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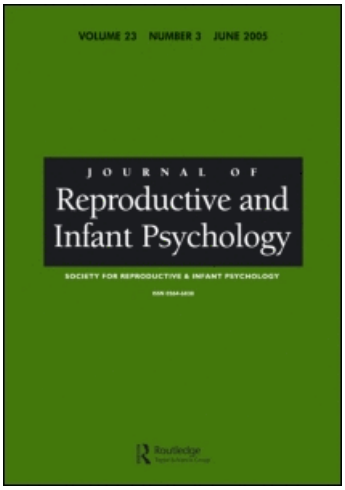

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Long term follow-up of emotional experiences after termination of pregnancy: women's views at menopause

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The objective was to explore women's long-term experiences and perspectives on their terminations of pregnancy (TOP) when perimenopausal. Eight women attending a menopause clinic who had experienced termination a minimum of 10 years previously (mean 24 years) completed semi-structured interviews. Transcripts were analysed using Template Analysis. Five TOP themes were identified: '*Impression left*' involved sadness, regret, and guilt which affected women's self-perceptions. '*Judgement*' encompassed judgement on themselves and how censure was feared from others. '*Growth and development*' noted the development of resilience and compassion for others. '*Coming to terms and managing effects*' identified beliefs in the correctness of the decision, but effortful avoidance of thoughts still intruding into life. '*Contradictions*' identified dramatic inconsistencies within almost all individual accounts indicating lack of resolution and full acceptance. Considering menopause and TOP together revealed a further three themes; *Changes to thinking*, *Menopause as a time of reflection* and *Linkages or separateness*. For some women termination may be continually reappraised in their changing life context and remain an active yet hidden feature managed through active avoidance. Menopause was viewed as a time of vulnerability to TOP-related negative thoughts, especially where wishes for more children were unfulfilled. Accessibility of post-termination counselling throughout life is recommended.

Keywords: termination; pregnancy; long-term follow up; menopause; psychological; qualitative

Introduction

Background

Termination of pregnancy (TOP) is a common procedure, with 195,296 legal TOPs being carried out in England and Wales in 2008 (National Statistics Website, 2009). Recent reviews suggest that TOP brings relief, is generally associated with low levels of distress, and women having a termination experience and those who continue their unwanted or wanted pregnancies will have similar outcomes (Bradshaw & Slade, 2003; Coleman, Reardon, Strahan, & Cougle, 2005).

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However, evidence from longitudinal studies concerning longer-term implications beyond two years post-TOP is limited. Some information relates to psychiatric care, drug use and suicide. Psychiatric admissions are more common among low-income women who terminate their pregnancy than among those who carry a pregnancy to term, both in the short term, and long term four years after the pregnancy event (Reardon et al., 2003). Compared with women who gave birth, women having undergone TOP are significantly more likely to use various substances during their next pregnancy, suggesting a possible need to alter mood as it can be argued that use of substances helps people to manage difficult feelings by facilitating disconnection from them (Coleman, Reardon, Rue, & Cougle, 2002). In Finland, the suicide rate after TOP has been found to be three times the general suicide rate and six times that associated with live births (Gissler, Hemminki, & Lonnqvist, 1996).

More recently, studies focusing on special groups, using other designs or opportunistic analyses of other samples also suggest less positive outcomes. One study found that five-year outcomes post-TOP indicated anxiety and depression was significantly higher than in the general population and failed to show the pattern of decrease reported following miscarriage (Broen, Moum, Bodtker, & Ekeberg, 2006). A major longitudinal study in New Zealand identified an increased risk of later mental health problems in women undergoing TOP, particularly concerning anxiety and drug use, even when potential confounding factors were accounted for (Fergusson, Horwood, & Ridder, 2006; Fergusson, Horwood & Boden, 2008). The confusion surrounding the nature of implications of terminations is reflected in disparity in statements from the American Psychological Association (Major et al., 2008) and the Royal College of Psychiatrists (RCPsych, 2008) who do not reach a shared consensus. The former concludes no relationship between TOP and increased risk of mental health difficulties and the latter views current research as ‘inconclusive’. It must also be noted that the longer-term implications, more than five years post-TOP, are considered relatively rarely.

Another gap in the literature concerns the experience of prior termination around the phase of menopause as women reach the end of their reproductive capacity. Becker et al. (2001) suggest that psychological distress during the menopausal transition may indicate a personal psychological or physiological vulnerability rather than a specific reaction to the menopausal events. Menopausal women who have experienced negative life events are known to report higher scores on psychological morbidity tests (Gath et al., 1987). However, women also identify positive aspects of menopause (Hvas, 2001), including personal growth and a relief at the end of menstruation and attached problems, such as fear of pregnancy. Although a small proportion of women may present at the menopause with depression and anxiety, there is little evidence of raised prevalence and such responses cannot be attributed to menopause status alone (Deeks, 2003). The influence of psychological factors, lifestyle issues, personal psychological vulnerability, interpersonal relationships, body image, role and socio-cultural factors must be considered, resulting in the need to understand individual menopausal experiences within the context of women’s lives. One aspect in this context, the role of prior termination, clearly merits exploration.

It is likely that emotional response to TOP is complex and more in-depth and detailed understandings may be gained through using qualitative approaches which explore and reflect women’s experiences in their own words, rather than in response to predetermined concepts and categories measured by questionnaires. Whilst the latter approach has many strengths, it does not allow for the range or richness of understandings that can be generated by the former. Such qualitative approaches can

facilitate subsequent quantitative studies ensuring measurement of relevant domains is carried out. Lie, Robson and May (2008) provide a narrative review of qualitative studies related to any aspect of termination. Whilst there are studies that focus on aspects of decision-making and experience of mode of termination and short-term consequences, there are few which focus on longer-term experiences and none in relation to menopausal experiences. One study has explored women's reflections upon TOP over time (Goodwin & Ogden, 2007). Some women reported no subsequent negative emotions whilst others revealed 'persistent upset'. However, participants had their TOPs on average five years previously and the country of TOP and ethnicity was varied. One qualitative study stands alone in considering women's responses to TOP over an extended period of at least 15 years (Trybulski, 2006). However, the study included illegal TOPs, the recruitment process was unclear and the analysis was unverified, being conducted by a single researcher. It was also conducted within the USA, a different cultural context where social stigma and politicised views concerning termination may be more pertinent. Experiences of prior TOP around the menopause and whether there are cross-linkages remain unexplored.

Sound qualitative studies, within a UK setting, are required to fully understand any longer-term impact of living with a history of TOP. A critical realist perspective was utilised in the current study. According to Ussher (2003), this 'affirms the existence of reality but recognizes its representations are mediated by culture and language', thus the information gathered from women concerns accounts of their actual experiences but takes into account that how women think and talk about these may be influenced by prevailing societal and cultural views. The aim was to utilise an approach to analysis, which enabled both prespecified foci to focus the participants on specific areas of interest, whilst allowing for emergent themes.

Aim

To explore women's experiences of (a) living with prior TOP in the longer term towards the end of their natural reproductive lives, and (b) their perceptions of separateness or linkages between their menopausal experiences and TOP. This concerned whether women made connections between these two aspects of their experience or viewed them as distinct and unrelated.

Method

Participants and procedure

Women were attending a clinic for perimenopausal symptoms and had had a legal TOP at least 10 years before the time of interview. The pregnancy must not have occurred as the result of rape. A reproductive history is routinely taken as part of the initial assessment at the Menopause Clinic. The clinic doctors (specialists in the menopause and family planning) were requested to approach all prospective participants fulfilling criteria over a period of four months. Women were informed of the study, which focused on their experiences of menopause, termination of pregnancy and their own perspectives about existence or non existence of any linkages. Of 15 women who fulfilled criteria and were approached, 8 participated.[1] Ages ranged from 35 to 63 years (mean: 47 years). All were white British, with English as a first language and in a heterosexual relationship, with only one not married or cohabiting.

Social class was not formally recorded, but women came from diverse areas of the city with a wide range of social deprivation indices and included both owner-occupiers and council tenants. Two women were childless and the remainder had between one and four children. All but one of the women were employed (with jobs ranging from professional to manual roles) and were using Hormone Replacement Therapy. Two women had had three TOPs.[2] All the TOPs occurred between 10 and 34 years previously[3] (mean=24 years, less than 20 years=3 women, more than 30 years=3 women). The range of age at TOP was 17–32 years (mean=24 years).

Ethical clearance was gained from a local National Health Service (NHS) Ethics Committee. Ethical arrangements allowed for the opportunity to meet with a clinical psychologist, subsequent to the interview although no participant required this. The authors had no competing interests.

Researcher characteristics

The researcher's beliefs may influence the experiences that participants recall (Hess, 2006), including the researcher's experience and attitude towards TOP and knowledge of these areas. An awareness of one's own beliefs and constant reflection on them therefore offers the optimal opportunity to reduce bias in such studies. For example, if the researcher communicated disapproval of a participant's choices due to their own beliefs about TOP, either verbally or non-verbally, participants may be less inclined to share certain aspects of their experience of TOP. The interviewer (KD) was a 26-year-old white female with no children. She had no particular religious or political affiliation and no prior contact with, or strong views concerning, TOP or the nature of menopause or whether a relationship between the two existed. Due to the clinical origins of the research, the researcher expected that some women *may* report adverse affect related to the TOP, but did not presume this to be the case. The second coder (AH) was a white female researcher experienced in qualitative analysis, aged 43 years with two teenage children. The analytical process was witnessed by a third researcher (PS) experienced in qualitative research. All are trained as psychologists.

Interview procedure

Data were collected through semi-structured interviews carried out between December 2005 and April 2006. Interviews took place in private; six in clinic, and two in their own home. Interviews lasted a mean duration of 61 min. A semi-structured format with open questions was used allowing freedom to discuss pertinent issues and experiences (see Topic Guide in the Appendix). Care was taken to ensure openness and neutrality of questions. The interviews were conducted within an ethos of relaxed, non-judgemental acceptance and active listening, whilst encouraging women to reflect on their experiences. All interviews were audiotaped and transcribed verbatim.

Analytic procedure

Template analysis was employed to analyse transcripts (Crabtree & Miller, 1999; King, 1998). This allows the inclusion of a-priori themes so that specific areas of interest may be addressed as well as those entirely emergent from the data. When a thematic heading was prespecified (for example, 'termination'), the specific content in terms of its subthemes and other related themes/subthemes was entirely emergent;

women were specifically asked about each area, but questions were designed to allow them to express their experiences, whatever these may be. This methodology is seen to occupy a middle ground between content analysis with its predetermined codes and grounded theory (Glaser & Strauss, 1967; Weber, 1990).The analysis of transcripts involved the following stages (King, 1998).

(i) A research diary was kept to facilitate researcher reflexivity and so consider views and thoughts over the course of the project and the potential implications on analysis. For example, the researcher's thoughts and reactions to the participants' narratives may influence the analysis of the data. The research diary aims to reduce this by promoting a reflective and therefore self-aware stance.
(ii) To check accuracy and encourage further reflection on the interview, the researcher listened to each interview again with the corresponding transcript.
(iii) The researcher and another member of the research team read the first transcript. Both separately conducted preliminary 'open' coding to identify possible themes and met to discuss these. Any discrepancies were resolved and rationale for these decisions was agreed. Along with the original interview schedule, this allowed an initial template to be created.
(iv) The next transcript was then coded with respect to the original template. Again, interpretations from the two researchers were compared and discrepancies resolved. As a result of this process, the template was modified and reapplied to the preceding transcript.
(v) Step (iv) was repeated for each transcript. The transcript was always analysed with respect to the most recent template. This template was then modified as appropriate and reapplied to preceding transcripts.
(vi) By the end of the process, all transcripts had been coded using the same template, derived after analysis of the final transcript.
(vii) All themes were then listed with relevant codes from each participant, to ensure that codes had been reliably applied to each transcript and themes were distinct as recommended by King (1998). Themes had to include codes from half of the women for inclusion in the template.
(viii) As a result of (vii), the template was further refined and reapplied to the transcripts.
(ix) Themes were labelled in a way that encapsulated the participants' experience and checks back were again made, to ensure the themes generated reflected the original text from which they were derived and that contradictory evidence was not present.
(x) An 'audit trail' was compiled of the analytical process (King, 2003). This displayed successive versions of the template and its application for each participant, detailing and providing a rationale for changes.

Three broad themes were prespecified: *experiences of the menopause*, *perspectives on continuing impacts of TOP* (whatever their presence/absence or valence) and *consideration of the menopause experience and TOP together; separateness and linkages*. The *experiences of the menopause* theme is not described here as this is not the focus of the article. The emergent themes within each of these prespecified themes form the final template.

Reliability and validity

The process of creating lists of themes and joint analysis meant that the emerging template was tested and challenged at each stage through seeking contradictory information, therefore promoting the validity of the final version (King, Bell & Thomas, 2004). A web-based introduction to the technique and exemplars are available (King, 2003).

Results

The final template is outlined (Figure 1[4]) followed by a detailed supporting account. We have ensured quotes are drawn from all participants.[5] Where different perspectives or conflicting information was presented this is clearly identified.

1. Termination of pregnancy

1.1 Impression left by TOP

Women spoke with great emotion about the feelings resulting from TOP; all expressed sadness. For some it was seen as an indelible stain on their history that had somehow

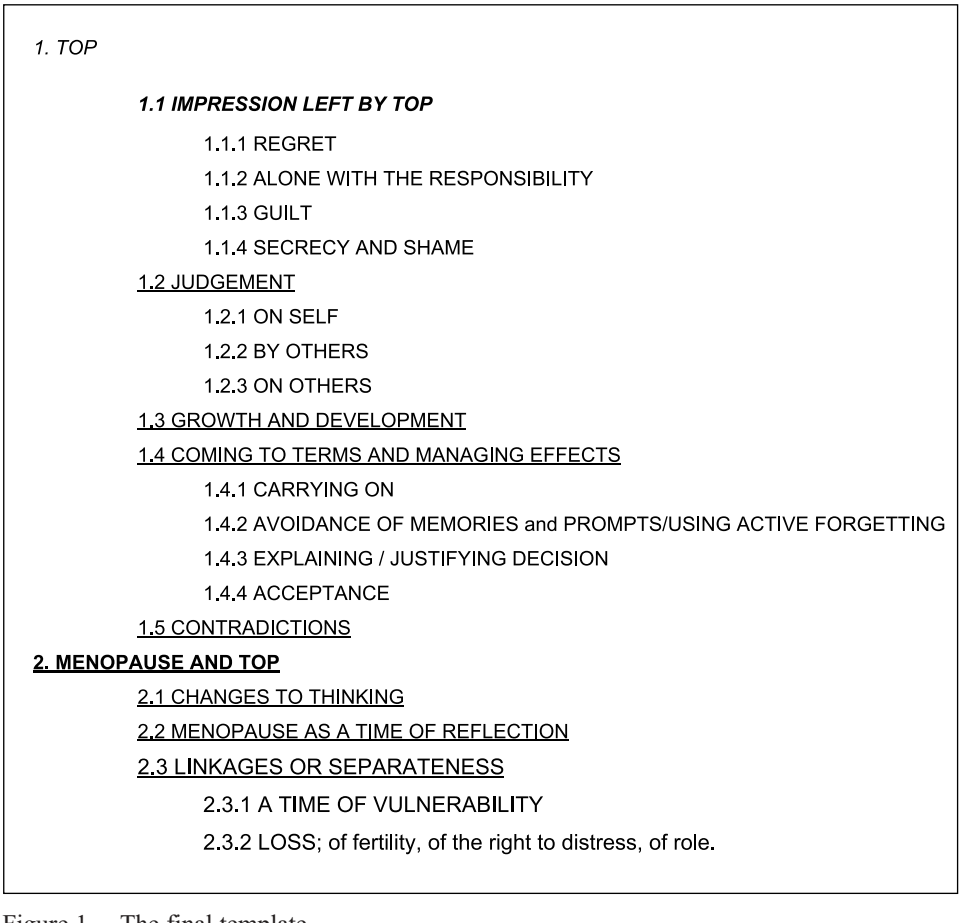

Figure 1. The final template.

soiled her person, making her 'damaged' and permanently different from how she had been before.

> its like having a CV with a black mark on it, like you want to get rid of it but you're not going to be able to because it's always going to be there. It's like a blot in your copy book if you know what I mean? (Ann, 43)

1.1.1 Regret

Regret was expressed by all, although for some this was balanced with the belief they had made the correct decision. Others regretted the circumstances that culminated in TOP being necessary.

> I wish I'd had the baby now, but my life's a lot happier (Jenny, 45)

> I just regret that I weren't in a proper relationship (Barbara, 63)

> it's something that I'd just rather not have happened, I question it (Ann)

1.1.2 Alone with responsibility

Partners who fathered the child were not told about the TOP, promoted TOP, or left the decision to the woman. Women felt that regardless of their partner's stance, the decision was ultimately theirs. Claire was still in the same relationship and reported her partner used the TOP in arguments, compounding her sense of isolation with the decision being her responsibility.

> so I basically just took on board myself (Sue, 51)

> he (partner) told me in no uncertain terms that he didn't think it was right, and he talked about my age and everything like that to make sure I wasn't competent at my age but it was my decision in the end, I wasn't forced into it, I wasn't made to do it (Tina, 35)

> he keeps saying to me, oh we would have had (number) kids by now, I had to tell him to be quiet (Claire, 42)

1.1.3 Guilt

Guilt emerged as a subtheme with expressions of guilt or statement of its absence with the inherent implication of its expectation. Three women expressed a belief that they did not feel guilty in relation to the TOP but rather the effects of it, by 'depriving' children of a sibling or parents of a grandchild, by their 'selfish' actions. Others expressed guilt alongside relief or anger at the circumstances.[6]

> I felt guilty, I thought some people could look at me and see that I were guilty, that I'd done something wrong … sometimes I wish I could not feel this, weight in my chest and this guilt that I feel (Elaine, 52).

> I feel some guilt, you know, because it's like taking a life isn't it (Barbara)

> I'm not racked with guilt about it (Ann)

> my daughter's an only one … and she always said, she'd never want an only child … and we did discuss it and said, oh, you know, how did you feel about being an only child,

> she said, well, I'd always got loads of friends mum, but it would have been nice to have a brother or sister … and I think well, she could have done (Sue)

1.1.4. Secrecy and shame

TOP was often discussed in terms as 'a dirty secret' (Claire), 'cheap' (Elaine), 'tacky' (Sue), or 'seedy' (Ann) and as a source of shame that 'haunted me' (Ann) and was 'not talked about' at the time or currently. Three women had kept it secret from current partners and Barbara had only told her current partner after 10 years. Partners, when told, were generally perceived to be 'supportive and understanding' and this reduced negative emotions relating to the TOP.

> it's something that I just want to, hide from him (Ann)

> it's always been on my mind that I wanted him to know, I was scared actually that somebody else was going to tell him (Barbara)

> he was really nice and supportive. I felt better when I'd actually told him because he's the only person I've actually told it to because I've told him, I feel as if I've confessed (Elaine)

Few women had discussed TOP with other children but had considered the impression of the TOP upon their family structure. The TOP also had an effect on existing relationships with parents. The decision whether or not to keep the TOP a secret had consequences upon women's relationships both at the time and in the long-term.

> I don't want the kids knowing (Claire)

> I think it's a shame that my daughter hasn't got a sibling, so when I die she won't be by herself (Mary, 47).

> telling my mother was probably worse thing I did, because she was so Victorian, you know, in her ways (Barbara)

> I don't think I ever felt the same way about them, after that [parents telling her to leave their home if she did not terminate her pregnancy] (Elaine)

1.2. Judgement

Judgement pervaded many aspects of women' lives, apparently due to the impact of TOP.

1.2.1 On self

All women talked about TOP negatively influencing their views of themselves. By taking the majority of responsibility for the decision, 'something that you've chosen to do yourself' (Tina), predominantly only the self was judged as 'bad' or at fault, with little or no consideration of the context within which this decision was made. In cases where the individual appeared to have some acceptance, the TOP still led to portrayal of themselves in a negative light. Judgement of self as weak was also apparent in some accounts.

> I was just so depressed, I didn't want to live anymore, I was suicidal and I started drinking, because all I could think about is that I've murdered this baby … it's something I don't think I'll ever, forget what I did (Elaine)

> I just think I must be a bad person all them years ago to do what I did, everybody's allowed to make one mistake, I made three, too many (Mary)

> I think things like, when people are desperate for children, it's, it's sometimes I feel so selfish (Sue)

> I'm just a selfish cow aren't I? (Claire)

> maybe I should have been stronger and, stood up for my beliefs, and what I actually really felt (Tina)

Three women discussed how fears had related to future fertility as a consequence or 'punishment'. Women who had not gone on to have further children also shared this view. Tina explained that the TOP 'made me decide that I wanted to be pregnant again' and she very quickly became pregnant 'as a result', seeming to judge the TOP as wrong and being able to rectify this with a subsequent pregnancy.

> the only fear I ever had, was when I thought how I'd never be able to have another child and I also thought it, that if I did, there'd be something terribly wrong with it and that'd be my fault (Jenny)

> I know it sounds a bit stupid but I feel as if it's like, is this my judgement? It's like, it's as if this is my punishment [no more children] (Ann)

1.2.2 By others

Judgement by others was perceived as, and presumed to be, negative. Some women described friends as supportive when the topic was discussed. Others chose not to reveal their TOP. In the main, disclosure resulted in 'support' and 'understanding', rather it was fear of judgement that prevented it. However, some had experienced feeling judged. Perception of judgement from others was also attributed to outside agencies such as medical and nursing staff. Some women described their religion as compounding perceptions about judgement.

> it's haunted me … made me feel like a not very nice person, it's made me feel actually a bit dirty, if they knew what I was like they wouldn't want to be with me (Ann)

> they were fine, no-one judged (Mary)

> I mean a couple of work colleagues have confided in, you know, they, but I've never given that information that, you know, I've been in their shoes (Sue)

> I had enough guilt in me, I didn't want somebody else to tell me I were guilty, so I kept it secret … I became a Catholic which made it even worse I think, the Catholic side of me, but he [Catholic husband] would have condemned me (Elaine)

> I never liked, to say that I'd had, a termination because I think it would have an effect on relationships, that they'd think badly. I mentioned it once actually, it's changed her perception of me, I think I'm seen in a much more negative way (Jenny)

1.2.3 On others

Non-judgemental tolerance and understanding of others in similar situations was apparent and the 'right of the woman to choose' was expressed.

> when things come on about abortion … I find myself right sticking up for them, I think it's not fair for anybody to push it down their throat what they should be doing, I think it's just up to that person, not up to their parents or anybody (Ann)

Claire, despite saying she 'will probably have nightmares about it for the rest of my life', was a lone voice in criticising young mothers and their mothers, when she felt TOP was a more sensible option.

> if my daughter got pregnant, I would encourage her to terminate her pregnancy, there's no way I'd be one of those stupid women that you see on telly, letting their thirteen year old have a baby (Claire)

Societal change since participant's TOPs was commented upon, leading to a conclusion that women having TOPs today are less judged and somehow find the process 'easier'.

> in this day and age, times have changed, people's attitudes have changed, it's all the thing, so it doesn't matter, when I got pregnant and had an abortion things were just starting to change, now it's like, there's another one, don't worry about it. It's a completely different attitude now (Tina)

1.3. Growth and development

Women described positive consequences resulting from the TOP, including the TOP as a catalyst for the end of a 'bad' relationship that allowed movement to a happier relationship and, in some cases, further children.

> it made me sort myself out, I think it were a bit of a turning point when I think about it, I know I've got a strength there that I know I can rely on myself (Ann)

> Better quality of life … [knowing] that I could get pregnant (Barbara)

> inner strength … learning through what you do (Tina)

> the way that I feel now is quite strong about my beliefs, I'm very for it or against it, never in the middle (Elaine)

> it's given me more of an understanding how other people feel in the same situation, like I have done, able to offer, some support to other people (Tina)

1.4 Coming to terms and managing the effects

1.4.1 Carrying on

Women talked about coming to terms with the TOP by moving forward in their lives. 'Carrying on' was commonly discussed as well as the need to avoid any perceived negative consequences.

> [I] just went back to work and did my daily routine (Sue)
>
> life takes over, at first it's so hard you don't think you're going to get over it, but, life goes on (Jenny)
>
> it's not something you dwell on, unless you want to dwell on it and make yourself ill(Tina)

1.4.2 Avoidance of memories and prompts/using active forgetting

Memories of any event may be indistinct or feel removed many years later. However, all of the women described 'avoiding thinking about it' (Ann). As well as avoiding memories, women described actively trying to forget the TOP; that is, making a decision not to think about it. All participants spontaneously used the term 'blocking it out' as a universally adopted strategy.

> [I] try to push it to the back of my head (Mary)
>
> I've chosen to forget, so that's why I can't remember (Claire)
>
> I've buried everything (Barbara)
>
> [building a] bridge between you and that feeling, because you couldn't handle it, I suppose it's a way of coping (Jenny)
>
> switching it back off again [after the interview] (Ann)

This relates to a conscious denial or 'shutting off' (Jenny) from the feelings related to the TOP. This 'blocking off' strategy had been so successfully applied for some women that the experience of TOP felt detached. Women also avoided prompts to recollection. At times, memories seemed to intrude despite trying to forget. Women also described being prompted to remember TOP by television programmes or other people. 'Blocking out' the memory was difficult and imperfect as prompts managed to 'break through' and increase thoughts about the TOP.

> that isn't the person I am now, I'm so wholesome now, I feel like I'm a different person now, it's a distant memory that happened to somebody else (Ann)
>
> bring back a lot of, the old feelings, a bit, it's likened to being slapped in the face, a lot of it goes kind of unsaid and unthought, it's very difficult to describe how you feel, I think just, an awakening again of all those raw emotions (Jenny)
>
> I have flashbacks but they don't affect me (Sue)
>
> when people are talking about children and oh, haven't you ever wanted kids? And it makes me think about it (Ann)
>
> blocking them out and trying to get through things, doesn't work always and you don't realise how deep they are until you realise … they have sort of like had a knock-on effect in your life (Tina)

Elaine was unique in remembering every detail of her TOP, she did not avoid or actively try to forget, rather she seemed to use the details as a source of rumination.

> this child of mine would have been (number of years) this month, it's the (date) of (month) which is the day I was given and I still think about this baby and I think about it at Christmas, it's something I don't think I'll ever forget if I live to be a hundred I would never be able to say, yes, I did the right thing, because I know I didn't.

1.4.3 Explaining and justifying the decision

Participants justified their decision as well as explaining its context. It seemed important to some women that they stressed how much thought they gave to the decision. Alternatively, some stressed their certainty that they had made the correct decision. Other justifications or explanations included an unsupportive partner, bad relationship, not wanting the 'burden' or responsibility of more children, youth, and the desire to achieve personal goals such as career targets. Any uncertainty about the decision to terminate was actively managed.

> I'd never have done it any differently I'd have done exactly the same thing again, I wasn't thoughtless about it (Ann)

> I didn't think twice about it, I just didn't want another baby (Mary)

> I just knew that, I couldn't cope with another baby, financially as well as emotionally (Sue)

> trying to convince myself it was the right thing to do (Claire)

1.4.4 Acceptance

Acceptance of the decision was expressed by many. The minority did not display acceptance, but rather recognition that TOP had occurred as part of their personal history.

> it's probably the best thing I could have done, it doesn't particularly bother me anymore (Barbara)

> I made a mistake, you know, and I did the right thing (Claire)

> (I) can't alter the past, but it does affect me (Elaine)

1.5 Contradictions

Within every account, there were frequent contradictions and women displayed a lack of coherence when discussing their TOP. This was similar to an individual being unsure of an idea and so presenting opposing sides in order to reach a conclusion, the opposing rational and emotional aspects of the decision being voiced. These are separate comments within the same transcript.

> it don't haunt me in that I'm riddled with guilt about it, I don't give myself a hard time about it *versus* it's haunted me to be honest, I'm ashamed, I think it's just something else I have to hate myself about (Ann)

> when I became a mother, I thought I am a good person … logically it's (loss of fertility) not punishment, I'm older *versus* I can't ever look at it logically and think I did the right thing, it were wrong, I feel worse than a prostitute (Elaine)

> I think at the time I probably made the right decisions, it wasn't right to keep the baby *versus* I don't know if I made the right decision, I think that's what is upsetting (Mary)

> It [TOP] didn't have an effect on me *versus* I'll probably have nightmares for the rest of my life, I hate myself so much, unless you can cut it out of your head, you could torture yourself with it (Claire)

2. Menopause and TOP

Participants were asked how, if at all, they thought their TOP had influenced their experience of menopause, or vice versa. Whether women identified an association or not, care was taken to ensure responses were equally acceptable to the interviewer.

2.1 Changes to thinking

Changes were apparent in the way some, but not all women thought about TOP now they were menopausal. Many considered menopause as a marker of time with negative implications whilst others viewed the passage of time as a positive factor that allowed 'insight'.

> not thinking about it any more or any less (Jenny)

> not thinking about it any differently (Sue)

> I'm more removed from it (Ann)

> thought about it more as I've got older (Barbara)

> as I've got older I feel guilty and more aware of what I did … I think about it more now (Mary)

> I've never not thought about it, but it never hurt me as much as it has now, I feel as hurt as I did when I first had it done (Elaine)

2.2 Menopause as a time of reflection

Menopause was seen as a time of reflection, 'you start looking back on what you've done rather than looking forward to what you intend to do, it sort of puts things into perspective' (Ann). Numerous women commented they had not realised the effect of TOP at the time and only intervening years had allowed the space to reflect.

> thinking I'd be the same person afterwards, but I obviously wasn't, but you don't realise at the time, you weren't aware of exactly what you were going through, you don't realise how deep they are until you realise that you've done things that have, had a knock-on effect in your life (Tina)

> it really did affect me, a lot more than I ever thought it would, I just thought it would be okay (Elaine)

Women reflected on whether TOP had been the correct decision and some were still struggling with this, decades after the event 'I don't know if I've made the right

decision, I think that's what is upsetting' (Mary). All women reflected on the family they now had and thought about the child they had terminated. For the majority, this was a 'wondering' stance and these 'what ifs' tended to seem quite benign and wistful, being tinged with sadness.

> I've always thought of him … wondering how old he'd be, I do wonder about that child (Jenny)

> gazing wistfully, out of the window, wondering what it would have been like now, how old would it have been (Tina)

> I could have had a daughter or a son, a little granddaughter, that's blood, you know, that's my own (Barbara)

Reflecting on the TOP at the time was seen as something that may have been beneficial; 'there wasn't any counselling as such or anything, maybe it would have been good' (Jenny).

> most important is trying to get somebody to listen to you so that you can get help, I didn't get counselling, it would have either helped me listen to myself and, come to terms with what I was doing in one way or another, it would have given me the space and time, and it would have helped me maybe have closure on it (Tina)

2.3 Linkages or separateness

2.3.1 A time of vulnerability

Four women discussed the menopause as a vulnerable time that had made it increasingly difficult to 'manage' their feelings about TOP. Menopause was seen as a time of vulnerability to increased low mood and a consequently an increase in thinking about TOP.

> I think menopause is just depression really, well it is for me, it just gives you a handful of regrets about everything when you go into the menopause, it's [TOP] something that's lurking in your past that if you're a bit down it comes back at you (Ann)

> I don't think about it every day, it's sometimes, if I'm a bit low probably, it's since I've been in menopause that might have brought it out (Barbara)

> It's only since the menopause has come on that I actually feel really guilty again, I mean I sometimes sit on my own and I've cried because I feel guilty, but I have noticed that has happened more obviously since I've gone into the menopause (Elaine)

Anne clearly describes menopause and her resulting depression as a factor making it harder to 'block out' the TOP, 'I mean me armour's been chipped a bit and it starts allowing it to get through'.

2.3.2 Loss; of fertility, of the right to distress, of role

The linkage between menopause and TOP was mediated by the theme of loss for many women, although this was displayed with a differing focus. For some, menopause had emphasised the loss of fertility and future opportunity for more children, which seemed to heighten the sadness and negative affect associated with the TOP.

> maybe it's because I've come to the end of my child-bearing years, that I think more about it. I can't have children, so now, it's been brought home to you, you've had the children you're ever going to have, that's it, there's no more and I could never have that child because it's gone (Elaine)

> I feel as if I've played around with that precious thing until now when it's been took away, I think, I don't think I'm going to have kids full stop and I think I wasted that opportunity. I've missed my chance, as if I frittered that chance away (Ann)

> It's like part of you has gone, when you go through the menopause, part of you being a woman what's gone, reproducing, I think it's quite sad that I can't have any more children but then again, I terminated me children so I shouldn't feel sad (Mary)

Within these quotes there is a sense of not being entitled to express sadness at having no further children. Rather there is a feeling that this 'right' was lost when they had a TOP, and these women should accept and bear their current state without emotion, they somehow 'deserve' this 'punishment'.

2.3.3 Separateness

Previous TOP and experience of menopause were viewed as discrete and unrelated by three women. Sue explained that the TOP had not 'influenced me in any way' and saw no relationship between the events; however, she attributed this to the fact that she had had a hysterectomy and 'couldn't have any more children anyway'. Jenny, possibly the woman who seemed most accepting of her TOP, was clear that she saw 'no link' between the two events at all. Likewise, Claire thought the two things were 'totally different'.

Discussion

1. Termination of pregnancy

Participants described the long-term emotional impact of their TOP(s) as predominantly negative, even if balanced with a belief they had made the correct decision.

All participants spoke of judgement because of the TOP, either judgement of themselves, by themselves, or of others. Fear of judgement and negative perceptions by others was often a component in concealment of the TOP, even if the individual 'accepted' the TOP. Evidence confirms that women who feel stigmatised by TOP are more likely to keep it a secret from family and friends. Such concealment has been linked to increased thought suppression, intrusive thoughts and psychological distress in women two years post-TOP (Major & Gramzow, 1999). The limited literature on short-term coping post-TOP emphasises the role of others in mediating a woman's psychological status, including her perceptions of support from others, and status of relationships (Coleman et al., 2005). Just as relationships influence coping and distress, so resulting perceptions and attitudes continue to influence not only the individual but also her interaction with close others.

A growth in personal resilience was discussed as well as a perceived greater understanding of others in difficult circumstances were revealed in themes in the present study (Hess, 2004; Kero, Hogberg, & Lalos, 2004). Additionally, women described their experience resulting in specific views and attitudes towards others undergoing TOP, with the majority supporting existing findings that women post-TOP report generally positive attitudes towards TOP (Alex & Hammarstrom, 2004).

Participants' accounts included a commonality of avoidance and 'trying to forget', but continuing to think about the TOP, prompted or not. Three recent quantitative studies indicate women have recurrent thoughts about TOP that they suppress or find intrusive (Speckhard & Mufel, 2003; Rue, Coleman, Rue, & Reardon, 2004; Broen, Moum, Bodtker, & Ekeberg, 2005). Two participants here recounted 'flashbacks' and 'nightmares' about the TOP. These accounts are indicative of 'post-abortion syndrome', characterised as similar to post-traumatic stress disorder (PTSD), where individuals have intrusive thoughts or images, which they attempt to avoid (Lavin & Garcia, 2005). Whilst there do appear to be some similarities between post-traumatic stress symptoms and elements of participants' account, post-abortion syndrome is not a recognised psychiatric condition and such labels are open to political application (American Psychiatric Association, 1994). However, results here imply that concealment and distress may have an effect in the much longer-term than currently presumed, and this warrants further investigation.

Women reported knowing that the TOP was 'the right thing to do', but maintained a negative perspective of the self as 'bad' or 'guilty'. This presentation of opposing attitudes and emotional states is indicative of cognitive dissonance (Festinger, 1957), that is, when two simultaneously held attitudes are inconsistent, resulting in psychological conflict. The theory assumes a drive towards cognitive consistency to reduce psychological discomfort, where the individual integrates these conflicting views into one consistent opinion which is therefore more psychologically comfortable. This explains the inconsistency in some women's self-perceptions, for example split into 'good mother/person' and 'bad person who had a TOP' and apparent inability to integrate these opposing views. The justification and contradiction themes illustrate that memories have been 'blocked out' to such a degree that inconsistency remains unresolved.

Models of adjustment to events or changed circumstances suggest that several processes are involved: (1) a search for meaning in the experience, (2) attempts to gain mastery over the event and over one's life and (3) efforts to restore self-esteem through self-enhancing evaluations (Taylor, 1983). Accomplishment of all components implies integration of the event into the self and obtaining a position of relative psychological comfort. Justification and explanation themes could be perceived as an attempt to accomplish these aspects. It may be that life events and changes over time in attitudes to TOP may result in continued or repeated efforts to adjust to this cognitive inconsistency. Participants illustrated the influence of the event extending decades post-TOP.

Considering all the themes together, it was clear that for some of these eight women TOP continues to be a source of negative thoughts and feelings at least a decade after the event; fear of judgement appeared to prevent women from disclosing although some recognised growth as a result of TOP. Women actively tried to forget or avoid prompts to memories of the TOP, despite some reporting acceptance of the experience. For some, the experience is not integrated successfully into their perception of self and strongly contradictory perspectives within the same individual persist.

2. Menopause and TOP

Menopause was described as a specific marker in time, allowing reflection upon TOP and how it had been perceived over the years. Erikson's life stages explain women's accounts of an increase in thinking about TOP at the time of menopause. Erikson

described how we develop in non-linear psychosocial stages (1950, 1968; see Erikson, 1997 for a review), the final of these stages, integrity versus despair, is where the older person evaluates the previous stages of their life. Whilst menopause is a mid-life event it does mark the end of natural childbearing potential and as such could be considered to trigger review of this area of womanhood. In this context, if these retrospective glances reveal a sense of satisfaction then integrity is hypothesised to be achieved, and if not the individual will experience despair. Some women appeared to illustrate this lack of integrity when discussing their TOP, indicating a possible lack of satisfaction.

It is of note that women's accounts imply that menopausal experience is not influenced by TOP; rather that for some women menopause impacts on thoughts about TOP. For some, the menopause is a time of vulnerability, as low mood associated with perimenopause allows increased negative thinking (Avis, 2003; Deeks, 2003) and so lowers 'defences' to thoughts about TOP. For some of the women in the study this was illustrated in their thinking about TOP and menopause as characterised by loss. Such negative thinking has a central role in the maintenance of depressed mood (Beck, 1970, 1976) and depressed individuals selectively attend to events that confirm their negative view of themselves. Previous TOP may be viewed as an additional stressor that can exacerbate the vulnerability and maintain the low mood. This idea is reflected by Ann's statement, 'my armour's been chipped a bit and it starts allowing it to get through'. For some women, the menopause and its inherent biological consequences may serve as a new filter through which they reappraise their thoughts and feelings about their TOP.

Three women in the study did not support this association between TOP and menopause, supporting the notion that participants felt free to represent their experiences without conforming to a perceived expected narrative. This also implies that further research is required to consider this association between TOP and menopause, to gauge the presence and prevalence of such vulnerability in the general population.

Strengths and limitations

Validity was ensured by two researchers coding separately, and a consensus being reached on resulting codes and themes derived (King et al., 2004). Critics of qualitative research argue that personal bias is inherent in analysis. Given the emotive and politically sensitive nature of the topic, the awareness of personal views as well as the process of parallel analysis by two individuals and checking by a third minimises this concern. Where women showed different patterns to a theme this was specifically noted.

For all participants a significant period of time has elapsed since TOP, this research focuses on the implications of this procedure as the women remember and perceive it today. Women who seek treatment for menopausal difficulties tend to report more psychological symptoms than non-patient samples (Ballinger, 1985; Morse et al., 1994). Additionally, the psychiatric history of participants prior to TOP is not known and these women had previously disclosed their TOP during clinic assessment, presuming a readiness to discuss TOP. Both of these factors may influence the views of the eight women involved in this study. There is also evidence to suggest that UK societal attitudes to TOP have become significantly more liberal during the 1990s, since these women had their TOPs (Bradshaw & Slade, 2003). It cannot be assumed that women experiencing TOP today will respond in the same way. In addition, the nature of the sample must be considered, as whilst it included women

of diverse socio-economic status all participants were of white ethnic origin and most had current partners.

Clinical implications

The study indicates that some women face strains in living with the experience of TOP in the longer term. The work provides an insight into the very long-term consequences of this procedure for these participants. Qualitative work does not claim generalisability; however, it is of interest that participants stressed the value of being able to discuss the TOP with a neutral third party, to be able to voice some of the thoughts, confusion and sadness some had carried alone for so long for fear of repercussion or judgement. It is likely that women may benefit from the availability of post-TOP counselling services not necessarily just in the immediate aftermath, but at different points after the procedure.

Notes

1. Individually itemised information about participants is not included to ensure the anonymity of participants recruited from a small clinical setting.
2. One participant was unsure of the exact number so, with her consent, this was verified.
3. Dates are those reported by participants. Where a woman had more than one TOP the individual mean is used in calculating the overall mean.
4. Highest order codes are written in bold underlined uppercase text, the next level are written in underlined uppercase text, the third order codes in uppercase text.
5. Please note all names used are pseudonyms and the age of each woman is written after their name for each first included quote.
6. This quote contradicts Tina's previous quote. Such contradictions occurs in all transcripts and are discussed later.

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Appendix

Topic guide re termination

- **Please tell me about the circumstances surrounding your termination.**

Prompts; Number of terminations undergone
Age of woman at time of termination
Relationship status of woman
Method of termination
Weeks gestation at time of termination
Reason for termination (i.e. sexual assault, foetal abnormality, unplanned pregnancy)
Circumstances surrounding decision to have termination
Concealment of procedure from others

- **What was this like for you and your relationships at the time?**

Prompts; Feelings/thoughts after termination and their intensity
Reaction of partner of the pregnancy and other involved parties

- **What is this like for you and your relationships now X years on?**

Prompts; Feelings/thoughts about termination and their intensity
Reaction of partner and other family members

- **How did you move from how things were initially after the termination to how things are now?**

i.e. how have feelings changed over time towards the TOP?

- **Looking back, in what ways if any, either positive or negative, has the termination influenced your life and relationships?**

Prompts; Children
Partner
View of self

- **How, if at all, has the termination influenced your experience of the menopause?**

i.e. What kind of thoughts do you have about it?