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EMPIRICAL RESEARCH QUALITATIVE

'My biggest fear is that people will forget about him': Mothers' emotional transitions after terminating their pregnancy for medical reasons

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Abstract

Aims and objectives: To explore women's emotional responses throughout the process of terminating a pregnancy for medical reasons.

Background: Making the choice to terminate a desired pregnancy for medical reasons has a negative impact on women's health, as it is a distressing process that involves making hard decisions and readjusting one's expectations of an idealised pregnancy.

Methods: A qualitative phenomenological study was conducted following the COREQ checklist. Fifteen semi-structured interviews and two focus groups were conducted with women who had terminated their pregnancies for medical reasons, previous to and during the COVID-19 lockdown. Subsequently, we analysed the content.

Results: One main category, emotional journey during the process of terminating the pregnancy, and six subcategories were identified: (I) representation and desire to become a mother, (II) main concerns, (III) impact of the news, (IV) decision-making, (V) emotional responses before termination for medical reasons and (VI) emotional responses after termination for medical reasons. All contributed to understanding the specificities of the different phases that make up the emotional journey of terminating a pregnancy for medical reasons.

Conclusions: The findings of this study suggest that there are a number of predominant emotions that professionals need to be aware of in order to help women work through them and lessen the impact of pregnancy termination on their mental health. COVID-19 had different connotations depending on the women's experiences.

Relevance to clinical practice: Our results highlight how important the role of healthcare staff is in caring for these women and their partners, which involves recognising their emotions throughout the process. Our results also underline how useful it is to conduct qualitative studies in this context, since they constitute a set of activities and interventions that result in the administration of nursing care in itself.

Patient or Public Contribution: The ultimate goal of the action research study is to design a positive mental health intervention. Participants will contribute to the design and final approval of the intervention.

KEYWORDS
congenital abnormalities, COVID-19, decision-making, eugenic abortion, pregnancy, Prenatal diagnosis, qualitative research

1 | INTRODUCTION

According to the Center of Reproductive Rights (2022), 14% of women of reproductive age live in countries where the law allows termination of pregnancy for health or therapeutic reasons, and 22% live in countries where it is also allowed when the woman's life is at risk. One day they are happily pregnant and the next day, they are coping with uncertain results and an unexpected possible diagnosis which will lead them to make a choice. To interrupt a desired pregnancy due to foetal anomalies, sometimes incompatible with life, or because the mother's health is at risk, entails a transitional period in which women suffer from emotional distress, anxiety, depression and shock, as reported by other authors who have explored women's emotional responses during the process of terminating a pregnancy for medical reasons (TFMR) (Akdag Topal & Terzioglu, 2019; Aktürk & Erci, 2019; Atienza-Carrasco et al., 2020; Irani et al., 2019).

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

- This study helps to underline the usefulness of understanding the termination for medical reasons' process as a whole, as well as the specificities of the emotional experience of each phase and its impact on the other phases.
- It provides evidence of the impact of COVID-19 on the experience of termination of pregnancy for medical reasons.
- It highlights the important role healthcare staff play in caring for these women and their partners, which involves recognising their emotions, helping to ease their suffering, accompanying them during moments of vulnerability and supporting them during the transition.

2 | BACKGROUND

Despite the evolution of the concept of motherhood in recent years, its essence and its classic ideals are still present in our history and culture (Montes Muñoz, 2007; Palomar Verea, 2005), with the gestation period being synonymous with projects, discussions and activities related to the birth of the baby (Montes Muñoz, 2007). This feeling of expectation overcomes fear of the possible risks (Vidal Estruel, 2013) and couples gain an understanding of techniques such as ultrasound as a method for viewing the baby, rather than for detecting foetal anomalies. As such, they are poorly prepared to receive bad news (Bijma et al., 2008; Guy, 2018).

Receiving uncertain or abnormal results is a distressing process for couples and accelerates the need to readjust pregnancy expectations and make decisions (Werner-Lin et al., 2016). Women describe stressful situations from the time of diagnosis until sometime after the termination, triggering emotional distress and grieving processes (González-Ramos, Zuriguel-Pérez, Albacar-Riobóo, & Casadó-Marín, 2021).

Based on the theory of Meleis et al. (2000), the termination of pregnancy for medical reasons is understood as the transitional period between the expectation of what motherhood and fatherhood was meant to be, and the new reality without a baby. In her theory, Meleis refers to the continuities and discontinuities of human beings' life processes, to the exchanges between the person and her environment and to the interactions between nurses and the couples who are undergoing this transition (Mora-López, 2016). Achieving a healthy transition involves different personal, community or social factors. Personal conditions include cultural meanings, beliefs and attitudes linked to the transition experience (e.g. abortion stigma), socioeconomic status, anticipatory preparation and knowledge.

Schumacher and Meleis (1994) have described emotional distress, insecurity, anxiety and depression during the transition process. Following a successful transition, distress gives way to well-being. Therefore, transition is a process of vulnerability in which nursing intervention is necessary to alleviate distress and accompany and support mothers and couples.

In Spain, a total of 5055 pregnancy terminations were registered in 2020 due to a risk to the health of the pregnant woman; 2733 were due to a risk of serious foetal anomalies and 271 were due to foetal anomalies incompatible with life or that would have led to extremely serious and incurable conditions (Ministry of Health, 2021). Despite these figures, there are few studies on the subject.

For all the reasons described above, the aim of this study is to investigate women's emotional responses throughout the process of voluntary termination of pregnancy for medical reasons (from the moment they find out they are pregnant until after the termination). This study is part of a broader doctoral thesis that aims to design a

mental health intervention to help reduce the impact of terminating pregnancy for medical reasons on mental health.

To this end, the use of qualitative and, especially, focus group discussion as a data collection technique is considered interesting as it could also provide women with a therapy in itself by helping them to learn about and identify with the experiences of others who have gone through the same process (Kamranpour et al., 2019).

In addition, several recent studies suggest that the COVID-19 pandemic also had an impact on women's physical and emotional health and care (Diamond & Colaianni, 2021; Rice & Williams, 2021). As such, the authors consider it important to understand the impact that the lockdown had on how they experienced the process.

3 | METHODOLOGY

3.1 | Design

This study applies a phenomenological qualitative approach, following the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007; Supplementary File S1). It is based on the understanding of each woman as a human being who lives, feels and perceives in a unique way and the need to understand how the phenomenon of TFMR affects her emotions in order to better understand the woman and provide appropriate care. Therefore, this phenomenological approach allowed us, from a scientifically rigorous perspective, to delve into the experiences and emotions of women who have undergone a TFMR process from a comprehensive and experiential perspective. It uses semi-structured interviews, focus groups and the field diary as data collection techniques.

3.2 | Participants and recruitment

The study was conducted entirely in the women's hospital in Vall d'Hebron, Barcelona (Spain). The principal investigator is a female doctoral student who is part of the hospital's nursing research group and works as a nurse in the hospital. The PhD addresses women's emotional needs and the promotion of positive mental health in women who terminate pregnancy for medical reasons. The research group also included Dr LC, nurse and anthropologist, expert in qualitative methodology and gender and lecturer at the URV; Dr EZ, nursing research coordinator at the hospital and methodology specialist; and AC, a specialist midwife working in the prenatal diagnosis service. None have direct experiences of TFMR.

Participants were recruited on an intentional, non-probabilistic basis, with the collaboration of AC, who was the link between the principal investigator and the women who had undergone the termination process. The principal investigator was not part of the women's care team.

Participants were selected based on the following criteria: women over the age of 18 who spoke Spanish or Catalan and who had terminated their pregnancy for any medical reason allowed in Spain (risk to the health of the pregnant woman, risk of serious foetal anomalies and serious or incurable illness of the foetus), and who had terminated their pregnancy in the last 2 years, the period during which the bereavement process takes place. There was no gestational age limit for the time of termination. Women who were diagnosed with a severe mental health disorder prior to termination and for whom participation in the study would have been counterproductive, were not included.

Subsequently, the principal investigator (ZG) telephoned the women who met the inclusion criteria, provided them with detailed information about the study and explained what their participation would involve. During these phone calls, the principal investigator confirmed that the women were computer literate for the purposes of video conferencing. All the women said they were computer literate and they had an electronic device with Internet access, so there was no bias.

If the participants so desired, their partners were also able to participate in the fieldwork. A total of 15 women were recruited until data saturation occurred. Three of them chose to be accompanied by their partners for emotional support, but only one partner actively participated in the interview. Four women declined to participate in the study. Two did not offer reasons and the other two for health reasons (melanoma and anxiety).

3.3 | Data collection

The data collection methods used for the study were semi-structured interviews, focus groups and a field diary. It was decided to combine these methods of data collection because, although the groups contribute less depth to the topic of study as each person has less time to express themselves, they provide information of a more consensual nature and complement the data obtained in the interviews. The data obtained were worked on together.

Semi-structured interviews were selected as a method as they allow the interviewee to offer their version of reality and a construction is made based on their interpretation and experience of the facts (Verd & Lozares, 2016). All interviews were conducted by the principal investigator, who followed a script that contained key points (motherhood, termination of pregnancy, emotional health, health care) but remained dynamic and flexible. Questions were devised on the basis of the authors' previous scoping review (González-Ramos, Zuriguel-Pérez, Albacar-Riobóo, & Casadó-Marín, 2021; González-Ramos, Zuriguel-Pérez, & Casadó-Marín, 2021). Example questions included: 'how do you find out about X (reason for the termination of pregnancy)?', 'did you ask someone close to you for advice on what decision to make?' and 'what was your main concern about the termination of pregnancy?' The first interview was used as a pilot test to finalise the script, and no changes were necessary. The interviews lasted approximately 60 to 120 minutes. None needed to be postponed or repeated.

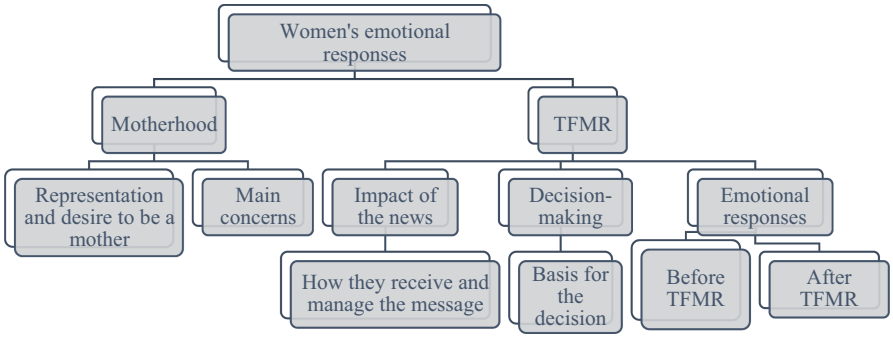

FIGURE 1 Coding tree [Colour figure can be viewed at wileyonlinelibrary.com]

TABLE 1 Examples of categories and subcategories

Meaning units from interview, focus groups and field notes	Name of meaning units/codes	Subcategories
The moment you are positive, the connection is there, even if it is just a few cells, even if it is an embryo. The connection is there and you are aware that something is already growing inside you, not to mention when you feel it, don't you? you notice that it moves and that is already for life (focus group 1. Woman, 38 years of age).	Describing how she felt when she found out she was pregnant.	Maternity
When you have the illusion of getting pregnant, but, above all, when you stay and live it, for you it already exists (focus group 1. Woman, 35 years of age).	The significance of pregnancy in her life.	
But the feeling of being pregnant is super cool. I mean, I recommend it to everyone. If not, do it. I mean, it's super nice. And then what goes with it is even more beautiful, right, it's joy (interview. Woman, 40 years of age).	The experience of being pregnant.	
I went over every day, every day, what I had done. And I couldn't find anything. I, well, I don't know. I blamed my work, my day-to-day stress. I blamed myself a lot. (interview. Woman, 29 years of age)	The mother looks for the cause in her actions (after).	Emotional responses
I felt like a bad mother for having taken the decision to take his life, didn't I, because I could feel it and I said: 'He's alive, poor baby!' (interview. Woman, 29 years of age).	She feels like a bad mother for deciding to terminate the pregnancy (before).	
There were times when. I went through the stage of guilt: 'I must have done something wrong in the pregnancy, what have I done that has affected the baby?' I started to analyse myself (interview. Woman, 38 years old).	The mother feels guilty and looks for the cause within herself (after).	

Focus groups were selected as a technique to explore how the meaning of loss is collectively constructed and because of their potential value as a therapeutic technique (Kamranpour et al., 2019). Of the 15 women who took part in the interviews, 11 chose to participate in the focus groups as well. The other four declined to participate because of time constraints or because they did not wish to interact with other women. Two focus groups were held, one with five women and one with six women. The groups were not formed according to any specific criteria, but according to time availability. The groups were homogenised, relocating those women who did not have a preference regarding the proposed days. No script was used. The participants gave a brief presentation of their story and marked the content of the groups through the experiences they shared about the whole process of TFMR. At the beginning of the video conference, they were given guidelines to facilitate communication as an online group. They all agreed the meeting should be recorded in order to analyse the group dynamics in more detail. The groups lasted for 2 h.

The field diary was selected as a technique to provide complementary information to the other two techniques, based on the principal investigator's notes during and after the interviews and focus groups.

Data saturation was discussed among the authors when it was considered that the information obtained in the interviews did not provide new elements relevant to the objective of the study.

The interviews and groups were held between August and November 2020.

Given the sensitivity of the subject under the study, a possible limitation of the online data collection was the lack of physical contact between researcher–informant, nurse–patient that might have provided comfort. However, as the women were at home at the time of the interviews, the researcher was able to enter fully into the phenomenological field of the individual, who expressed her subjective feelings from her natural environment. During the videoconferences, an informal atmosphere was generated which allowed participants to feel comfortable enough to describe their private lives and to add other elements and objects (tattoos, photographs) to what they had to say. This was an additional bonus that could not have been obtained had the data been collected face-to-face.

3.4 | Ethics considerations

The study was approved by the Clinical Research Ethics Committee of the University Hospital Vall d'Hebron, Barcelona (reference 457/19), and a subsequent amendment was approved to conduct the fieldwork by videoconference in order to adapt to the restrictions imposed due to the COVID-19 pandemic (González-Ramos, Zuriguel-Pérez, & Casadó-Marín, 2021).

The women who agreed to participate received an e-mail with the information sheet approved by the ethics committee, thus minimising the risk of spreading COVID-19 through physical contact. After answering their questions, if they were still interested in taking part in the study, they were sent a second e-mail explaining how to use institutional Microsoft Teams (the platform approved by the ethics committee) together with the agreed time and day.

At the beginning of the videoconference, participants were informed about the Microsoft Teams data protection policy. Oral informed consent was requested for participation in the study and for the voice recording, which is stored by the principal investigator in encrypted form to ensure participants' anonymity.

Due to the sensitivity of the subject and if after the fieldwork it became evident that it was necessary, patients had the option of receiving treatment from the hospital's perinatal bereavement psychologist.

3.5 | Data analysis

The principal investigator manually transcribed all voice recordings and completed the initial coding which was cross-checked by the other authors. The content was analysed by the qualitative software Atlas.ti 2 (version 9.0.7). Themes were identified derived from de data. We chose content analysis as the data analysis technique as it is a context-sensitive, neutral technique based on unstructured information that is then coded using researcher-generated units of analysis (Tinto Arandes, 2013).

We organised the information in order to establish relationships, to interpret it and to draw meanings and conclusions (Figure 1). In order to provide more details on the data analysis process and at the request of the reviewer, a small number of verbatims from the meaning units were selected (Table 1). The coding process was undertaken as follows: (1) reading the texts, (2) fragmentation, (3) assigning textual fragments to categories, (4) defining categories and subcategories, and (5) data analysis. The analysis process was verified by the rest of the research team, who exhaustively reviewed each phase. In addition, to guarantee the criteria of rigour (reliability, validity, credibility, consistency and confirmability, and applicability), we worked with different data collection methods until the discourse was saturated (semi-structured interviews and focus groups), carried out methodological triangulation with the available evidence, and checked the ability of the qualitative phenomenological methodology to respond to the research objective (which was to explore women's emotional responses throughout the process of TFMR) in relation to the characteristics and sensitivity of the research context and the participants.

One of the researchers checked the transcript against the recording in order to correct any transcription errors or omissions. If necessary, the researcher could contact participants with specific questions about their transcripts, rather than sending full transcripts to all interviewees for them to review. This joint researcher review and targeted revision can improve the quality of transcripts without requiring interviewees to review their full transcript (Hagens et al., 2009). The final phase of the project focused on designing a positive mental health intervention, which would have a direct impact on the follow-up provided to the women.

4 | RESULTS

4.1 | Participants' sociodemographic and obstetric characteristics

Data provided by the participants were collected in order to gain an in-depth understanding of the sociodemographic and obstetric characteristics of the participants (Table 2).

The participants in the study were aged between 25 and 45 years. Most of them were from Spain, although one Moroccan and two Latin American women were also interviewed. All of them lived in the autonomous community of Catalonia: 12 women lived in the province of Barcelona, two lived in the province of Tarragona and one in Girona. Nine of them were married, and six were single women living with a partner.

As for their level of education, ten of them had university education in different fields (tourism, engineering, economics, etc.), three had vocational training (hairdresser, nursing assistant), and two had completed secondary education. All of them are actively working, some as employees of companies and others are self-employed. With regard to religion, the majority consider themselves atheists or non-believers, two are non-practising Catholics, one is a practising Muslim and another is a Protestant Adventist.

In relation to obstetric characteristics (Table 3), the participants had terminated their pregnancy between 3 months and 2 years before the interview. Ten of the participants have other children in addition to the pregnancy they terminated for medical reasons and, of this group, three were pregnant at the time of the interview. Of the medical terminations performed, nine were due to risk of foetal anomalies, while six were due to foetal anomalies incompatible with life or extremely serious and incurable disease. These terminations were performed at gestational ages ranging from the 9-week group to the 23-week or more group. More specifically, they occurred between 13 and 36 weeks' gestation. In addition, six of the participants had some other type of termination, either miscarriage, termination for medical reasons or at the woman's request.

TABLE 2 Socio-demographic characteristics of the participants. Prepared by the authors

Socio-demographic characteristics of the participants	
Variable	**Cases ($n = 15$ women)**
Age	
25–29 years old:	5
30–34 years old:	1
35–39 years old:	5
40–45 years old:	4
Country of birth	
Argentina	1
Brazil	1
Spain	12
Morocco	1
Marital status	
Single	6
Married	9
Level of education	
Secondary education	2
Vocational training	3
University degree	10
Employment status	
Self-employed	5
Employed	10
Religion	
Atheist	11
Non-Protestant Catholic	2
Muslim	1
Protestant	1

TABLE 3 Obstetric characteristics of the participants. Prepared by the authors

Obstetric characteristics	
Variable	**Cases ($n = 15$ women)**
Other children	
No	5
One child	7
Two children	3
Other pregnancy terminations	
Yes	6
No	9
Reason for termination	
Risk of foetal anomalies	9
Foetal anomalies incompatible with life/severe and incurable disease	6
Gestational age	
9–14 weeks	4
15–22 weeks	7
23 or more weeks	4

Note: Three of the 15 women were pregnant at the time of the interview.

4.2 | Qualitative findings

In order to gain an in-depth understanding of the emotional journey experienced by the women during the disruption process, and given the amount of relevant data identified in this category, we decided to focus the present study on this category and its six emerging subcategories (Table 4). The subcategories are presented chronologically to better illustrate the process: the desire to become a mother, the principle fears regarding pregnancy, the news of the diagnosis, the decision to undergo TFMR and the emotional response in the days before and after the termination.

4.2.1 | Representation and desire to be a mother

It was considered important to investigate what motherhood meant to the participants in order to gain a better understanding of their emotional response to terminating their pregnancy.

The first question was 'What did you feel when you were told you were pregnant?' The most frequently repeated expressions in response to this question were 'joy' and 'happiness', either by itself or accompanied by 'fear'. All said that the pregnancies were desired and, for the majority, sought either in the traditional way or through in vitro fertilisation. The reasons that led them to seek pregnancy were varied, including because motherhood had an important place in their lives, because they wanted to experience it for the first time, because they wanted to expand their family, or because they were close to 40 and saw it as their last chance to conceive. Their responses were more linked to emotional and affective reasoning and they expressed they had had a meditated and, for some, intrinsic desire from a very young age.

> 'The moment you are positive, the connection is there, even if it is just a few cells, even if it is an embryo. The connection is there and you are aware that something is already growing inside you, not to mention when you feel it, don't you? You notice that it moves and that is already… for life'.
>
> (CBV, second daughter, 21 weeks gestation)

Most of the women understood motherhood as the act of giving unconditional love to their son or daughter.

> 'It's like you stop living for yourself because you start living for someone else, isn't it?'
>
> (LVC, first child, 22 weeks gestation)

TABLE 4 Emerging subcategories. Own elaboration

Category	Subcategories
Emotional journey during the process of terminating the pregnancy	I. Representation and desire to be a mother
	II. Main concerns
	III. Impact of the news
	IV. Decision-making
	V. Emotional responses before TFMR
	VI. Emotional responses after TFMR

Participants who had previously terminated a pregnancy reported a change in their understanding of motherhood. Thus, if before the abortion they experienced it as a beautiful process full of optimism, after the abortion, there was a 'loss of innocence' in terms of the risks it could entail, especially in terms of pregnancy.

> 'We did carry a very strong emotional burden and it was very draining. (…) I mean, it was a very wanted, very desired and very difficult pregnancy'.
>
> (LSM, second child, 19 weeks gestation)

However, at the time of the interviews and focus groups, most of them shared their desire to experience motherhood again and three of them were already pregnant.

4.2.2 | Main concerns

During the interviews and focus groups, the most common worries raised were related to viability, health and the absence of genetic problems or miscarriages. In order to try to have more control over these factors, some of the women underwent check-ups, analyses and additional tests for diseases in private clinics, in addition to the check-ups offered by the public health system. It was noted that while health was the women's main concern, the intensity of concern varied for those with a history of loss. They felt a sense of loss and found it difficult to feel confident that their pregnancy would go smoothly.

> 'My case is a bit difficult because after three losses, the child I have is adopted and this was through in vitro with egg donation. So I was happy, but I always had doubts. It's very hard for me to be confident about it. It's that 'happy, but let's see' feeling'.
>
> (MBS, three miscarriages, 19 weeks gestation)

> 'I didn't imagine it would be so strong, but I was thinking, "is it all right, does he not have any kind of syndrome or anything?"'
>
> (EK, first child, 22 weeks gestation)

In fact, in the dynamics of the groups, each woman introduced herself. Usually, they would introduce themselves by giving their name and the reason that they had decided to opt for a termination. One of the participants in group 1, who was pregnant at the time, described her discomfort at learning about other illnesses during the introductions.

4.2.3 | Impact of the news

When we asked the women how they found out about the foetal anomaly, all of them mentioned the routine 12-week, 20-week or later ultrasound scan. Depending on their past experiences, some were more nervous at the appointment or, on the other hand, they were happy and positive, unprepared for possible bad news.

> 'When I got the news… well, you can imagine. Horrible. Horrible because, I tell you, it was a shock because it was like, what are you telling me? I mean, my mind couldn't conceive what they were telling me because it was like, it can't be what they are telling me'
>
> (LAS, first daughter, 29 weeks gestation).

NEG, who had a child prior to the termination, says that the moment she saw the ultrasound she knew something was wrong:

> 'Just by looking at the ultrasound I saw that it was wrong. The moment the ultrasound started and the baby was located, I saw that it was wrong, they told me that there was a lot of fluid in the head and I saw that it looked very different to how it should' (NEG, second child, 13 weeks gestation. Pregnant at the time of the interview).

Another aspect that alarmed the women was the non-verbal language of the professional who was performing the ultrasound, as well as them calling other colleagues to assess the test.

> 'When you look at a doctor and they are more or less fine, and then all of a sudden they become serious. In other words, what he is going to say is not right. You are all aware of this, aren't you? You give everything away with your face. When you see the face, you're like, "OK, kill me"'
>
> (VDA, one living child and one previous termination, 13 weeks gestation).

In this context, a period of uncertainty begins from the moment the doctors detect the possible anomaly, until they verify it and inform the woman about the possibilities available. For this reason, some of the interviewees and their partners took anxiolytic medication during the waiting period.

> 'It's a real nightmare for a mother because you feel your baby inside, you just have to wait and you don't

know what's going on. You don't know if your baby is well and you don't know what you're facing'
(ADG, first child, 23 weeks gestation).

For participants who went through this process during the COVID-19 pandemic, some were told the results when they were alone in the consultation room, and in other cases, by telephone, which meant a perception of greater distance in the delivery of the message.

'We were in lockdown, I couldn't leave the house and go to see anyone. They called me, they told me, they didn't even ask me if I was alone or if I had… you know? Someone to be with. They called me, they told me the news and that's it, and they hung up, you know?'
(COF, first daughter, 26 weeks gestation)

4.2.4 | Decision-making

The decision-making process is influenced by the diagnosis the parents are facing. According to the interviewees, the expected quality of life of the baby is the most important factor.

'In fact, I told the doctor, "if you don't guarantee me 100% that this child will not depend on me, nor on a doctor, nor on a hospital, it doesn't make any sense"'
(LVC, first child, 22 weeks gestation, Wolf-Hirschhorn Syndrome).

There are also other factors that have a significant influence, such as the impact on family dynamics and on the lives of the other children they already have, dependency and the need for special care, as well as the economic impact of care and the time spent on care. Finally, they also highlight society's attitude towards a person with a certain disease.

'I have the feeling that the world is already complicated enough without having to come into it with an additional problem, because, in the end, a person who has a certain dependency is always dependent on someone. It may be on me, but the day that I am not there, or I can no longer be there, it will be on their sister or on someone else' (GAO, second daughter, 13 weeks gestation. Trisomy 21).

As for the people involved in making the decision, most couples made the decision together, although some consulted with health professionals, foundations, family and close friends. In some cases, religion was a factor, so they also consulted with religious experts.

'We also asked in the mosque. Well, people who have studied that more, who know more, and they told us that yes, there is also a clause, as in all religions, that if the foetus is not 120 days old, that we can terminate. (…) I also want to have peace of mind, don't I?' (FEB, two children and one miscarriage, 17 weeks gestation. Trisomy 21. Muslim)

4.2.5 | Emotional responses before TFMR

'Why me?'

The predominant emotion expressed by the interviewees was sadness associated, above all, with the shock of the news and the paradigm shift it implied with respect to what they had planned with their partners. The interviewees reported that they spent the days prior to the termination in isolation in order to avoid giving explanations to others and to be able to shed tears in private.

'I couldn't stop crying. Anxiety and stress. Basically, I was asking myself, why me? Why me? And what had happened to him. I would go over every day, every day, what had I done. And I couldn't find anything'
(ADG, first child, 23 weeks gestation).

The guilt for interrupting the baby's development was also very present among women, especially those who were at an advanced stage of gestation:

'The intuition I had is that I take that and my daughter is going to die. I'm going to take that and my daughter is going to die. And indeed (…) because I, inwardly, was also saying goodbye to her. Asking her for forgiveness'
(CBV, second daughter, 21 weeks gestation).

Other fears the women experienced before the termination were childbirth (or caesarean section), especially in the case of first-time mothers, and the moment of foeticide—time of induced foetal death—since one of their greatest concerns was that the baby would not suffer. To a lesser extent, some women feared seeing the dead baby, as the situation did not fit in with the expectations that the mothers had created in their minds before establishing physical contact, or going to the hospital during the pandemic because of the insecurity it generated.

On the day of the termination, the doctors tried to place the couples in the delivery rooms furthest away from the others. However, from the delivery rooms, it is still possible to hear everything going on in the other delivery rooms, the joy of the parents and the crying of their newborns. The women were understanding of the infrastructure and appreciated the efforts of the midwives, but pointed out that it was an added difficulty.

'It's very nice, the light and the dark at the same time and such, but (…) it's a bit… bizarre that you're in the same place having both things going on'
(KMF, first daughter, 22 weeks gestation).

> 'Listening to the mums screaming, well, but listening to the baby cry? It's really hard'
> (LVC, first child, 22 weeks gestation).

For one of the interviewees, during the state of alarm declared by the Spanish government because of the pandemic, her termination was performed by curettage. She was not in a delivery room, and given the limited number of visitors in the hospital, no one could come in to accompany her. She was alone for the twelve-hour process.

4.2.6 | Emotional responses after TFMR

'You learn to live with it'.

In the weeks following the termination, the sadness and pain are compounded by a sense of emptiness and loss.

> 'We have lived through a nightmare because, as I said, it has been very hard because she was very advanced. It was a birth, we had her in our arms. It's something that leaves you with an emptiness and a… you feel very sad, very lost'
> (LAS, first daughter, 29 weeks gestation).

Anger and rage also appeared as signs of protest against what they consider an unjust death.

> 'I mean, you go home alone. You are fat and alone. You produce milk but you don't have a baby, right? There's someone who's prepared the room and that room is empty, right? There are a lot of things that you're left with, like 'argh', the after, right?' (MBA, third child, 36 weeks pregnant. Pregnant at the time of the interview)

Two of the interviewees stated that they had been suffering from anxiety since the termination and that the disorder was accompanied by physical responses such as insomnia or tachycardia, as well as constant worry and suffering for their loved ones. This suffering was also present for four other interviewees when they saw pregnant women and assumed that they might be in danger.

> 'Then also what happened a lot at the beginning was like… I saw someone pregnant and thought "ouch!", my mind already turned on a warning chip to say, danger!'
> (LAS, first daughter, 29 weeks gestation)

> 'For example, Instagram, right, when someone has announced that they are pregnant, I think, "well, don't let anything happen to you", you know?'
> (LVC, first child, 22 weeks gestation)

Grief at the loss was, in turn, accentuated on significant dates: the due date, the anniversary of the termination date or during the holidays such as Christmas. Seeing pregnant women, especially if the pregnant women were part of their family or close circle of friends, proved very stressful. It led them to compare the situation with what they had experienced or what they were going through, and made them ask themselves the same question: why did it go well for them and not for me?

> 'Yes, I am happy for them, obviously I am happy for them, but you have… I mean, your brain is very happy for those people, but your heart isn't, it has that side that well, it feels it, it reminds you that you're not' (GAO, second daughter, 13 weeks gestation).

Social isolation contributed to the bereavement experience. They were apathetic and avoided facing social situations that put them under emotional strain as they had to relive the experience of the termination and give explanations.

> 'At first you don't know what to say to people. And you don't know what you want to say to them, do you? Not because of the people themselves, but it is true that people have their opinion, don't they?'
> (FEB, two children and a miscarriage, 17 weeks gestation)

Speaking of the state of alarm, several of the interviewees reported that the lockdown had a positive impact. It helped them to confront the situation and to talk to their partners about a subject that had been taboo for some time. It also helped them to avoid talking about it in social contexts such as at work. Other respondents regretted having so much free time to be alone and think about the termination, as they were unable to see their loved ones and their partners were working.

Some respondents saw a new pregnancy as a key factor in resolving the grief, but the failure to achieve it caused them anxiety. For others, although they still wanted to become mothers, they felt that not enough time had elapsed and they did not feel ready, or preferred to wait because of the state of uncertainty caused by COVID-19. Thus, in their subsequent pregnancies, they feared that history would repeat itself.

> 'Especially during the pregnancy of my youngest daughter, I had a very bad pregnancy, I was constantly touching my belly if I didn't feel her move: 'Hey! Move!'. At every ultrasound scan I was thinking "tell me that she is fine, that nothing is wrong, that she doesn't have any organs out of place"' (NPS).

On the one hand, they had to learn to differentiate the two pregnancies as individual processes, but on the other hand, they wanted to connect the two experiences.

> 'I have to find a way that I can fit her (pregnancy termination baby) in so she will be with me from now on,

for the rest of my life, whatever I go through, right, and this baby is part of what I am going through in the present' (MBA, third child, 36 weeks gestation. Pregnant at the time of the interview).

Another important manifestation of fear was that they or their loved ones would forget about the baby, as they associated it with a lack of recognition or suffering from them in the eyes of the rest of their close circle.

'What I felt, and still feel, is that people will forget about him. This is my biggest fear (she gets emotional), but anyway. It's fear and it's a feeling of pity, like I'm betraying him, or… you know? It's like not feeling bad in front of people (…) it's like I don't care enough' (LVC, first child, 22 weeks gestation).

In Spain, after a termination of pregnancy due to foetal anomaly or disease, women are referred for genetic analysis to determine the possible causes of the anomaly/disease that led to the termination. However, it is not always possible to establish a causal relationship.

'I don't know why it is wrong either. So, since I don't have an explanation, what do you do? It was me, was it? I don't know'
(VDA, one living child and one previous termination, 13 weeks' gestation).

'In the end, when you carry a baby inside you, you feel responsible for everything that happens to your baby. (…) I would have blamed myself just as much for thinking or saying: "Jeez, it's inside you, it's up to you"'
(ADG, first child, 23 weeks gestation).

Some women also felt guilty for deciding to terminate the pregnancy.

'On the one hand, yes, I feel bad that I didn't want that person to come into this world and be part of my life. It's a person that will never exist, isn't it?'
(GAO, second daughter, 13 weeks gestation)

Finally, some of the women referred to the process of personal growth they had experienced.

'It changes the point of view from which you see many things, doesn't it? It's one of those situations that make you grow up a bit, even if it's because of something bad'
(KMF, first daughter, 22 weeks gestation).

'It's more a question of learning, isn't it, of understanding the magnitude of being pregnant in order to pay attention to the moment you are living in, because they are not moments that are eternal, or that last' (MBA, third child, 36 weeks' gestation. Pregnant at the time of the interview).

5 | DISCUSSION

The aim of this study was to use phenomenology to investigate the emotional journey experienced by women throughout the process of terminating their pregnancy for medical reasons, from the importance that each woman places on the fact of being a mother, to coping with the termination after the fact. Healthcare professionals play a critical role in the experience of termination and childbirth and, therefore, must be prepared to give accurate and respectful information and be able to provide compassionate care (Asplin et al., 2014; Irani et al., 2019).

Palomar (2005) argues that the experience of motherhood is automatic, without a conscious reflective process and that it is linked, on the one hand, to emotions, affections and desires and, on the other hand, to social mandates linked to traditions, customs, norms and beliefs. However, the interviewees reported that their pregnancy was the result of a considered decision. Moreover, they referred to a maternal-filial bond since they were aware that they were pregnant, which led to a mutual emotional dependence (Imaz Martínez, 2007). Based on the discourses and different experiences and García de Diego (2019), it became clear that there is no single narrative on motherhood, although for all of them it played an important role in their lives.

As a result of technological advances, there are more and more prenatal tests available to couples and health professionals who wish to carry them out, in order to obtain information that informs them of a possible abnormality (Hodgson et al., 2016; Werner-Lin et al., 2016). In this regard, Guy (2018) and Bijma et al. (2008) refer to women being ill-prepared to receive bad news because they regard ultrasound as a technique for visualising the baby, not as a method for detecting foetal anomalies. According to our study, women with a previous history of some kind of abortion (spontaneous, medical) experienced greater anxiety and mistrust about the likelihood that the pregnancy would go well. However, women with no experience of abortion did not expect that anything would go wrong with the pregnancy or that their baby might have a syndrome or disease. In line with Meleis' theory, our findings confirmed that this poor pre-transition preparation could prevent a healthy transition, adaptation to the situation and a realignment of roles.

Receiving uncertain or abnormal results is distressing and accelerates the need to understand complex medical information, meet with specialists, readjust expectations about the pregnancy and make decisions (Werner-Lin et al., 2016). In this context, a period of uncertainty begins from the moment doctors detect a possible anomaly, until they verify it and inform the couple of the possibilities available. The interviewees report that while waiting, they searched the Internet for information and photographs to try to better understand what was happening and why, as described by Lalor et al. (2007) and Irani et al. (2019).

According to Lou et al. (2018), many couples are at some point, even before pregnancy, faced with the prospect of becoming pregnant with a baby with an abnormality and the possible choice they

would make. Even though for some this conversation helps to consolidate the decision, our findings indicate that the reality of being faced with the decision produced a dilemma influenced by different factors (de Souza Patrício et al., 2019). Most couples made the decision between themselves (Gaille, 2016; Lou et al., 2018).

As indicated by results obtained in previous studies (Gaille, 2016; Hodgson et al., 2016; Lou et al., 2018), some factors that influence decision-making are repeated. For example, the fact that their children cannot do the same as other children and the need for lifelong support for special needs, as well as possible bullying; the fact of not being able to pay as much attention to current or future siblings and the indirect assignment of a lifelong responsibility, and the impact it would have on the couple's own life (constant worry, increased workload, lack of social support, less freedom to develop professionally and personally). In addition, the respondents in our study added the economic impact of having a child in need of special care as a factor to be considered.

As for religion, although it is a factor to be taken into account (Choi et al., 2012; Consonni & Petean, 2013; de Souza Patrício et al., 2019; Gesser-Edelsburg & Shahbari, 2017), it seems to have a significant but not decisive influence (Gaille, 2016).

The available evidence shows that the most prevalent emotions during the process are emotional distress, anxiety, depression and shock (Akdag Topal & Terzioglu, 2019; Aktürk & Erci, 2019; Atienza-Carrasco et al., 2020; Carlsson et al., 2016; Guy, 2018; Irani et al., 2019; Ramdaney et al., 2015; Ridaura et al., 2017; Rocha et al., 2018; Sun et al., 2018), as well as grief and bereavement (Irani et al., 2019; Qin et al., 2018; Ramdaney et al., 2015; Ridaura et al., 2017; Sriarporn et al., 2017).

In this study, several emotions recurred among participants throughout the process, including sadness and grief, stress, anxiety, guilt and fear, although they had different connotations in the days prior to terminating the pregnancy compared to afterwards.

In accordance with the study by Asplin et al. (2014), the predominant emotion reported by the respondents was sadness. In line with the findings of Irani et al. (2019), women also experienced stress and anxiety due to not knowing the cause of the abnormality. Generally, from 16 weeks onwards, there is more physical experience and they feel the foetal movements, and from 20 weeks onwards, more morphological details can be seen in the ultrasound (Ridaura Pastor, 2015). This leads to the sensation that something inside has autonomy with respect to the rest of the body (Imaz Martínez, 2007). Thus, in more advanced gestations, women felt pain and a strong sense of guilt for interrupting the development of the foetus (Baena-Antequera & Jurado-García, 2015).

Guilt is also very present in the later stage (Carlsson et al., 2016; Curley & Johnston, 2014; Irani et al., 2019; Kirkman et al., 2017; Maguire et al., 2015; Ridaura et al., 2017). Following termination of the pregnancy, couples begin to search for the cause of the foetal abnormality (Consonni & Petean, 2013). However, it is not always possible to establish a causal relationship. It is in these cases, although not exceptionally, that the mother, who has historically been blamed for the causes of her children's health problems (Palomar Verea, 2005), begins to look for the blame within herself: what did I do wrong?

Consistent with studies by Maguire et al. (2015) and Consonni and Petean (2013), social isolation contributed to the bereavement experience. Triggers for grief, as reported by Maguire et al. (2015), included reminders of pregnancy such as baby clothes, which depict the silhouette of the child and have great power to evoke and make it feel present and palpable (Imaz Martínez, 2007), or seeing pregnant women.

Thus, in their own subsequent pregnancies, the fear of recurrence was very present (Carlsson et al., 2016; Irani et al., 2019) and they were distressed, especially every time they had a check-up such as an ultrasound scan. Therefore, according to Rillstone and Hutchinson (2001), parents put an emotional armour mechanism in place, delaying attachment to the baby and attaching to health professionals and selected individuals.

The results are therefore consistent with Meleis et al. (2000), who illustrated the connection between transitional conditions related to personal circumstances, meanings and beliefs, and activity to decrease vulnerability. For all interviewees, their pregnancy was intentional and the termination was an important moment in their lives for which they were unprepared. As in other fields of nursing (Donsel & Missel, 2021; Emond et al., 2019; Mora-López, 2016), it would be useful to use this theory as a reference to help couples during the experience of loss; that is, by creating preparation and management strategies beforehand (which facilitate the transition); by creating optimal conditions for the transition and by accompanying them during the process.

Finally, in terms of the study's limitations, although pregnancy terminations due to the mother's health were part of the inclusion criteria, it was not possible to include any women from this group, because the cases we had available were due to social dystocia or psychiatric causes, meaning participation in the study could be counterproductive for their mental health. For future research, it would be useful to tailor the project's design and resources to the needs of this particular group. As for the specific influence of religion on decision-making, it cannot be said that there was data saturation, since most of the participants were atheists, except for four, who were believers of different religions. Furthermore, no conclusive results can be drawn on the influence of sociodemographic or obstetric characteristics, as the sample was not equally representative for all parties.

6 | CONCLUSIONS

In this study, we wanted to explore women's emotional journeys during the process of terminating a pregnancy for medical reasons by delving into their emotions in each phase of the process in order to understand it as a whole. It is an individual and complex process in which there is no single emotional response and which is influenced by different factors, such as the desire to become a mother or knowing the exact aetiology of the diagnosis. However, the results

suggest that there are a number of emotions that recur in most of the stories that could be worked on to help reduce the negative impact of the termination on mental health, namely fear, uncertainty, shock, anger, sadness, anxiety and apathy. There is also no single experience of the impact of the COVID-19 pandemic, given that it offered an escape for some, but served as a constant reminder for others.

7 | RELEVANCE TO CLINICAL PRACTICE

This study highlights the important role healthcare staff play in caring for these women and their partners, which involves recognising their emotions, helping to ease their suffering, accompanying them during moments of vulnerability and supporting them during the transition. The Meleis model can serve as a reference. Similarly, the study also underlines the usefulness of conducting qualitative studies in this context, since, ultimately, they constitute a set of activities and interventions that result in the administration of nursing care in itself.

AUTHOR CONTRIBUTION

Study idea and investigation: Zuleika González-Ramos; and data analysis and interpretation, drafting, writing and revising the manuscript; and approval of the version of publication: all authors.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

CLINICAL TRIAL REGISTRATION NUMBER AND NAME OF TRIAL REGISTER

This study has been approved by the Ethics Committee for Clinical Research of the Hospital Universitari Vall d'Hebron (reference 457/19).

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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