeakable: what would life look like, tentatively exploring multiple options. This may be the only opportunity the person has had to verbalise thoughts and emotions on this topic. Not trying to persuade; using the person's words; eliciting ownership of decision; gently addressing dissonance, ambivalence, tears and unquestionable certainty. Tentative opening to how their decision may affect the important relationships in their life (partner, family, children, friends). Telling and not telling, and how that might affect their relationships. Exploring the person's values, hopes and fears. Tentative questions about self knowledges.

Planning and imagining care after the abortion	*What are your concerns?* If the person mentions fear of regret: *Have you experienced regret before?* If they express sadness or guilt: *Have you encountered sadness before?* *How do you manage sadness?* *How will you recognise it?* *Who will notice?* *How can you prepare for sadness?* *What do you know about yourself that will help?* Recognising and acknowledging the loss (recognising that the pregnancy may be precious to the pregnant person) and finding ways of honouring the loss.	Exploring histories of regret: what alerted the person, how they made a decision at the time, what they know now, what they have learnt about themselves, how this knowledge translates to their current situation. Exploring the history of sadness in life, the shaping of guilt, exploring values. Disenfranchised grief, and finding ways to grieve that meet the person's emotional and cultural needs. How to look after the pregnancy (our clinic offers an ipo, a small clay pot made by a local potter for burial). Offering the ipo often makes the loss tangible.
Poroporoaki Concluding the encounter	Try to ensure that there are no misunderstandings: that the counsellor and the person have understood what the other has said. Bringing the conversation to a close with focus on how the person is making the decision: what values are privileged or prioritised, what matters to them. Reading the notes taken, if any. Offering back some of their words captured. *Is there anything that needs to be said that has not been said or asked?* Ensuring that the person is clear about the next steps. In the mahi at the clinic, this includes the clinical aspect of abortion care: medications, pre-medications and clear manageable information about surgical procedure, support, follow up and contraception. This aspect of care is woven into the flow of the conversation, as part of the person's life: managing periods, managing fertility, daily living, relationships.	Checking that the words resonate. Maintaining a connection, offering follow up, providing space to talk.

Table 1: The Hui Process for abortion decision-making counselling

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References

Bird, J. (2003). *Challenging orthodoxy*. https://www.johnellabird.nz/uploads/4/8/3/6/48368959/challenging_orthodoxy_plenary_2003.pdf

Bishop, R. (2014). *Preparing the parrots: A training college graduate on the cultural corruption of teachers*. https://treatygate.wordpress.com/category/waikato-university/russell-bishop/

Cockrill, K. (2014). Commentary: Imagine a world without Abortion stigma. *Women and Health, 54*, 662–665. https://doi.org/10.1080/03630242.2014.919986

Cockrill, K., & Hessini, L. (2014). Introduction: Bringing abortion stigma into focus. *Women and Health*, *54*(7), 593–598. https://doi.org/10.1080/03630242.2014.947218

Cook, C., Brunton, M., Pukepuke, T., & Tan, A. (2018). Exploring communication during the journey from noticing bodily changes to a diagnosis of endometrial cancer. *Journal of Clinical Nursing, 27*(5–6), 1262–1275. https://doi:10.1111/jocn.14173

Cook, C., Clark, T., & Brunton, M. (2014). Optimising cultural safety and comfort during gynaecological examinations: Accounts of indigenous Māori women. *Nursing Praxis in Aotearoa New Zealand, 30*(3), 19–34.

Crocket, K. (2013). Narrative therapy. In J. Frew & M. Spiegler (Eds.), *Contemporary psychotherapies for a diverse world* (pp. 459–500). Routledge.

Davies, B., Browne, J., Gannon, S., Hopkins, L., McCann, H., & Whilborg, M. (2006). Constituting the feminist subject in poststructuralist discourse. *Feminism and Psychology, 16*(1), 87–103.

Doka, K. (1999). Disenfranchised grief *Bereavement Care, 18*(3), 37–39.

Frank, A. (2013). *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press.

Frank, A. W. (2018). What is narrative therapy and how can it help health humanities? *Journal of Medical Humanities, 39*, 553–563. https://doi.org/10.1007/s10912-018-9507-3

Freedman, J. (2014). Witnessing and positioning: Structuring narrative therapy with families and couples. *Australian and New Zealand Journal of Family Therapy, 35*, 20–30. https://doi.org/10.1002/anzf.1043

Hannah, C., Cook, C., & Manea, T. (2019). Women-centred abortion care: Legitimising a disenfranchised aspect of healthcare [Editorial]. *Nursing Praxis in Aotearoa New Zealand, 35*(2), 4–6.

Hoggart, L. (2017). Internalised abortion stigma: Young women's strategies of resistance and rejection. *Feminism and Psychology, 27*(2), 186–202. https://doi.org/10.1177/0959353517698997

Hoggart, L. (2019). Moral dilemmas and abortion decision-making: Lessons learnt from abortion research in England and Wales. *Global Public Health, 14*(1), 1–8. https://doi.org/10.1080/17441692.2018.1474482

Joffe, C. (2013). The politicization of abortion. *American Journal of Public Health, 103*(1), 57–65. https://doi.org/10.2015/AJPH.2012.301063

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: A framework to enhance the doctor-patient relationship with Māori. *New Zealand Medical Journal, 124*(1347), 72–78.

Neimeyer, A. R. (2004). Fostering posttraumatic growth: A narrative elaboration. *Psychological Inquiry, 15*(1), 53–59.

Schank, R. C. (1990). *Tell me a story: A new look at real artificial memory*. Scribner.

Parry, R., Jones, B., Gray, B., & Ingham, T. (2014). Applying a Māori-centred consultation approach for engaging with Māori patients: An undergraduate medical student case study. *Journal of Primary Health Care, 6*(3), 254–260.

Purcell, C., Brown, A., Melville, C. & McDaid, L.M. (2017). Women's embodied experiences of second trimester medical abortion. *Feminism and Psychology, 27*(2), 163–185.

Thomas, L. (2020). Poststructuralism and therapy – what's it all about*? International Journal of Narrative Therapy and Community Work*, (2), 85–89.

Weingarten, K. (2010). Hope in a time of global despair. *New Zealand Journal of Counselling, 30*(1), 1–14.

Weingarten, K. (2016). The art of reflection: Turning the strange into the familiar. *Family Process, 55*(2), 195–210. https://doi.org/10.1111/famp.12158

Winslade, J., Crocket, K., & Monk, G. (1997). The therapeutic relationship. In G. Monk, J. Winslade, K. Crocket, & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope* (pp. 53–81). Jossey-Bass.

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ISSN: 1446-5019