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A Qualitative Study on the Psychological Experience of Pregnant Women with Abnormal Induced Abortion of Fetuses under 20 Weeks of Pregnancy

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Abstract

Objective: This paper aims to understand the psychological experience and needs of pregnant women who need induction of labor due to fetal abnormalities at less than 20 weeks of gestation through in-depth interviews. **Methods:** Using the phenomenological research method in qualitative research, 12 pregnant women with fetal abnormalities less than 20 weeks of gestation in the obstetrics department of a hospital from January to April 2023 were selected as the research objects for semi-structured in-depth interviews. After information was collected to saturation, Colaizzi content analysis method was used to sort out, analyze and refine the data. **Results:** Through the interview results, three themes were refined from the transcript. Those are: 1) the support and assistance needed during the induction of labor; 2) inner feelings after labor induction; 3) The vision of future life. **Conclusion:** Abnormal fetal development at <20 weeks of gestation can cause anxiety, depression, guilt, loneliness and other negative emotions for pregnant women, and they need to get corresponding psychological support, especially during the period from fetal abnormality to induction of labor, pregnant women have to experience many physical and mental suffering, and need to get the care of family, relatives, friends, medical staff and society. Medical staff can help them seek multi-directional support, provide professional knowledge, and help them with self-management.

Keywords

<20 Weeks of Gestation, Fetal Abnormalities, Induction of Labor, Psychological Experience, Qualitative Research

1. Introduction

Fetal abnormalities refer to anatomical and/or functional abnormalities that occur during the development of an embryo or fetus due to genetic, environmental, or a combination of genetic and environmental factors. The common congenital defects of newborns in clinic, mainly including Cleft lip and cleft palate, cardiovascular malformation, Spina bifida, etc, are important causes of perinatal death [1]. Data shows that 80% of fetal developmental abnormalities occur before 12 weeks of pregnancy, so early diagnosis of fetal developmental abnormalities is crucial [2]. Since pregnancy, pregnant women have gradually developed a deep affection for the fetus, especially during baby activity. Pregnant mothers can express their care for the fetus by counting the movements themselves [3]. The natural pattern of fetal movement occurs around 18 - 20 weeks of pregnancy. Pregnant women who are less than 20 weeks of pregnancy often cannot intuitively feel the presence of the fetus [4]. Early diagnosis of fetal developmental abnormalities and timely termination of pregnancy can not only reduce the pain of pregnant women, but also reduce fetal birth defects and perinatal mortality, and improve population quality [5]. Fetal malformation induced abortion is a huge emotional trauma event for pregnant women and their families. At present, many literatures has found that such pregnant women have complex negative emotions such as sadness, anxiety, depression, and post-traumatic stress disorder. If insufficient support is not provided, it will increase the intensity and duration of grief for induced abortion parents [6]. In order to study the inner experiences of pregnant women facing fetal abnormalities and provide corresponding intervention strategies. Using the phenomenology research method, this study conducted a qualitative interview on the psychological pressure and needs of pregnant women facing fetal abnormalities. The report is as follows.

2. Object and Method

2.1. Research Subjects

Using purposive sampling method, pregnant and postpartum women with fetal developmental abnormalities who were hospitalized in the obstetric ward of a certain hospital from January to April 2023 and required induction of labor were selected as the research subjects. Inclusive criteria: 1) Pregnant women with dysplasia of fetus <20 weeks of gestation; 2) Age ≥ 20 years old; 3) Have basic reading and comprehension skills, with normal vision and hearing, able to express clearly in language, and no other mental illness; 4) Agree to participate in this study and sign an informed consent form. Exclusion criteria: 1) Induced abortion due to stillbirth or other reasons (such as unmarried pregnancy, unexpected pregnancy, maternal physical condition, family reasons, etc.); 2) Having serious audio-visual or cognitive impairments that may affect the correct answers to questions; 3) Individuals with previous mental illness; 4) After the researcher's explanation, they refused to participate in this study. When the information in this study was saturated, the sample size was 10 cases. After the sample size was

saturated, two further interviews were conducted with the study subjects to verify whether there were any new topics emerging. Finally, 12 study subjects were determined.

2.2. Research Methods

This study adopts a semi structured personal in-depth interview method to collect data. Conduct open, unguided, and implicit interviews with the interviewees until the information reaches saturation and no new topics appear. Generally, collect about 10 samples. Before the interview, introduce the purpose of the survey to the respondents and explain that the survey strictly follows the principle of confidentiality. The true identity of the respondents will not be disclosed, and the interview results will be completely anonymous to protect privacy (A1 - A12). Obtain the trust and cooperation of the respondents, sign an informed consent form, and choose the interview location based on their wishes and survey needs. This interview was conducted in a natural, quiet, and secluded setting, such as a hearing screening room, conference room, etc. The entire interview was recorded synchronously, carefully listening and observing the interviewees' emotions, facial expressions, sentence pauses, intonation, and body language, and taking notes. Develop an interview outline based on research objectives, previous literature, and clinical expert opinions. During the interview process, the researcher flexibly adjusted the questioning method and order based on the interview outline guidelines and the actual situation of the interviewees, appropriately pursued valuable questions, respected the interviewees' language, and did not make judgments. The interview mainly revolves around the following questions: 1) What kind of assistance do you most want from receiving the diagnosis results to making the abortion decision? Can you explain why? 2) Do you need the care and support of family and friends? What do you think is the most meaningful support at this stage? 3) Is the medical staff in the ward helpful to you? What do you want them to do? 4) What is your inner feeling after induced abortion? 5) What are your expectations for your future life? The duration of each interview is approximately 30 - 40 minutes.

2.3. Data Analysis

The researchers sequentially code the interviewees based on the interview time, listen to the recording repeatedly within 24 hours after the interview ends, and combine the interview records to transcribe the recorded data into text format word by word, sentence by sentence. They also organize the nonverbal information observed during the interview, such as the interviewees' expressions and movements. This study adopts Colaizzi's phenomenological data 7-step analysis method. Two researchers independently read, analyze, encode, classify, and extract the extracted topic. When there are different opinions on the extracted topic, the research group will discuss together and ultimately determine the topic. After selecting the topic, return to the interviewee for verification to increase the reliability of the results [7] [8].

3. Results

3.1. Topic 1: Support and Assistance Needed during Induced Abortion

3.1.1. Psychological Support and Assistance for Spouses

The most important support and assistance system during the induced abortion process should be emotional support from the spouse, as the mother desires emotional communication with her spouse after experiencing an induced abortion event. Case A1: My husband has always been very concerned about me. He thinks that getting pregnant is a matter for both of us. During my early pregnancy, I vomited heavily during pregnancy, and he thinks I worked very hard. Now, when encountering such unfortunate situations, I have to face them together. I am particularly dependent on him mentally (showing a pleased smile). Case A3: My husband and I are childhood sweethearts. He has been very helpful to me and has provided me with strong psychological support. Although he is also mentally uncomfortable, he has always shown great strength (choking) in front of me. Case 4: My husband has been accompanying me for a long time, guiding me and enlightening me at any time. When we first learned that the fetus was dysplasia, we were in a bad mood, but he always comforted me and let me see it through. He looked at this matter optimistically. He was more rational, and felt that we should face it when something happened.

3.1.2. Psychological Support and Assistance from Family Members

Informing parents of abnormal fetal conditions can help alleviate the emotions of pregnant and postpartum women, but due to the influence of traditional Chinese culture, family members tend to suppress their emotions and try to hide them as much as possible after induced abortion. Case A2. Case A9: When my husband told his parents, his mother was secretly crying. She was careful not to be seen by me (with tears in her eyes), and she gave me meticulous care in life. Case A11: I couldn't accept it. It was difficult to pass through that period. It was my mother who was always with me and gave me a lot of psychological support.

3.1.3. Psychological Support and Assistance from Family and Friends

Talking to friends can provide emotional support and reduce negative emotions and stress inside. Case A3: I will tell my best friend about the situation, share my experience this time, and prepare for the next time. Case A4: I would tell a better friend, but I would not tell others (shaking my head), because this is my third pregnancy, the first time I had an abortion due to an unexpected pregnancy, the second time the fetus stopped developing at 9 weeks of pregnancy, and this time the fetus needs to be induced to labor due to dysplasia, all of which are bad conditions (wiping tears). Case A8: I will actively talk to my best friend because it is a process of psychological venting.

3.1.4. Support and Assistance from Medical Staff

Pregnant women often refuse to accept the diagnosis results of fetal dysplasia at the initial stage. Pregnant women and their families usually show suspicion,

denial of reality, or unwillingness to give up the fetus with luck. Case A3: I most want to understand the cause (in a positive tone), and I am afraid that the same problem will occur in the next child. Will there be any difficulties during the pregnancy process? I'm afraid my body won't be able to bear it because it will also have an impact on my fertility. Case A7: When I first learned about it, I collapsed. My body has always been healthy, and all the examination indicators are normal. Why does fetal abnormality happen to us? I couldn't accept it psychologically, and during that time I was very frustrated and eager to receive professional answers from medical staff. Case A9: For an elderly primipara like me, it is not easy to conceive a child. If it is a minor deformity or a defect that can be corrected through surgery after birth, I would like to keep it. I hope to continue pregnancy and give birth to a healthy fetus, but I am worried about giving birth to an unhealthy baby.

3.2. Topic 2: Inner Feelings after Induced Abortion

3.2.1. Anxiety and Worry

Induced labor with dysplasia will cause great psychological pressure to pregnant women, and the direct impact is mainly psychological sadness, anxiety, depression, self blame, shame and other negative emotions [5]. In addition to concerns about the induced abortion itself, there is also anxiety about future family harmony and stability. Case A1: My husband and I have been married for over 10 years, and we have been pregnant three times without success. Our neighbors will also talk to me behind my back. Although my husband and his parents haven't said anything, it's hard to say. People and things are changing, right? It is also possible that the relationship will break down due to this. Case A6: Due to years of marriage without having a child, I feel ashamed and unable to look up in front of my neighbors. Case A10: The period from identifying fetal abnormalities to induced labor has been the biggest challenge I have encountered in over 20 years, and it is truly the biggest challenge. I am extremely anxious, conflicted, painful, and worried.

3.2.2. Guilt and Solitude

Some pregnant and postpartum women feel guilty about fetal abnormalities, believing that their careless diet in daily life has led to their children's abnormalities. Case A2: In the early stages of induced abortion, especially when I first learned the news, I felt too guilty and didn't want to communicate with others. I wondered if others would laugh at me if they found out. I just want to choose to escape. I just want to lock myself in the room. Case A5: I have been confessing to this child in my heart, feeling sorry for him and unable to keep him. If there is a chance, I hope he can still come and be my baby (crying). Case A6: Due to extreme guilt, I am unwilling to share my journey with others. I feel that no one can understand my feelings and feel lonely, lonely, and empty when I see healthy children in my family and friends, gradually closing myself off from the outside world.

3.2.3. Communication and Exchange

The occurrence of fetal abnormal induced abortion is a disillusionment of hope for the mother and spouse, and the role transition has led to a psychological gap. During the admission period, my family and I urgently hope to receive the attention and assistance of medical staff. Case A1: Since I did not understand the environment and medical staff after admission, and because of the fetal dysplasia, I hope the nurse will pay more attention to me and give me psychological comfort. Case A10: I am very grateful to Dr. Chen for accompanying me at the bedside during my frequent contractions and particularly painful stomach. He taught me methods for reducing respiratory pain, explained the process of production, comforted and enlightened me, and made my abortion process very smooth. Case A12: Due to self blame, my mood has always been in a low state, resulting in a lot of bleeding during the production process. I am particularly grateful to the night shift nurse that day. Her skilled movements and gentle words made me feel her care for me, which made me no longer afraid psychologically. I believe that having her and the doctor in my presence is safe.

3.3. Theme 3: Vision for Future Life

3.3.1. Looking forward to the Future

Looking forward to the future is also a way of coping. The first thing to do is to learn self-management, develop new life and work plans, and look forward to a better future. Case A2: In the future, it is necessary to develop good lifestyle habits, such as going to bed and getting up early, eating regularly, and not drinking coffee harmoniously. Case A5: If I want to change my lifestyle, such as in terms of work, I wonder if it's necessary to work so hard like this. Why am I giving birth so late? It's because I didn't want to give birth in the early stages, and there are also issues with being too busy with work.

3.3.2. Actively Seek Hospital Assistance

In addition to being more acceptable, hospital intervention psychological intervention can also develop policies that are in line with objective circumstances based on the results of follow-up visits. Case A7: It is best to establish a group where professional medical staff are responsible for free consultation, as there are too many outpatient patients. Medical staff can help us analyze the causes and doubts. You can open a public welfare outpatient clinic with a fixed time per week for specialized doctors or nurses to visit, whether it is a physical outpatient clinic or a virtual group form. Case A10: In terms of psychology, normal postpartum women may experience postpartum depression. Is there a special institution to provide psychological counseling for a group like us? Because we are different from infertility, we may have many psychological questions.

3.3.3. Network System Support

Establishing a network support system is beneficial for seeking emotional support and reducing anxiety. Case A9: I want help from the government, hospitals, or even the internet, hoping to meet people who have experienced the same sit-

uation. I think it's possible to create a group where everyone can chat, even if the fetal abnormalities are different, the feelings of being a parent are the same. Case A12: If you have an online platform, you can ask how to do it without wasting too much time. You can induce labor earlier.

4. Discussion

Regarding the support and assistance needed by pregnant and postpartum women during induced abortion, and considering the adverse effects of fetal loss and sadness on families after induced abortion, it is recommended that medical staff improve individual coping skills through professional support and assistance in clinical work, correctly face and accept the reality of loss, and ultimately achieve healthy family development.

Although pregnant women who are less than 20 weeks pregnant may not feel fetal movement temporarily and their feelings towards the fetus are not particularly strong, induced abortion, as a negative event in daily life, can easily cause serious adverse effects on pregnant women. The psychological support of spouses is considered crucial, and some pregnant women are even willing to share their inner experiences with their spouses during this period. However, an increasing number of studies [7] [8] currently point out that fathers of children do not have sadness reactions compared to pregnant women, and their sadness experiences are often overlooked. In clinical work, on the one hand, influenced by traditional culture, people are deeply secretive about death. On the other hand, in order to protect unfortunate families, medical staff usually use euphemistic language and adopt an evasive and downplayed attitude in their work, avoiding directly discussing the heavy topic of loss after induced abortion with family members [9] [10]. The original intention of adopting avoidance or dilution may be to reduce the negative impact of loss on the family, but it often fails to achieve the expected effect, which may actually be counterproductive. Therefore, nursing staff should first realize that the sadness reaction of pregnant women and their families after experiencing abnormal fetal induced abortion is normal. They should be comforted through gentle persuasion and appropriate body language, and promptly guide their negative psychology and adjust their mentality. Secondly, full recognition and understanding should be expressed for the family's sad response, encouraging them to engage in reasonable emotional venting. At the same time, medical staff should establish a good human bonding between pregnant women and their parents, avoid the family blaming pregnant women blindly, and provide care and support, so that pregnant women and their families can face the induced labor event and the difficulties it brings. The emotional warmth and understanding of family members are the protective factors for the mental health of pregnant women [11]. Good social support can reduce the psychological problems of pregnant and postpartum women [12].

In view of the inner feelings after induction of labor, after experiencing the induction of labor with dysplasia, some pregnant and lying in women have al-

ways been unable to face the loss of reality and avoid talking and communicating. It is recommended to establish a care and support service model for abnormal induced abortion of fetuses under 20 weeks of pregnancy, to provide assistance to pregnant women and families after induced abortion, and to avoid harm caused by induced abortion to women.

After experiencing the induced labor event of fetal dysplasia, most of the pregnant women and their families are worried about another bad pregnancy. The next pregnancy is no longer full of joyful expectations, but accompanied by higher levels of anxiety and depression. The pregnant women are eager to get relevant support from medical personnel [13]. This suggests that medical and health institutions can provide information and emotional support for this type of population, such as follow-up and continuous support. Medical staff can negotiate with pregnant women and their families to develop a follow-up plan after discharge, including the time, location, frequency, etc. of follow-up. A personalized follow-up plan should be developed based on the needs of pregnant and postpartum women, which usually includes analysis of various examination results, exploration of the cause of fetal death, next pregnancy plan, and possible next steps of treatment [14].

Provide continuous support and assistance to pregnant women and their families who have experienced induced abortion in response to their aspirations for future life, both postpartum and during their next pregnancy.

Looking forward to the future life can enable pregnant women to receive more medical information, pay attention to themselves, bid farewell to unhealthy lifestyles in the past, better manage themselves, better adapt to future life, and prepare for the next pregnancy. The study by Wojcieszek *et al.* [15] involved 2716 women with experience of fetal abnormal induced abortion, of which 66% became pregnant again within one year after the induced abortion event. These populations are usually more cautious when dealing with re-pregnancy. They hope to receive more prenatal outpatient examinations and undergo more ultrasound examinations during pregnancy. Medical personnel should provide them with more understanding and support, and carefully evaluate the relative benefits of medical interventions and examinations [16]. At the same time, parents hope to obtain information about other social support resources, including local support organizations (such as social work groups, end-of-life care organizations, mourning mutual assistance groups), perinatal loss support networks, psychological counseling, and other reading materials [17].

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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