COPING WITH PREGNANCY TERMINATION AMONG THAI WOMEN

PARADEE PRASERTWONG

DOCTOR OF PHILOSOPHY

IN NURSING SCIENCE

GRADUATE SCHOOL

CHIANG MAI UNIVERSITY

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A THESIS SUBMITTED TO CHIANG MAI UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN NURSING SCIENCE

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ABSTRACT

Pregnancy termination without medical indications is morally, socioculturally, and legally disapproved in Thai society, leading to a higher risk of mental health problems and a lack of access to health care assistance for women who have had such experience. This qualitative study based on feminist perspectives aimed to describe their feelings, coping strategies, and support. Twelve participants, living in Nakhon Nayok province, were recruited to the study. Their experience ranged from 10 to 26 years. In-depth interviews, reflexive questioning, and non-hierarchical relationships building were implemented to give them voice and courage to speak for their own sake. Narrative analysis (Sosulski, Buchanan, & Donnell 2010) was used for data analysis through feminist lens. Trustworthiness of the study was achieved through member checking, peer debriefing, and reflexive journal writing. The results showed that:

1. Following pregnancy termination, the participants developed the feelings of suffering from their wrongdoing which was rooted from their beliefs in destroying or killing their own baby, or stopping their baby from being born. Their feelings of suffering were expressed as the feelings of (a) being wrong: sad, guilty, sinful, stigmatized, shameful, and anxious; (b) being haunted: senses of illusive pictures, sound, or touches of the dead baby, leading them to feel crazy, confused, scared, and unhappy; and (c) being failed in life: difficulties, obstacles, and no progress.

2. To manage their feelings of suffering, the participants took responsibility for their wrongdoing. Firstly, they accepted their mistakes instead of putting the blame to others. Secondly, they protected their self – values by keeping their stories as a secret. Thirdly, they sought forgiveness from their dead baby, mostly through various religious rituals, to liberate themselves from sins and bad Karma, to obtain the peace of mind, and to pray for the baby's rebirth to a new better life. Finally, they empowered themselves through learning from their mistakes, not being stuck in the past, becoming stronger, and living their life in a better way.

3. Considering support, the main sources of support were from religions and followed by family. No one sought out or obtained professional support. However, through reflexive questioning if support were available, their expectantly desired support was just empathetic understanding without condemnation. They also suggested that men should share responsibility, and that health care services should be provided to support their physical and emotional recovery.

The women who have experienced pregnancy termination have substantially long-termed suffering but they devote great time and effort to managing their mental health challenges with virtually no health care support. Not only empathetic understanding given to these women, but both informal and professional support should also be provided to enhance their healing. Fairly, men should be responsible and become involved in this issue. Further research can be emphasized on accessible and gender-sensitive healthcare services.

หัวข้อดุษฎีนิพนธ์	การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย	
ผู้เขียน	นางภารดี ประเสริฐวงษ์	
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บทคัดย่อ

การยุติการตั้งครรภ์ที่ขาดข้อบ่งชี้ทางการแพทย์ยังไม่เป็นที่ยอมรับในสังคมไทยทั้งด้านศีลธรรม สังคมวัฒนธรรม และกฎหมาย ทำให้สตรีที่มีประสบการณ์เกิดความเสี่ยงต่อปัญหาด้านจิตใจและไม่สามารถเข้าถึงความช่วยเหลือได้ การวิจัยเชิงคุณภาพโดยใช้มุมมองสตรีนิยมนี้มีวัตถุประสงค์เพื่ออธิบายความรู้สึก กลยุทธ์การเผชิญปัญหา และความช่วยเหลือ ผู้เข้าร่วมวิจัยมี 12 คน ซึ่งพำนักอยู่ในจังหวัดนครนายก และผ่านประสบการณ์มาแล้ว 10-26 ปี การสัมภาษณ์เชิงลึก คำถามสะท้อนคิด และการสร้างสัมพันธภาพแบบเท่าเทียมกันช่วยให้สตรีได้มีสิทธิมีเสียงและกล้าที่จะพูดเพื่อตัวของเธอเอง ผู้วิจัยใช้การวิเคราะห์เชิงเรื่องเล่า (Sosulski, Buchanan, & Donnell, 2010) เพื่อวิเคราะห์ข้อมูลผ่านแนวคิดสตรีนิยม สร้างความเชื่อถือได้ของการวิจัยโดยการให้ผู้ให้ข้อมูลตรวจผลวิจัยเบื้องต้น การทวนสอบ และการบันทึกสะท้อนคิด ผลการวิจัยมีดังนี้

1. หลังจากการยุติการตั้งครรภ์ ผู้เข้าร่วมวิจัยรู้สึกเป็นทุกข์จากการกระทำผิดซึ่งมีรากฐานมาจากความเชื่อว่าเป็นการทำลายหรือฆ่าบุตรของตนเอง หรือขัดขวางบุตรไม่ให้เกิด ความรู้สึกเป็นทุกข์นี้แสดงออกมาเป็น (ก) ความรู้สึกที่ตนเองผิด: เสียใจ ผิด บาป ถูกตีตรา อับอาย และกังวลใจ (ข) ความรู้สึกว่าถูกหลอกหลอน: โดยภาพ เสียง หรือการสัมผัสของบุตรที่ตายแล้ว ซึ่งทำให้เกิดความรู้สึกว่าสติไม่ดี สับสน กลัว และไม่มีความสุข และ (ค) ความรู้สึกว่าชีวิตล้มเหลว: มีความยุ่งยาก ประสบอุปสรรค และไม่ก้าวหน้า

2. เพื่อจัดการกับความรู้สึกเป็นทุกข์ ผู้เข้าร่วมวิจัยรับผิดชอบต่อการกระทำผิดของตนเอง ประการแรกคือการยอมรับในความผิดพลาดแทนที่จะตำหนิกล่าวโทษผู้อื่น ประการที่สองคือการปกป้องคุณค่าของตนเองด้วยการปกปิดเรื่องราวไว้เป็นความลับ ประการที่สาม คือการแสวงหาการให้อภัยจากบุตรที่ตายไปแล้วซึ่งส่วนใหญ่เป็นการปฏิบัติพิธีกรรมทางศาสนา เพื่อให้ตนเองหลุดพ้นจากบาปหรือกรรม เพื่อให้จิตใจสงบสุข และเพื่อให้บุตรไปเกิดใหม่ด้วยชีวิตที่ดี ประการสุดท้ายคือการเสริมพลังอำนาจให้ตนเองด้วยการเรียนรู้จากความผิดพลาด ไม่ยึดติดอยู่กับอดีต เข้มแข็งขึ้น และปรับปรุงชีวิตไปในทางที่ดี

3. ด้านความช่วยเหลือนั้น แหล่งความช่วยเหลือที่ได้รับเป็นส่วนใหญ่คือศาสนาตามมาด้วยครอบครัว ผู้เข้าร่วมวิจัยไม่เคยร้องขอหรือได้รับความช่วยเหลือจากบุคคลในวิชาชีพต่าง ๆ อย่างไรก็ตามจากการตั้งคำถามสะท้อนคิดว่าถ้ามีความช่วยเหลือให้ ผู้เข้าร่วมวิจัยขอเพียงแค่ความเข้าใจด้วยความเห็นอกเห็นใจ ไม่กล่าวโทษตำหนิ ผู้เข้าร่วมวิจัยยังให้ข้อเสนอแนะว่าผู้ชายควรร่วมรับผิดชอบและควรมีการจัดบริการสุขภาพที่ช่วยฟื้นฟูร่างกายและจิตใจ

สตรีที่ผ่านการยุติการตั้งครรภ์ทนทุกข์มากมายเป็นเวลายาวนานนั้นได้พยายามและทำสุดกำลังเพื่อจัดการกับสิ่งท้าท้ายทางจิตใจ ไม่ใช่เพียงความเข้าใจอย่างเห็นอกเห็นใจเท่านั้นที่ควรให้แก่สตรีเหล่านี้ ควรให้ความช่วยเหลือทั้งแบบไม่เป็นทางการและแบบมืออาชีพเพื่อให้สตรีผ่านเหตุการณ์ไปด้วยดี เพื่อความยุติธรรมควรให้ฝ่ายชายร่วมรับผิดชอบและเข้ามามีส่วนร่วม ประเด็นการวิจัยต่อไปควรเน้นเรื่องบริการสุขภาพที่เข้าถึงได้และมีความไวต่อเพศสภาวะ

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STATEMENT OF ORIGINALITY

The study entitled “Coping with Pregnancy Termination Among Thai Women” was qualitative feminist research that aimed to describe the feelings, coping strategies, and support that these women obtained and expected to obtain after pregnancy termination. These women likely managed their struggle alone since pregnancy termination without medical indication is unacceptable. As a result, they had to conceal their stories and were unable to access to healthcare services. At the same time, there has been no comprehensive protocol of mental care for these women. Therefore, this study was essential and can contribute to the development of healthcare services for these women so they can continue with their lives.

The results of this study serve as new knowledge obtained from the direct experiences of the women. The results were not obtained from other studies and have never been published. This research has never been submitted for a degree in any other institution.

ข้อความแห่งการริเริ่ม

การวิจัยเรื่อง “การเผชิญปัญหาการยุติการตั้งครรภ์ในสตรีไทย” ครั้งนี้เป็นการวิจัยเชิงคุณภาพแบบแนวคิดสตรีนิยม มีวัตถุประสงค์เพื่ออธิบายความรู้สึก กลยุทธ์การเผชิญปัญหา และความช่วยเหลือที่สตรีได้รับและคาดว่าจะได้รับหลังการยุติการตั้งครรภ์ สตรีกลุ่มนี้มักจะเผชิญปัญหาตามลำพังเนื่องจากสังคมไทยไม่ยอมรับการยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์ สตรีจึงต้องปกปิดเรื่องราวเหล่านี้ไว้ และไม่สามารถเข้าถึงความช่วยเหลือ ในขณะเดียวกันยังขาดแนวทางในการดูแลด้านจิตใจที่มีความละเอียดลึกซึ้งแก่สตรีกลุ่มนี้ ดังนั้นจึงมีความจำเป็นที่ต้องศึกษาครั้งนี้ เพื่อที่จะนำไปสู่การพัฒนาแนวทางการดูแลแก่สตรีกลุ่มนี้ให้สามารถดำเนินชีวิตต่อไปได้

ผลการศึกษาในครั้งนี้เป็นองค์ความรู้ใหม่ที่ค้นพบจากประสบการณ์ของสตรีโดยตรง ซึ่งไม่ได้มาจากผลการศึกษาของผู้อื่น และยังไม่มีการตีพิมพ์เพื่อเผยแพร่แต่อย่างใด ที่สำคัญผลงานนี้ไม่เคยถูกเสนอเพื่อขออนุมัติปริญญาในสถาบันการศึกษาอื่นมาก่อน

CHAPTER 1

Introduction

This chapter presents several topics including the background and significance of the research problems, research questions, objectives of the study, definitions of terms, as well as scope of the study.

Background and Significance of the Research Problem

Termination of pregnancy before 22 weeks' of gestation is defined as abortion (Reproductive Health Division, Department of Health, Ministry of Public Health, Thailand [RHD, MPH, Thailand], 2013). Induced abortions are a global concern in developing and developed countries. In Thailand, abortion is illegal and strongly disapproved by the society when there are no medical indications. Since abortion is a taboo and stigma, the term "pregnancy termination" has been recently preferred among many scholars. In this study, pregnancy termination is employed to indicate abortion without any medical indication.

In Thailand, public hospital data reveal that each year approximately 30,000 abortions take place, yet most abortions are carried out in private sector facilities, in unmarked abortion clinics, or by self-induction; consequently, 300,000 to 400,000 abortions likely occur each year (Arnott, Sheehy, Chinthakanan, & Foster, 2017). According to the Abortion Surveillance in Thailand Report 2013 or ASTR 2013, induced abortion was 32.7% of 1,119 cases, and induced abortion due to socioeconomic or family matters (mostly were unsafe) accounted for 31.4% of all abortions (RHD, MPH, Thailand,, 2013). Nearly half of abortions are unsafe; and almost all unsafe abortions (97%) and severe complications of unsafe abortions take place in developing countries (World Health Organization [WHO], 2017). In November 2010, 2,002 aborted fetuses were found hidden at three temples in Bangkok (Chaturachinda, 2014). This finding implies that the abortion rate is substantially underestimated. Induced abortions are more

prevalent among Thai women 20 years of age and older than among adolescents with approximately 60.9-73.0% VS 27.0-39.1% (RHD, MPH, Thailand, 2011). Adolescents and adults have different experience and perspectives on pregnancy termination. Adult women age ranges from 20 to 59 years whereas reproductive age is 15-44 (WHO, 2009). In this study, the experience following pregnancy termination were explored among Thai adult women during the reproductive age, aged 20-44, regardless of age at which they terminated their pregnancy. Adolescents are not included in this study. However, the reported incidence of 20-44 years age group is not available.

In Thailand, a study conducted in government hospitals revealed that over 61% of 13,090 cases of induced abortions were performed by providers outside the standard health care system (Chinthakanan, Rochat, Morakote, & Chaovisitseree, 2014). Unsafe abortions lead to high morbidity and mortality rates. According to the WHO, approximately 68,000 women die of unsafe abortions annually, making this type of being abortion one of the leading causes of maternal mortality (13%) (Haddad & Nour, 2009). The survey in 787 government hospitals by the Department of Health, Thailand, found the morbidity rate at 40% of total abortions with the mortality rate of 300:100,000 abortions (Chaturachinda, 2014). The mortality rate in developed countries is less than 1 death per 100,000 safe abortions, indicating the tremendous public health problems of unsafe abortion in Thailand (Chaturachinda, 2014).

Women who have experienced an unsafe abortion are confronted with serious problems in physical, psychological and economic aspects (Chunuan et al., 2012). The lives of these women are in danger from hemorrhage requiring blood transfusions, cervical tear, uterine perforation, intestinal perforation, pelvic inflammatory diseases, peritonitis, tetanus, renal failure, heart failure, septicemia and sepsis (RHD, MPH, Thailand, 2013). They may further develop the problems of infertility (WHO, 2007) and premature delivery (Hardy, Benjamin, & Abenhaim, 2013). Many complications following unsafe abortion threaten women's lives and also lead to psycho-emotional problems.

Although survivors of unsafe abortions feel relieved when the problems have been solved, several emotional reactions unavoidably develop. Based on previous findings, women undergoing induced abortion expressed feelings of sin, bad *Karma* and uneasiness

(Lerdmaleewong & Francis, 1998; Nithitantiwat, 2013; Sirithanawutichai, Rangso, Intaranongpai, & Kuasit, 2008). Thai women feel very ashamed about abortions and would prefer to keep them secret. However, these women continue to suffer shame, even when their secrets are not disclosed (Komon, 2010; Pingprasert, 1991). For women who have the experiences of unplanned pregnancy and consented to kill a human being from undergoing abortion, the burden of severe grief or guilt can be unbearable because they believe that abortion is the same act as killing a newborn (Coleman, Boswell, Etzkorn, & Turnwald, 2017). Some women felt guilty because they caused their family regret (Sujiinnaprum, 2011).

Stress, fear and anxiety are also psycho-emotions found in women who terminate their pregnancy. In Thailand, a study in one gynecological outpatient department show that 100 subjects (36.9%) who terminated their pregnancy met criteria for anxiety (Roomruangwong & Tangwongchai, 2009). Based on the analysis of 22 studies in 1995-2009, abortion was tied to a 34 percent increased risk for developing an anxiety disorder (Coleman, 2011). The traumatic events occurring around pregnancy termination can lead women to develop post-traumatic stress disorders (PTSD). Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event. Invasive procedures, such as dilatation and curettage, cause severe pain and frighten a woman as life threatening procedures, especially in self-induced abortions and abortions performed by unskilled persons. The circumstances of hemorrhage, infection and death caused by unsafe abortions can trigger PTSD. In some cases, only some PTSD symptoms such as fear and avoidance commonly occur within a short period of time. These women may not experience PTSD but they continue to require mental care to confront their fear. In unplanned pregnancy, women's perception of abortion is a loss (Coleman et al., 2017). Some Thai adolescent women felt grieved and mourn over their fetus after abortion (Komon, 2010). Kanchanapusit, Thitadilok, and Singhakan (2009) found grief to be a dynamic post abortion process. The abnormal grief after abortion occurs quite frequently a prevalence of 72.6%. Saelim (2003) found women who had terminated their unwanted pregnancy have significantly higher rates for depression than women who carried pregnancy to term. Based on the analysis of 22 studies by Coleman (2011), a 110 percent increased risk of depression was found in abortion, and the rate was 37%.

Termination of unwanted pregnancies causes women to experience many emotional and psychosocial problems, including sin, shame, guilt, stigma, stress, fear, anxiety, traumatic feelings, post-traumatic stress disorders, sadness, loss, grief, and depression. To recover, the women use several strategies to cope with these emotions. 'To cope with' refer to 'to deal with and attempt to overcome problems and difficulties' (Merriam-Webster, 2019a). Coping strategies, problem-focused coping and emotion-focused coping, refer to the specific behavioral and psychological efforts an individual employ to tolerate or alleviate stressful events (Taylor, 1998).

Through a qualitative study, Stålhandske, Ekstrand, and Tydén (2011) found four different existential strategies employed by women with induced abortions: 1) detachment strategies: to create a distance from the pregnancy, in order to avoid difficult emotions, 2) interpretation strategies: to relate the experience to one's worldview, in order to make it morally acceptable, 3) social strategies: to share the experience with others, in order to gain acknowledgment and acceptance, and 4) symbolic strategies: to express the experience in bodily ways, in order to handle its emotional significance symbolic or ritual strategies. Considering coping process, Strasrynska (1999) found "restoring wholeness-tending the garden," as the coping process for induced abortion that consists of 3 stages: 1) surviving the struggle, 2) beginning the healing process (the power of love), and 3) becoming whole. In pregnancy termination, emotion-focused coping seems to be commonly used since an individual is unable to manage the source of a problem. Emotion-focused coping strategies can be empowering, moving on, and talking with counsellors that will help women adjust and move on, and doing things that make them feel better (Children by Choice, 2016). A wide range of emotion-focused forms of coping is found in the literature, such as avoidance, minimization, distancing, selective attention, positive comparisons, and wresting positive value from negative events (Lazarus & Folkman, 1984). In terms of effectiveness of coping strategies on grief, the self-directing religious problem solving and forgiveness relieved grief after abortion but religious avoidance, discontent and plead activities were found high levels of grief (Geoghegan, 2000). However, in one study, religion, religiosity, and religious coping were not associated with abortion-related emotional distress (Fountain, 2007). Denial and repression were found to be effective in the short-term but were related to high stress in the long-term (Speckhard, 1985).

Defense mechanisms are involuntary coping mechanisms, categorized into 4 levels: 1) psychotic defenses, such as psychotic denial, 2) immature defenses, such as passive aggression, dissociation, and projection, 3) intermediate defenses, such as displacement, isolation, repression, and 4) mature defenses, such as suppression and humor (Vaillant, 2011). Sekudu (2001) describes the mechanisms used by women who have had induced abortion as follows: 1) rationalization: give reasons for having an abortion, 2) repression or denial: not aware of any negative feeling as though the abortion never happened, and 3) compensation: carry the next baby to term to serve as a substitute for the aborted baby.

Since there are several emotional feelings after pregnancy termination, a wide variety of coping strategies can be employed by the women, depending on the women's particular emotions and coping skills. Rationalization for pregnancy termination and forgiveness may alleviate the feelings of guilt. Religious beliefs that included a concept of a forgiving were found to be engaged as a means of coping with guilt following abortion (Speckhard, 1985). Some religious rituals are adopted to minimize the feeling of sin and bad *Karma*. The central concept of worthiness indicated by meaning making, grace, forgiveness, and honesty; and 4 co-concepts (awareness, transparency, empathy, and grieving) were found to be the strategy for coping with abortion shame (Chavier, 2015). Some women may control their shame by keeping the issues of abortion in secret and isolating themselves from others, namely social isolation. Avoidance from the events or persons that remind traumatic feelings is used for coping with fear and anxiety. Sadness requires grieving process. It is essential to obtain empirical evidence on how these defense mechanisms and coping strategies are employed for particular emotional feelings and circumstances, and also on their functions and effectiveness.

In Thailand, Ratchukul (1998) found that the women after abortion was philanthropic charity and devotion to a fetus in order to reduce guilt and sin, which helped women feel better. In miscarriage and therapeutic abortion, Thai women experienced a loss of hope, and gained emotional balance through self-motivation, in belief *Karma*, fulfillment of the obligations of being a good mother, and escape from unbearable memories (Chaloumsuk, 2013). Moreover, these women required information and emotional support. However, coping with emotional problems in Thai women after

unsafe abortion, who likely experience more stressful events than women with therapeutic abortion, are unlikely explored in-depth.

Coping will be smooth and effective if an individual has adequate coping resources. Coping resources are primarily the properties of a person in handling stress, including health and energy, positive beliefs, social skills, problem-solving skills, material resources, and social support (Lazarus & Folkman, 1984). Social support is one form of coping resource obtained from social networks. Social support can be emotional, informational, and tangible support (Schefer, Coyne, & Lazarus, 1981). Support may come from organizations in terms of services provided by professional, trained employees, typically paid for their work. Informal support includes the support provided by partner, family, friends, colleagues, neighbors, and community members. A recent study revealed that social support helped the post-abortion women overcome obstacles, while insufficient support was experienced as an obstacle itself (Ostrach & Cheyney, 2014). Women who perceived high support from their partners, families, and friends had higher self-efficacy for coping, a trait that predicted better adjustment to abortion (Major, Richards, Cooper, Cozzarelli, & Zubek, 1998). Canário, Figueiredo, and Ricou (2011) found that social support provided by the partner was a key aspect in the psychological recovery after abortion, particularly for women with high coping resources. One qualitative feminist study was conducted in 12 Thai women with unwanted pregnancy termination and 11 partners (Chatchawet, 2009). The results showed that the women expected their partners to care for them in the following 6 ways: 1) assisting with pregnancy termination, 2) not abandoning the women, 3) affectionate caring, 4) reparation, 5) basic care needs, and 6) financial care. However, coping strategies in managing the women's painful feelings are not the focus of Chatchawet's study. In addition, the forms of support from family, friends, and health care providers are not explored. These issues need to be scrutinized in order to know how to enhance the women's accessibility to coping resources.

According to Steinberg (1989) and Havanon (1986), post-abortion women need to recover emotionally and require post-abortion counseling. The counseling should acknowledge any loss a woman feels and facilitate her to deal with the loss on her own ways. A woman should receive written documents describing the range of emotional

reaction and hot-line counseling to take home after the abortion. These health services are available only in countries where abortion is legal. In Thailand, psychological care is provided to women after therapeutic abortion, likely based on the concepts of grief and loss. Differently, health services for women undergoing abortion without medical indications are still problematic due to the negative attitudes of the service providers toward abortion (Chaturachinda, 2014).

According to the state of the art of post pregnancy termination in Thai women, some gaps of knowledge can be identified based on the existing knowledge mentioned above. One qualitative study was conducted about the experiences of miscarriage and termination of pregnancy for fetal anomaly among a group of Thai women (Chaloumsuk, 2014). The women experienced loss of hope, then gained emotional balance, and needed for intervention. This study provides some pictures how the women feel and go through the termination of wanted pregnancy conducted by professional healthcare providers under the quality healthcare facilities and the supportive atmosphere. However, their experiences are unlikely applicable to the women who do not want the pregnancy and the abortion is conducted by unskillful persons without quality equipment, under the high pressure and a lack of support. There was one descriptive study on stress and coping after criminal abortion in adolescents (Chaisuwan, 2005). The methods used were discussion with her boy friends, parents and friends, keeping herself busy by reading books, watching television or listening to radio, talking with her friends and promising not to do and abortion. Another study in adolescents after illegal induced abortion revealed that there were varieties of adaptation, including avoiding the situations that triggered abortion memory, consultation, searching information, and so on (Komon, 2010). However, the study did not focus on adult women. In addition, a feminist study of women with unwanted pregnancy termination of their partners indicated that the termination was mutual sex-shared responsibility and male partners provide various support to the women (Chatchawet, 2009). On the other hand, the women's experience in coping after pregnancy termination has not explored for deep understanding.

Several qualitative studies on coping processes after pregnancy termination were conducted within the western context, which may not be applicable to Thai Buddhist context. Many studies of unwanted pregnancy termination in Thai women were

conducted by experts of other disciplines such as social science, humanities science and so on, which did not deeply explain health problems, and the results were only suggestions of health care services delivery but detail and how to do were limited. There are several studies on psychological stress of women after unwanted pregnancy termination but the knowledge of coping with unwanted pregnancy termination in Thai women has not explored deeply. Authentic understanding on coping from the women experiences is essential for helping the women go through their pain quickly and effectively. It also prevents the women from psychological illness. Therefore, exploring experience of women in terms of coping strategies, and coping resources in Thai women after unwanted pregnancy termination is very important on the ground that can be created the effective nursing intervention programs, counseling programs, and nursing practice guidelines. These quality interventions have to meet the women's needs and fit to the women's nature. Understanding the women's experience, including their strength and limitation, is essential for nurse to know how to provide patient-centered care, aiming to empower the women to manage their painful experience in their own ways. Since all previous intervention research was developed and implemented by the researchers, excluding the women, nurses, and other related personnel. All stakeholders did not participate in the research. After the completion of the study, the studied intervention was not continued. However, this gap of knowledge is hardly to be filled in without clear understanding of the women's experience as mentioned above. Therefore, at this stage, exploring Thai women's experience in terms of their feelings, coping strategies, and support is more the priority.

Based on holistic approaches, nurses-midwives take on important roles in psycho-emotional care in addition to the physical care provided to women who are hospitalized with abortion complications and visit outpatient departments for post-abortion follow-up. However, this psycho-emotional care is limited and non-comprehensive. Nursing practice guidelines are not well developed. The root of this limited nursing practice is the lack of deep understanding on coping and support among these women. These women have various difficulties beyond grief and loss. More serious emotional problems, including fear, anxiety, shame, guilt, and traumatic feelings, are commonly experienced by these women, which can be related to anxiety disorders and depression (Coleman, 2011). Accordingly, their recovery process is probably more complex and demanding than the

women undergoing therapeutic abortion. General counseling techniques are employed, for the most part, but particular issues surrounding pregnancy termination may be omitted. There are several approaches for crisis intervention, which one of them is intervention using the client's coping strategies (Garland & Bush, 1982), based on the fact that clients are the ones who cope with their difficulty encountered whereas nurses are the facilitators. The gap of knowledge causes inadequate understanding about coping strategies and support in these women thereby leaving the counseling process to general approaches and less effectiveness. Psychological care for unsafe-abortion women in Thailand requires empirical evidence on the coping strategies they employ and the support they obtain and need. This study wishes to fulfill this gap of knowledge.

In addition to the individual aspect of women's psycho-emotional responses and coping, the broader aspects, in terms of sociocultural context, especially values on pregnancy and abortion, need to be taken into consideration on psychological experience of a woman with abortion (Major et al., 2009). A woman who regards abortion as conflicting with religious, spiritual, and cultural beliefs has a more stressful experience than a woman who does not regard abortion as contradicting her own values or those of others in her social networks. Based on feminist perspectives, women's lives are oppressed by unfair sociocultural and political values. Ideology of motherhood and nurturance are social controls aims at preventing children maltreatment by their mothers. As a mother, a woman is obligated to be morally right, behave with good manners, love and be kind to her children, and to exert all efforts to raising her children. Women's natural capabilities, or maternal instinct, are demolished when they choose not to have a child or to have a child out of wedlock (Leskošek, 2011). Empirically, a study in Chile revealed that women matured into "real women" through motherhood, and the anti-abortion debate was found to be strongly connected to the discourse on motherhood and the natural body (Kohlmark, 2012). When an unwanted pregnancy is terminated, a woman is seen as violating the sociocultural norms of motherhood and legal regulations. These judgments are internalized by women who develop suffering and live with psychological pain in silence. A little mental support from family and friends, as well as health personnel is accessible. The unavailability of mental support and mental care services lead to unfair treatment for women following pregnancy termination since these services respond only to the women's basic needs.

In this study, feminist perspectives are employed to understand women's experiences in coping with pregnancy termination without gender bias, further hoping to improve the women's well-being. Rationally speaking, feminism also guides how to conduct a study, and design research procedures with methods for generating gender-equality knowledge. Based on a feminist standpoint theory, feminist research differs from conventional research in the following three aspects: gender issues, high value of women's experience (including researchers) and research on the same critical plane (Harding, 1995). In this study, the women who experienced pregnancy termination were empowered to speak out for their own sake without fear of social judgment. Thus, the previously silent voice will be taken into consideration. Their life hardship and oppressive conditions under social constrains was explored in order to fairly understand them rather than to judge or condemn them. Women's capability to cope with difficulties after pregnancy termination and the support women receive and expect from lay people and health care providers will be uncovered. Hopefully, new and fair insights will be gained, which can be applied to assist women in working through their recovery process faster and more effectively. Psychological problems can be further prevented in the long-run, leading the women to live productive lives with fair treatments.

Research Objectives

The objective of this study was to understand coping with pregnancy termination among Thai women. The details of the objectives can be specifically described as follows:

1. To describe feelings of women following pregnancy termination.

2. To describe coping strategies employed by women to manage their feelings following pregnancy termination.

3. To describe support which women actually obtain and expectantly desire for enhancing their coping with their feelings.

Research Questions

In an attempt to gain understanding on the experience of Thai women in coping with pregnancy termination, the question addressed in this research was "What is coping with pregnancy termination among Thai women?"

Three specific research questions were as follows:

1. What are the feelings of women which develop following their pregnancy termination?

2. What are the coping strategies which the women employ for coping with their feelings following pregnancy termination?

3. What are the support which the women actually obtain and expectantly desire for enhancing their coping with their feelings?

Definitions of Terms

The terms employed in this study are defined as follows:

Pregnancy termination refers to ending a pregnancy without any medical indications. This term is used instead of abortion, in order to avoid stigmatizing the women.

Coping with pregnancy termination means dealing with the feelings following pregnancy termination through various strategies and support. In this study, coping with pregnancy termination, including feelings, coping strategies, and obtained and expected support, was explored through qualitative research from the feminist perspectives.

Feelings of women with pregnancy termination refer to the feelings of women developing from their experience in terminating their pregnancy, leading them attempt to cope with the feelings. In this study, the feelings were explored based on the feminist research.

Coping strategies refer to the implicit and explicit actions performed by the women to manage their negative feelings caused by pregnancy termination. In this study, the coping strategies were explored based on the feminist research.

Support for women with pregnancy termination refers to any helps the women actually obtain and expectantly desire for enhancing their coping with the negative feelings. In this study, the support was explored based on the feminist research.

Thai women refers to Thai adult women during the reproductive age, aged 20-44 years, living in Nakhon Nayok province, having ever terminate pregnancy without medical indications and the last termination was ten years ago or longer.

Scope of the Study

This study narrated the experiences of Thai adult women during the reproductive age in coping with pregnancy termination. The study was conducted among the women who had experienced in pregnancy termination without medical indications ten years ago or longer, and lived in Nakhon Nayok province. Data collection commenced after receiving approval from the Research Ethics Committee of the Faculty of Nursing, Chiang Mai University from January 2017 to January 2018.

CHAPTER 2

Literature Review

This literature was reviewed to help the researcher generate research questions and objectives worth studying. The known knowledge helped the researcher be sensitive to data and be able to interpret and understand what messages the participants wanted to send out. Importantly, existing knowledge did not direct nor control the researcher. The literature review is described based on the topics of an overview of pregnancy termination, feelings following pregnancy termination, coping with pregnancy termination, and feminist perspectives on pregnancy termination.

Part A: Overview of Pregnancy Termination

An overview of pregnancy termination includes the following topics: definitions of pregnancy termination and related terms, clinical classification of abortion, unsafe abortion techniques, situations and trends of pregnancy termination in Thailand, reasons and factors of pregnancy termination, and consequences of pregnancy termination. At the end of this part, health care for women following pregnancy termination, obstacles of pregnancy termination in Thailand, and empirical evidence of nursing intervention are mentioned.

Definitions of Pregnancy Termination and Related Terms

Pregnancy can be terminated at any periods of pregnancy with or without medical indications. Abortion is defined as spontaneous or induced termination of pregnancy before fetal viability (Cunningham et al., 2014). In the past, abortion is assumed traditionally as loss of conceptive products prior to 28 weeks or a fetal weight lower than 1,000 grams (WHO, 1970). Because of the advanced medical technology in some developed countries, the criteria of abortion reduce to the gestation before 20 weeks and to the fetus weight of 500 grams or less (Cunningham et al, 2014). According to the Abortion Surveillance in Thailand Report 2013 (ASTR, 2013), which was conducted by

the Reproductive Health Division, Ministry of Public Health, Thailand, (RHD, MPH, Thailand, 2013), abortion is defined when pregnancy is terminated before gestational age of 22 weeks. Termination of pregnancy at 22 weeks and older is defined as delivery. There are many types of abortion and terms used in abortion. The figure 1 illustrates the classification of pregnancy termination and related terms.

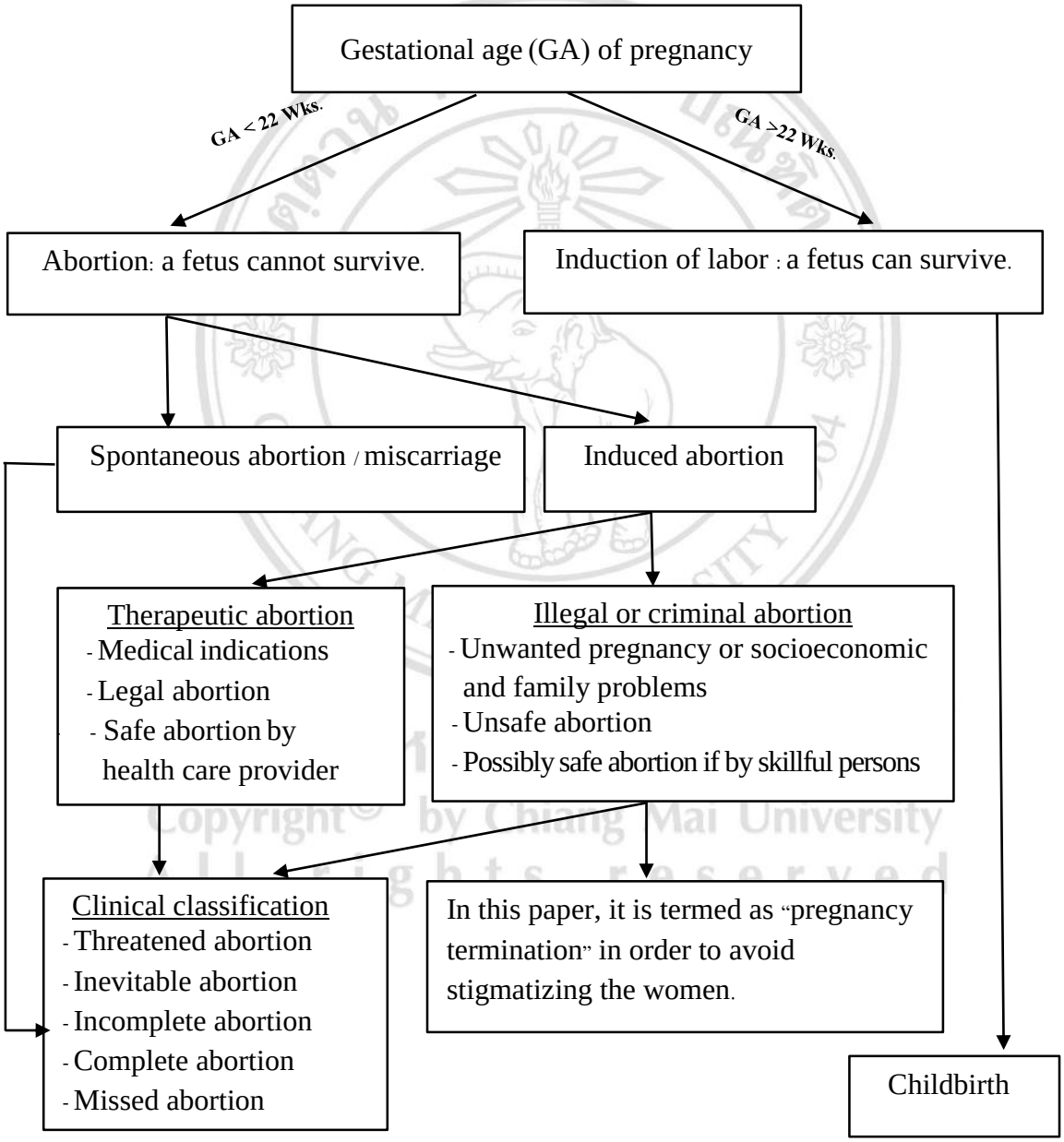

Figure 1. Classification of pregnancy termination and related terms

Abortion can be spontaneous or induced. Spontaneous abortion or miscarriage means the end of pregnancy that occurs from natural causes (Henderson & MacDonald, 2004). Spontaneous abortion can be classified as threatened, inevitable, incomplete, complete, and missed abortion (Surette & Dunham, 2013). An induced abortion is can be either an elective or necessary termination of a pregnancy either by a procedure or medication (American College of Obstetricians and Gynecologists, 2015), which can be either therapeutic abortion or illegal abortion. Most illegal induced abortions in Thailand are performed by non-health personnel (Warakamin, Boonthai, & Tangcharoensathien, 2004). Induced abortion without medical indications is illegal and termed by ASTR (2013) as "abortion with socio-economical or family reasons." Since this kind of abortion is likely performed by unskillful persons and causes various complications, it is also called unsafe abortion. According to the WHO (2012) an unsafe termination of pregnancy (abortion) can be defined as an elective procedure carried out with the intention of aborting an unplanned pregnancy. In such cases, the abortion might be performed either by an unskilled person or in a setting that fails to meet minimum medical requirements, or both.

According to the criminal law of Thailand, chapter 4, section 301-305, especially 301, any woman who caused herself to an abortion or allowed other person to procure her to the action shall be imprisoned not out of three years or fined not out of six thousand baht, or both. Pursuant to Section 95, offenders in criminal cases who are not indicted and tried in court within a specified period of time after an offense has been committed will be subject to a 10-year sentence precluding prosecution. Therefore, the punishment will be expired for ten years and above. Therapeutic abortion is performed the legal or safe abortion, approved when there are medical indication of severe abnormally or the aim to preserve the termination mother's health (Thailand Lawyer Online, 2018). For a pregnancy termination to be legal, the procedure must be done by a licensed medical practitioner, such as a doctor, nursing practitioner, doctor's assistance or nurse/midwife, with the objectives and of aborting a pregnancy considered or proven to involve a first-trimester fetus in the uterus and producing a fetus that is no longer living (National Center for Health Statistics, 2016). The termination of a pregnancy (abortion) is recommended when the mother's life or health is threatened by pregnancy complications, when the fetus has been conceived under circumstances involving incest or rape, or when tests performed

during the antenatal period indicate critical anomalies in the fetus (Chawanpaiboon & Neungton, 2013; Henderson & MacDonald, 2004). The researcher summarizes the classification of pregnancy termination and related terms in figure 1.

In this study, it focused on pregnancy termination without medical indication which was likely unsafe. Accordingly, the following criteria can be applied either in whole or in part to determine a termination of pregnancy as unsafe (WHO, 2012):

1. Absence of consultation or recommendations before the termination of pregnancy.

2. Performance of the termination of pregnancy by a person who does not possess the necessary skills to do so; pregnancy termination in an unsanitary environment, or even an abortion performed by a licensed health officer, but not in a licensed or proper medical facility.

3. Termination of pregnancy triggered by a medication for that purpose or the intake of a substance deemed hazardous.

4. Termination of pregnancy triggered when either the pregnant woman or medical officer either inserts an object into the uterus or performs forceful or aggressive massage of the abdominal area.

5. Termination of pregnancy involving an erroneous prescription of medication, or the issuance of abortion-inducing medication by a pharmacist with erroneous directions or no directions at all with the absence of monitoring or proper follow-up.

In conclusion, induced abortion can be classified as therapeutic or legal abortion with medical indications; and as illegal or unsafe abortion due to unwanted pregnancy, or socioeconomic or family problems. In this paper, the terms of Pregnancy Termination are used instead of illegal or unsafe abortion in order not to stigmatize women.

Clinical Classification of Abortion

The outcomes of abortion are classified based on clinical presentation judged by health care providers. It is helpful for treatment and care that can be divided into 2 types

including spontaneous and induced abortion. Induced abortion can be therapeutic abortion and illegal abortion. Spontaneous, therapeutic, or unsafe abortion can be threatened, inevitable, incomplete, complete, and missed abortion. Each type is described below (Surette & Dunham, 2013):

1. Threatened abortion: When a pregnancy is complicated by vaginal bleeding with or without cramping, but the cervix is closed, this may signal a threatened abortion. The pregnancy may continue or end.

2. Inevitable abortion: A clinical pregnancy is complicated by vaginal bleeding with cervical dilatation, and often with back or abdominal pain, indicates impending abortion and the products of conception do not pass from the uterine cavity. Inevitable abortion will end up with complete or incomplete abortion.

3. Incomplete abortion: The passage of some but not all of the conceptive products have passed from the uterine cavity. Bleeding and cramping usually continue until all products have been expelled, severe pain and heavy bleeding occur.

4. Complete abortion: All the products of conception have passed from the uterine cavity, and the cervix is closed. Slight bleeding and mind cramping may continue for several weeks.

5. Missed abortion: The term of missed abortion is used as incomplete abortion, that has been retained inside uterus after embryonic or fetal demised. Cramping or bleeding may be presented, but often there is no symptom. The cervix is closed, and the death fetus remains in the uterus.

Unsafe Abortion Techniques

Whether a termination of pregnancy is deemed safe or hazardous depends on the following: 1) The skills of the person performing the abortion; 2) the pregnancy termination method implemented; 3) the pregnant woman's health; 4) the gestational age of the unborn fetus. Unsafe abortion can be conducted with many methods such as surgical or medical techniques, and abdominal massage or chiropractic technique. Similar to therapeutic abortion, some unsafe abortion providers use surgical techniques

such as vacuum aspiration, dilatation and evacuation (WHO, 2014). In medical techniques, the common drugs used include intravenous oxytocin, intra-amniotic hyperosmotic fluid (20% saline, 30% urea), prostaglandins E2, Fα, E1, and analogues, intra-amniotic injection, extraovular injection, vagina insertion, parenteral injection, oral ingestion, antiprogesterones (RU 486 mifepristone, epostane), methotrexate (intramuscular, oral), various combinations of the above (Schorge et al., 2008).

Unfortunately, unsafe terminations of pregnancy frequently involve the pregnant woman or another person inserting a material object or substance such as a twig, coat hanger, root, catheter or folk remedy into the pregnant woman's uterus. The abortion is also deemed unsafe when erroneous dilation and curettage are performed by a person lacking the necessary skills, when the pregnant woman takes a harmful substance or when violent or forceful actions are applied. Some cases involve having someone violently or aggressively beat the lower abdominal area of the pregnant woman as a means of aborting the pregnancy. Potential complications from this type of pregnancy termination include uterine rupture and even death for the pregnant woman. Although there is some evidence that erroneous dosages of certain abortion-inducing medications or substances (e.g. prostaglandin analogue misoprostol) can actually minimize the side-effects and risk for mortality, the findings on this type of mishandling the termination of pregnancy are mixed. Thus, life-threatening complications remain a serious risk (WHO, 2012).

In Mahasarakham hospital, Thailand, Sirithanawutichai et al. (2008) found that the method known the most (60.0%) and the method used the most (62.9%) for criminal abortion in adolescents was injection of chemical substance through vagina. Recently, in the study in Songkla province, illegal induced abortions were found to be conducted by the following 3 methods: vaginal suppository, likely to be misoprostol-a synthetic prostaglandin E1 analog (43.5%); oral Thai herbal medicine (19.6%); and combined medication (16.3%) (Phaumvichit & Chandeying, 2012). In the past, the majority of abortion procedures performed in rural Thailand was abdominal massage, but presently, massage or chiropractic technique was found only 0.9% (RHD, MPH, Thailand, 2013).

Situations and Trends of Pregnancy Termination in Thailand

According to the document delivered by the WHO (2012), the global number of abortions dropped from 45.6 million abortions with the rates of 29 and 28 per 1000 women of childbearing age in 2003 and 2008, respectively. However, the rates were increasing in developing and developed countries. Abortion rates across the Asian sub-region ranged from 26:1000 in south central and western Asia to 36:1000 in southeastern Asia. Almost the half of abortion worldwide are unsafe. Among all abortions, unsafe abortion remained unchanged. Nearly all unsafe abortions (98%) and severe complications of the abortions take place in developing countries. The data from public hospitals in Thailand illustrated the annual abortion rate which is approximately 30,000 cases but the terminations of pregnancy performed in private settings by self-induction or unlicensed facilities or abortion clinics is likely high as 300,000 to 400,000 cases per year (Arnott et al., 2017). In reality, the statistics on covert terminations of pregnancy remain hidden. Nevertheless, Thai news reports revealed the discovery of 2,002 terminated fetuses at three different temple sites in Bangkok, Thailand (Chaturachinda, 2014). It implies that the reported rates are be substantively underestimated.

According to the findings of a study by Thailand's Department of Health at 787 state hospitals, the morbidity rate associated with abortions is as high as 40 percent with a mortality rate of 300 deaths per hundred thousand terminations of pregnancy. In contrast, the mortality rate for safe terminations of pregnancy in developed countries has been found to be less than one death per hundred thousand cases. The stark contrast in the above findings is an ominous statement on the frequently encountered impacts of unsafe terminations of pregnancy in developing countries such as Thailand (Chaturachinda, 2014).

In addition to the annual abortion cases aforementioned, the abortion rates over also reported. In the national survey, the rated increased from 1,425 in 2011 to 2,840 in 2015. The Induced abortion increased to 43.1% of 1,074 cases. Induced abortion due to socioeconomic or family matters (mostly were unsafe) accounted for 23.7% of all abortions, and accounted for 62.6% of induced abortion (RHD, MPH, Thailand, 2015). Locally, in Khon Kaen province and southern Thailand, unsafe abortion was found to be 36.8% (n=462) (Srinil, 2011) and 35.7% (n=402) of all abortions (Chunuan et al., 2012).

In one community hospital in Songkhla province, the rate was 29.4% (n=126) (Sutheerasak, 2004). Although unsafe abortion in Thailand is lower than the global rate (31.4% VS 49.0%).

Considering each age group, the 2015 survey indicates that the incidence in teenagers increased to 26.3% but the highest incidence still fell into the over 29 years of age group (20-24=26.8%, 25-29=15.8%, >29=31.1%) (RHD, MPH, Thailand, 2013). Differently, in the 2011 survey, the highest incidence was found in teenagers (30.7%) (20-24=25.3%, 25-29=14.2%, >29=29.6%) (RHD, MPH, Thailand, 2011). Based on the 2003 estimations from the World Health Organization (WHO) in women aged 15-44 years reproductive age, unsafe terminations of pregnancy occurred in 20-29 women per population of 1,000 (Chinthakanan et al., 2014). It can be seen that induced abortions among Thai women of 20 years of age and older were more prevalent than those in teenagers with approximately 60.9-73.0% VS 27.0-39.1%. In this study, the focus is on age 20-59 adult women and the terms "Thai women" refer to Thai women aged 20 - 44 years adult women and reproductive age.

Factors Related to Pregnancy Termination

To understand psycho-emotional health problems and needs of a woman after terminating her unwanted pregnancy, the reasons she gave to the terminating pregnancy should be reviewed. According to a cross-sectional study conducted in 400 pregnant women, unplanned pregnancy was found to be significantly correlated with the following factors: age, parity, level of education, economic status and spousal employment, spousal relationships, and contraceptive methods ($p < 0.0001$) (Najafian, Karami, Cheraghi, & Jafari, 2011). Several studies described factors influencing women's decisions on abortion and reasons they gave to. For example, Mdleleni-Bookholane (2000) revealed that the decision to abort pregnancy of pregnancy women has been found to be correlated with no preparation for childbearing, age group, interpersonal/spousal relationship issues, marital status and insufficient financial status/assistance.

According to Kuffour (2014), the root cause of most unsafe abortions is unintended pregnancy which occurs when a woman is unable to time or limit her childbearing. The decision to have an abortion is usually influenced by diverse, multiple and interrelated

reasons and factors such as age, religion, economic status, culture, relationship with others, reproductive history, resource limitations, interference with mother's education or work, unpreparedness for transition to motherhood and desire to have an abortion. These factors can be divided into four parts, including socio-economic factors, demographic factors, factors of abortion, and socio-cultural factors.

In Thailand, there are several factors that may contribute to unwanted and/or unplanned pregnancies, further leading to abortion. One study in Bangkok among 269 mothers with unwanted pregnancies shows that most of them were 15-20 years old, educated in primary and junior secondary levels, earned less than 5,000 baths per month, unmarried, and had no children (Wongviriyakorn, 2008). In the same study, the mothers who committed an abortion reported that they obtained advice from their friends but did not receive helps whereas those who continued their pregnancy made their decisions by themselves and obtained helps from some organizations or their parents. Sirithanawutichai et al. (2008) also found that friends had the most influence on criminal abortion among adolescents who admitted to Mahasarakham hospital. Another study of 13-24 years old women with unplanned pregnancy in Bangkok (n=120, students=25%, unemployment=20%) show that a half of the women who terminated their pregnancies had completed grades 5-10; the women who chose to raise their babies themselves were likely having a job (63.8%); unemployment rates in the women who terminated their pregnancy, who raised their child, and who gave up for adoption were 37.5%, 15.5%, and 10.0%, respectively (Naravage, Vichit-Vadakan, Sakulbumrungsil, & Van der Putten, 2005).

One study found that family issues, financial status and social factors have been cited as the key contributors among women who opt for unsafe terminations of pregnancy (Chunuan et al., 2012). Among the most frequently cited reasons for this decision were consideration of family embarrassment upon announcement of an unplanned pregnancy and a fear of having too many children. In terms of financial status, the most commonly cited reasons were income deficiency and overwhelming debts. Frequently cited social reasons include a sense of no preparation for parenthood, no desire for single motherhood and current enrollment in an educational institution. The circumstances related to an unsafe abortion were found the vast majority of the subjects made their own decisions to

terminate their pregnancy; 36.4% of them obtained advice from friends; and 14.7% obtained advice from boyfriends/lovers. In most cases, the person performing an unsafe pregnancy is the pregnant woman herself. This group is followed by other unskilled or unlicensed persons. Abortion Surveillance in Thailand Report 2013 (RHD, MPH, Thailand, 2013) reveals several factors of terminating unwanted pregnancy including age, number of pregnancy, number of childbirth, education status, economic status, and the relationship with the spouse, advice from a friend, the sense of taking assistance to help, helping from an institute and so on. According to Ratchukul (1998), the decision to have an abortion stems from social value, economic and educational constraints.

In summary, there are several studies describing factors influencing Thai women's decisions on pregnancy termination or abortion and reasons they gave to. These factors are concluded as socioeconomic and family problems.

Consequences of Pregnancy Termination

Postpartum period is six weeks after childbirth which is the time to recover nearly to the pre-pregnancy conditions. Differently, post abortion period is not defined. In clinical practice, the women will be checkup at 2 weeks after abortion to early detect complications. Generally, post abortion self-care is advised similarly to post-partum self-care. Physical recovery phase may be slightly shorter than post-partum period. Psychological recovery may take much time in care of unsafe abortion and complications. A leading cause of death among pregnancy women, unsafe terminations of pregnancy have been found to be associated with psychological, physical and economic (Chunuan et al., 2012). According to the findings of descriptive research on 402 women who had recently experienced spontaneous (miscarriages), therapeutic and unsafe pregnancy terminations in the southern region of Thailand, 35.7 percent (n = 143) of the women met the criteria for having had unsafe terminations of pregnancy (Chunuan et al., 2012).

Physical health problems. According to the Women and Newborn Health Service 2007, physical health problems can be short-term or long-term that impacts on women who terminated pregnancy. However, there is no exact timeframe for classifying short-term and long-term effects.

1. Short-term effects can be severe complications. The women may be in danger from hemorrhage requiring blood transfusions, cervical tear, uterine perforation, intestinal perforation or tear, pelvic inflammatory, peritonitis, tetanus, septicemia, renal failure, heart failure, septic (RHD, MPH, Thailand, 2013). In Songkla center hospital, among 92 women with illegal induced abortion, the most common symptoms were vaginal bleeding of all cases, followed by pelvic pain/discomfort for 90 in 92 cases (97.8%); septic abortion was found for 29.35% (septic shock=2 cases or 2.1%); anemia with blood transfusion (n =2, 2.1%), and cervical tear (n =1, 1.05%) were also found (Phaumvichit & Chandeying, 2012). In Khon Kaen hospital, 16% of 170 unsafe abortion cases developed severe complications including, hemorrhage requiring blood transfusions (18 cases, 66.6%), shock (17 cases, 63%), acute renal failure (6 cases, 22.2%), sepsis with disseminated intravascular coagulation (2 cases, 7.4%), and death (2 cases, 7.4%) (Srinil, 2011). It can be seen that hemorrhage and sepsis remain the significant short-term health problems.

2. Five millions of the women who survive unsafe abortion will suffer long-term health complications (Haddad & Nour, 2009). Long-term effects may be found as infertility and premature delivery. Altogether some 24 million women currently suffer secondary infertility caused by an unsafe abortion (WHO, 2007). In terms of fertility, the effects of abortion procedures are both direct and indirect. Direct effects include uterine scarring with a potential risk for ectopic pregnancies in the future. Indirect effects include fallopian tube infection, causing tubal pregnancies (Barnes, 2010). In terms of premature delivery, Hardy et al. (2013) found a significant increase in preterm delivery in women with a history of induced abortion, probably due to cervical insufficiency. Congruently, dilatation and curettage for termination of pregnancy was associated with an increased risk of subsequent preterm birth (Lemmers et al., 2015).

Economic consequences. Unsafe abortion is a massive effect due to high levels of morbidity and mortality but the economic and social costs are difficult to quantify exactly (Shannon & Winikof, 2010). According to recent findings among women who have undergone spontaneous/therapeutic pregnancy terminations, universal health care coverage is the most frequently selected mode of payment in both the unsafe termination and spontaneous/therapeutic abortion groups (Chunuan et al., 2012). The expenditure of

Ministry Public Health for abortion clients was approximately 2,654 baht/a case; the cost of treatments or post-abortion care was approximately 21,024 baht/a case (Mahawan, 2013). In Khon Kaen Hospital, the cost of treatment for women with unsafe abortion between October, 2007 and September, 2008 was 634,792 baht, averaging nearly 3,760 baht/patient (Srinil, 2009). Furthermore, the public costs of pregnancy termination can be reflected in part by the hospital-days required for appropriate medical care. Based on the findings of a study conducted in 402 women who had recently undergone spontaneous, therapeutic and unsafe pregnancy terminations in southern Thailand, hospital fees were reported to be slightly higher than in the women who had undergone spontaneous and therapeutic pregnancy terminations. The reason for the above cost disparity is that unsafe abortions frequently lead to more expensive abortion-related complications (Chunuan et al., 2012).

Psychological health problems. A woman chooses pregnancy termination for solving her personal problems, leading her to feel relieved at the beginning. After that the women's health problems develop in various aspects, which are dominantly mental or psycho-emotional problems. Based on the literature review the psychological health problems include four groups as follows: 1) shame, guilt, low self-esteem, sin and stigmatization, 2) stress, anxiety, and fear, 3) traumatic feelings and post-traumatic stress disorders, and 4) sadness, depression, and grief. The detail is described in the topic of the feelings of the women following pregnancy termination.

Health Care for Women Following Pregnancy Termination

In terms of counseling and family planning, women seeking to prevent or delay pregnancy require birth control services with further access to health service provision for abortion-related complications for both induced and spontaneous terminations of pregnancy. Moreover, it is recommended that women undergoing the above types of treatment be provided with access to health services for management of abortion-related complications in cases involving both spontaneous and induced terminations of pregnancy. These women are also candidates for counseling, reproductive health advice and a wide range of additional health and family planning services with the provision of contraceptives and follow-up care as required. Nursing care of women following

pregnancy termination includes the following topics: Essential elements of post abortion care, and physical and psychological care of women after pregnancy termination.

Essential elements of post abortion care. According to Corbett and Turner (2003), According to the post abortion care (PAC) model endorsed by the PAC consortium in May 2002, the key components of post-abortion care are viewed from both the perceptions of health providers and consumers based on a clear view of high service quality and service sustainability. The focus of the model shifts from medical treatment to the following aspects:

Unplanned pregnancies and unsafe terminations of pregnancy can be prevented by the cooperative efforts of both community and service providers. With this cooperation, essential resources can be implemented as a means of providing proper, timely assistance for pregnant women with abortion-related complications. Thus, health service provision can enable both reflection on and meeting of the expectations and needs of community residents as follows:

1. Identification and response to the physical, emotional health and other needs of women through counseling.

2. Necessary procedures and care for women with potentially life-threatening and other complications associated with unsafe and/or incomplete terminations of pregnancy.

3. Provision of birth control and family planning services aimed at guiding women through the process of spacing pregnancies or preventing unplanned pregnancies.

4. Provision of on-site or referral reproductive health and other related services to meet the broader sexual and reproductive health needs of all women, particularly women who have undergone either spontaneous or induced terminations of pregnancy.

Women who seek the prevention or delay of pregnancies require access to birth control. These women also have a need for service provision aimed at treating abortion-related complications in combination with proper sexual and reproductive counseling as well as other health-related service indicated by symptoms discovered during doctor's

visits/follow-up treatment. Access to contraceptives is imperative for this group (Corbett & Turner, 2003).

Physical care of women after pregnancy termination. WHO recommends the standards for management of complications caused by safe or unsafe abortion. Although complications from abortion are rare where performed by skilled personnel, every service delivery site at every level of the health system should be equipped and have personnel trained to recognize abortion complications and to provide or refer women for prompt care, 24 hours a day. Specifically, healthcare personnel should be provided with the training, support, and supplies to treat the following potential complications (Center for Reproductive Rights, 2010).

1. In the case of incomplete pregnancy terminations, health care staff required training and medical equipment for vacuum aspiration (first trimester terminations) and for dilation and evacuation (second trimester terminations). Particularly attentive care and monitoring for infection and/or hemorrhage are essential at this stage.

2. Failed abortion is defined as a condition where a pregnant woman remains pregnant, despite having had a surgical or medical abortion. In such cases, it is essential that health providers are capable of pregnancy termination.

3. For cases involving hemorrhage, medical facilities require the ability to quickly stop bleeding with the capacity to perform uterine evacuation and administer medication to stop the hemorrhaging. Additional necessities are the ability to provide intravenous fluid replacement, blood transfusions, laparoscopy, or exploratory laparotomy.

4. For infections, health providers require both equipment and training in treating infections potentially associated with unsafe terminations of pregnancy. The aforementioned treatment includes antibiotics and uterine evacuation when the uterus continues to contain fetal or other pregnancy-related remnants.

5. In cases involving uterine perforation, health providers require antibiotics and the ability to perform laparoscopies and laparotomies aimed at diagnosing and repairing any tissues damages by termination of pregnancy.

6. The WHO has also recommended that post-abortion family planning is an essential element of post-abortion care. It has stated that "both women who have terminated a pregnancy through unsafe, unhygienic, and often illegal abortions, and those who have utilized elective induced abortion services as allowed by the jurisdiction, are in critical need of family planning services. These women have demonstrated their determination not to bear a child, yet they face a strong possibility of future unwanted pregnancy and, for the former, of unsafe abortion. The extension of family planning services to all women who have had an abortion will have significant repercussions for preventing unsafe abortion and reducing maternal morbidity and mortality worldwide (Center for Reproductive Rights, 2010).

Psychological care of women after pregnancy termination. According to Steinberg (1989) and Havanon (1986), women with post abortion who need to recovery emotionally require post abortion counseling. Within the statutory guideline, the counseling itself may take the form of individual or group counseling. The counseling should acknowledge any loss a women feels. This acknowledgement might include the women's feelings of participation in a death experience. The counseling may be opened end, until a woman recovers. In addition, women who have gone through post abortion counseling, recovering from their own abortion, may provide support for women beginning to grieve. Moreover, abortion providers should also supply a telephone hot line, staffed by counselors, or women who have undergone counseling. Also, a women should receive written literature to take home after the abortion. Aftercare literature may describe the range of emotional reaction. The literature may also give the telephone hot line numbers or numbers for post abortion counseling.

Obstacles of Pregnancy Termination in Thailand

According to Chaturachinda (2014), Six years in the waiting, new regulations have been drafted for the medical regulation abortion, which are deemed permitted by law when a pregnant woman's mental health is at risk or in jeopardy. In 2005, these regulations were posted in the Royal Thai Government Gazette in 2005. Regardless, health provider perceptions of pregnancy termination have remained negative with the promise of numerous obstacles to overcome in the future.

1. Despite the need of some women to terminate pregnancy, doctors and some policy setters continue to harbor negative perceptions of abortion. If safe pregnancy terminations are to be provided in necessary cases, this climate of negativity needs to change.

2. To combat the unwillingness of numerous state hospitals to administer safe pregnancy termination services, health providers need to be informed and education about the amendment to medical regulations concerning pregnancy termination. This group also needs to be informed of women's rights concerning access to holistic care associated with pregnancy termination.

3. At present, manual vacuum aspiration kits remain inaccessible. To make matters worse, the kits are not even listed as necessary medical supplies.

4. Despite the amendment to the above regulation, women who have undergone pregnancy terminations remain subjects of stigmatization and discrimination, particularly when those women belong to young, marginal and underprivileged groups.

5. Medication-induced medical terminations of pregnancy involving drugs such as mifepristone and misoprostol are not included on the lists of medications registered for administration in Thailand.

Chaturachinda (2014) has recommended the immediate needs among the women with pregnancy termination are as follow:

1. In advocating a woman's right to safe, holistic pregnancy termination services, the series need to be highlighted as a "health need" that differs in no way from other health care provision. Thus, the fees for safe pregnancy termination services need to be paid by the universal health coverage scheme or the National Health Security Office (NHSO).

2. At the district and private community clinic level, there is a need to provide proper training for medical staff for the purpose of sustaining the capacity and networks of these medical facilities.

3. In order to make safe terminations of pregnancy accessible nationwide, the services require availability, accessibility and affordability.

4. Manual vacuum aspiration equipment must be supplied to all state hospitals.

5. The medications required for medical pregnancy terminations need to be approved, registered and included on Thailand's list of essential drugs.

6. Medical courses on safe, surgical and medical pregnancy terminations need to be revised.

7. Health providers and the public at large need to be desensitized on the issue of pregnancy termination.

In Thailand, quality physical care for women experiencing all kinds of abortion is available in all general hospitals. Health education for physical recovery and family planning is also provided by nurses. However, psychological care or mental healing immediately after the abortion and in the long-term is not well developed and provided, leading the women to mentally suffer and to develop psychological illness. Based on holistic care, midwives and nurses in obstetric emergency rooms and post-abortion units have direct responsibilities to providing not only physical but also mental care. Here, mental care is not the care of women with psychiatric illness, which provided by psychiatric nurses. Instead, it is caring for common and uncomplicated psychological problems, such as depressive symptoms, fear, anxiety, shame, guilt, anger, low self-esteem, etc., in order to prevent with psychiatric illness. If the problems are severe, the women will be referred to obstetricians.

Empirical Evidence of Nursing Intervention

Nurses take the important roles in psychological care provided to the women who experience pregnancy termination. This kind of nursing intervention needs empirical evidence for further develop nursing knowledge and nursing practice guidelines. Natalène, Callahan, and Chabrol (2010) examined women who have experienced spontaneous abortions (miscarriages), three clinical techniques, namely, support, psycho-education and cognitive-behavioral therapy, must be drawn from for psychological

support interventions to be effective. According to previous findings at three weeks following spontaneous abortion, implementation of the above three techniques was found to have yielded significant variances in scores for anxiety, depression and event impact. According to the findings of multiple regression analysis, intervention group and depression antecedents can predict post-miscarriage adaptation with statistical significance. For example, Hepburn (2014) conducted a study on the effectiveness of post-abortion counseling on self-esteem and post-traumatic stress disorder in a sample of women aged 20-24 years. According to the findings, it can be concluded that the women provided individual post-abortion counseling would gain improved self-esteem and less severe post-traumatic stress.

Sriarporn and Liamtrirath (2014) state that women and their families can cope with grief effectively because of the role of the nurse-midwives in informational and emotional support. Pengkasukuntho (2004) examined the situational adjustment nursing support programs featuring emotional, tangible and informational support can be assumed to ease grief among women post-miscarriage. In fact, the findings indicated that the program was capable of minimizing grief in this group with statistical significance. In the experimental group, the mean grief scores were lower than the same scores of the women in the control group with statistical significance.

Muenwatzai, Serisathien, Panitrat, and Boriboonhirunsarn (2010) examined an effect of a nursing care program for spontaneous abortion women on grief. The program was based on Swanson's caring theory, focusing on grieving of the women and support by their family members. The findings revealed that the mean grief scores in the experimental group were lower than the same scores of the women in the control group with statistical significance. ($p < .001$).

In therapeutic abortion, Kwadkweang, Serisathien, Phahuwatanakorn, and Boriboonhirunsarn (2014) examined the impact of a nursing program for female patients who decided to undergo therapeutic abortion and were being treated at Siriraj hospital. The results showed that the experimental group displayed a significantly lower average level of stress ($p < 0.01$) than did the control group. However, the detail of the program was not provided. In criminal abortion, Pingprasert (1991) found that counseling intervention for women who had complications from criminal abortion reduced anxiety

and enhanced self-esteem significantly. Sujiinnaprum (2011) examined the efficacy of counseling program and found that average score of anxiety decreased from a high to a moderate level. However, there was no a control group.

In conclusion, the intervention studied in Thailand are still limited and the studies on nursing or counseling procedures are not widely disseminated. The development of nursing intervention for women after pregnancy termination is still needed. Certainly, basic knowledge generated from women's experience is a basis for the program development. According to the literature review, emotional responses following abortion have been explored by several studies. However, psychological problems in the long-run in Thai women with pregnancy termination are not explored. Importantly, how the women cope with emotional and psychosocial problems in the Thai context and related issues surrounding coping is not well explored. Some psychological intervention studies were conducted in spontaneous abortion and therapeutic abortion. Therefore, exploring experience of women in terms of coping strategy and coping resources in Thai women after unwanted pregnancy termination is very important on the ground that can be created the effective nursing intervention programs, counseling programs, and nursing practice guidelines. These quality interventions have to meet the women's needs and fit to the women's nature. Understanding the women's experience, including their strength and limitation, is essential for nurse to know how to provide patient-centered care, aiming to empower the women to manage their painful experience in their own ways.

Part B: Feelings Following Pregnancy Termination

The second part of the literature review presents feelings of the women after pregnancy and related factors. 'Feeling' is an emotional state or reaction, which is synonymous with affection (Merriam-Webster, 2019a). The term 'psychological' refers to acting through the mind especially in its affective or cognitive functions (Merriam-Webster, 2019b). Accordingly, the terms feelings, emotional responses, mental/ psychological responses have similar meanings and they are interrelated.

Positive Feelings

Relief means happiness or relief as a result of something that brings to an end of fear or sadness (Johnson-Laird & Oatley, 1992). The most common positive emotional reaction after abortion is relief (Cohen & Crabtree, 2006; Stotland, 1997). In Thailand, a woman felt relieved following early post-abortion because she could solve her problem in the right way based on her personal right (Mahawan, 2013). For most women who have had miscarriages or abortions, the emotional impact is long-term. On the other hand, some of these women have been reported to have temporal emotional reactions under the same circumstances (Kanchanapusit et al., 2009). According to Foster, Gould, and Kimport (2012), the most frequently reported emotional reaction of women post abortion was relief (63%) and confident (52%); the significant minority anticipated feelings were a little sad (24%), a little guilty (21%), and anticipate poor coping (3.4%).

In addition to the feeling of relief, maturation can occur after the experience of pregnancy termination. Many women reported that the decision to have an abortion was a turning point in their life: marking a change from passivity to active responsibility, planning, and mastery of their destiny; making a necessary and painful decision, taking responsibility for their futures and their obligations (Stotland, 1997). A qualitative study of Thai couples who experienced unwanted pregnancy termination indicated that the couples had learnt to do the right things and had stronger bonding, and the women became stronger (Chatchawet, 2009). Even though some women feel relieved because they can solve their unwanted pregnancy problem, but many women have negative feelings such as guilt, shame, suffering, anxiety because they fear their stories will be disclosed and the effects to their future life (Komon, 2010; Pingprasert, 1991).

Negative Feelings

According to the extensive literature review, the negative feelings or psycho-emotional responses can be categorized into four groups as 1) shame, guilt, low self-esteem, sin, and stigmatization, 2) stress, anxiety, and fear, 3) traumatic feelings and post-traumatic stress disorders, and 4) sadness, depression, and grief.

Shame, guilt, low self-esteem, sin, and stigmatization. Shame is a specific physical expression due to the feelings of worthlessness, low self-esteem, and alienation (McFall & Johnson, 2009). Most of women who reported abortion said that abortion was shameful (Johnson-Hanks, 2002). Since abortion is illegal in Thailand, women with self-induced abortion bared the shame cast upon them by their families and communities (Shehan, Isaranurug, & Khan, 2003). Consequently, Buddhist teachings give limited room to the shame and humility of "abortionist" women in Thailand (Whittaker, 2002). Thai women feel very shameful for their abortion and really want to keep it in a secret. This is one way to protect their self-worth. However, the women still suffer shame although their secret is not disclosed (Komon, 2010; Pingprasert, 1991).

Guilt is a feeling of having done wrong or failed in an obligation (Miller, 2015). Guilt does not necessarily involve focusing on the self. Rather, guilt emphasizes actions taken and can, therefore, be viewed as an extrinsic factor. As a person considers having done wrong to another or others, guilt develops. In contrast, shame, is the result of intrinsic factors as a person reflects on dishonorable or disgraceful actions taken. From this perspective, the aforementioned actions need to remain concealed and felt or senses deep within the psyche of the doer (Harstade, Roxberg, Andershed, & Brunt, 2012). In pregnancy termination, the guilt is related not only to the ending of a potential human life but also to the unwitting or inopportune conception of that potential life, which implies a lack of self-control or lack of self-esteem (Stotland, 1997). For women who have consented to killing a human being, the burden of guilt can be unbearable (Coleman, 2008). In addition, Sujiinnaprum (2011) found that criminal abortion women felt guilty because they made their families regretted.

Low self-esteem is characterized by a lack of confidence and feeling badly about oneself (Firestone, 2019). There is no evidence that abortion harms women's self-esteem or life satisfaction in the short term (6 months to one year) (Biggs, Upadhyay, Steinberg, & Foster, 2014). Women who conceal their abortions are more likely to be ashamed of their abortions. This, in turn, it implies that the abortion threatens their self-esteem that are more likely to have lower self-esteem (Reardon, 2019).

Sins define the mind and have a bad effect on the psyche making it difficult to attain the stage of enlightenment (Sarao & Long, 2018). Thai people believe that abortion is a

worldly sin, a karmic sin, and is illegal (Whittaker, 2004). From a Buddhist perspective, termination of pregnancy interrupts the karmic cycle of birth and mortality by preventing the reincarnation of living things. Based on Buddhist teachings, women who submit themselves to pregnancy termination are subject to unavoidable karmic retribution (Whittaker, 2001). It is found that induced abortion women expressed feelings of sin, bad karma and uneasiness because of their decision to terminate their pregnancy (Lerdmaleewong & Francis, 1998). Approximately 91 percent of criminal abortion women admitted to Mahasarakham hospital thought that criminal abortion was sinful (Sirithanawutichai et al., 2008).

Considering stigmatization, as a social process in which a certain characteristic taints the identity of an individual women who have abortions, the woman perceives or anticipates judgment or disappointment from peers, family or the larger community. The woman may also experience or anticipate poor treatment such as verbal abuse or gossip (Berman, 2011). The circumstances for allowing termination of pregnancy are decidedly limited. Thus, pregnant women and health providers who conduct unsafe or illegal terminations are subject to legal prosecution. Moreover, abortion-related complications run rampant in this group, while religious leaders remain strong on their opposition to fewer or less stringent restrictions on pregnancy termination (Kumar, Hessini, & Mitchell, 2009). In Thailand, women continue to be subject to stigmatization and discrimination concerning the termination of pregnancy, particularly among Thai women who belong to young, underprivileged and marginal groups. Due to the stigmatization of pregnancy termination, inadequate training of health providers and the aversion of politicians to speak out on the issue of pregnancy termination, advancements in the expansion of accessibility concerning safe abortion remains slow at best (Chaturachinda, 2014).

Stress, anxiety, and fear. By definition, stress reaction can be described as physiological and emotional triggers that are generally, but not unavoidably, yielded by perceived demands or stress levels (Thoits, 1995). In Thailand, Chaisuwan (2005) found that adolescents who committed criminal abortion had a high stress level in the topics of fear of curettage and disclosure of her story, and a medium level of stress on being insulted by others and being absent from job or school.

The emotional states of anxiety and fear are different. While fear can be described as an intention to avoid leading to the flight action of the "fight or flight" response, anxiety can be explained as a fear or phobia that remains unresolved in what can be referred to as an undirected trigger in reaction to a perceived threat (Ohman, 2008). A woman with abortion has the feelings of anxiety and fear about complications of abortion on her health in general and reproductive health as many messages of unsafe abortion have been disseminated. They also fear that some people will know about their pregnancy termination, which can affect their future life (Komon, 2010; Pingprasert, 1991). From the study in one gynecological outpatient department in Thailand, 100 subjects (36.9%) met criteria for anxiety, and they were more likely to have an abortion at an earlier age (Roomruangwong & Tangwongchai, 2009).

According to the National Survey of Family Growth (NSFG), the findings of a study conducted in 10,847 primiparous women aged 15-34 years with unplanned pregnancies and no previous background of anxiety in the USA, the women who had undergone terminations of pregnancy were found to be 30 percent more likely to report the symptoms of generalized anxiety disorder (Elliot Institute, 2016a). Social anxiety was also found in multiple abortions (Steinberg & Russo, 2008). Based on the analysis of 22 studies in 1995-2009, abortion was tied to a 34% increase risk of developing an anxiety disorder (Coleman, 2011).

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Traumatic feelings and post-traumatic stress disorders. Psychological, or emotional trauma, is damage or injury to the psyche after living through an extremely frightening or distressing event and may result in challenges in functioning or coping normally after the event (Cascade Behavioral Health, 2019). It can be concluded that the defining characteristic of a traumatic event is the ability of that event to trigger feelings of fear, vulnerability or shock when reacting to impending pain or mortality (Yehuda,

2002). According to the American Psychiatric Association (2011), people who suffer from post-traumatic stress disorders (PTSD) often experience flashbacks or nightmares, have difficulty sleeping, and feel detached or estranged. It has been indicated that PTSD is a potential contributing factor to a number of major depressive, drug abuse/addiction/ alcohol abuse/addiction, conduct, anxiety and manic disorders leading to problems with escalating severity. Thus, diagnosis in the early stages and proper treatment are essential (Javidi & Yadollahie, 2012).

Termination of pregnancy has the effects of exacerbating already stressful situations, while impeding the application of coping skills. This is especially true in the case of women with negative experiences during childhood and previously traumatic events (Rue, Coleman, & Rue, 2004). The events occurring around unsafe abortion can lead the women to develop PTSD. Invasive procedures, such as dilatation and curettage, cause severe pain and frighten a woman as a life threatening conduct, especially self-induced abortion and the abortion by unskillful persons. The messages of hemorrhage, infection, and death caused by unsafe abortion motivate PTSD. In some cases, only some PTSD symptoms, commonly such as fear and avoidance, occur in a short period. These women may not experience PTSD but they still need mental care to go through fear. Pregnancy termination is marked by pain at the hands of a masked stranger. The procedure is not only personal evasive, but can elicit feelings similar to those experienced by rape victims. According to previous research findings, women who have been victims of sexual assault are at risk for higher levels of distress both during and after termination of pregnancy due certain similarities shared by these two occurrences (Elliot Institute, 2016b).

Sadness, grief, and depression. Sadness is conceptualized as a normal, time-limited response to loss (Leventhal, 2009). Mild feelings of sadness and loss are virtually universal among women who undergo abortion. Expression of sadness can be confusing to patients, their significant others, and care providers. A woman chooses to end a pregnancy, to have a procedure, but feels sad about it. Abortion is at best the least objectionable among several undesirable choices among women with unwanted pregnancy. There are many relationships and situations that women feel sad about losing even as they choose to end them, such as college educations, marriages, or having

children. It is necessary to move forward and to weigh the relative advantages as well as disadvantages of each possible course. Still, one feels a sense of regret for the course not taken (Stotland, 1997).

By definition, grief involves affective, physiological and psychological reactions to a person's of a significant "other". The distress associated with grief is generally persistent and severe (Brier, 2008). Grief is a process composing emotional, bodily, cognitive, and behavioral expressions. Grief affects women with perinatal loss and their families, both physically and psychosocially (Sriarporn & Liamtrirath, 2014). In therapeutic abortion due to fetal anomaly, the women experienced loss of hope (Chaloumsuk, 2013). Kreetiyutanont, Srisaeng, and Komwilaisak (2014) also found that termination of pregnancy due to fetal anomalies led the women to experience grief, which were associated with pregnancy desire, number of perinatal loss, gestational age, and religion beliefs. In both spontaneous and induced abortion, grief after abortion for 2 weeks were associated with low incomes, higher gestational age, and methods of treatments (Prohm, 2009).

In unwanted pregnancy, the women thought that abortion was the loss (Ratchukul, 1998). Kanchanapusit et al. (2009) found that grief was a dynamic process of post abortion. After perinatal loss or abortion the women would express different forms of grief with various intensity (active grief, difficulty coping or despair) regardless of the abortion types (spontaneous, therapeutic or criminal abortion). The abnormal grief after abortion occurred very often with the prevalence of 72.6%, especially in the young age, low socioeconomic status, and undesired pregnancy. In abortion, disenfranchised grief is experienced because women's grief is not openly acknowledged, socially validated or publically observed, leading to depression due to inability to process the grief (Johnson, 2015).

Depression is the cognitive features and the depressive experience is characterized by a negative view of the self, the world and the future (Beck, Rush, Shaw, & Emery, 1979). One well-known and common mental disorder marked by sorrow, disinterest or displeasure, guilt, low self-esteem, sleep disturbance, loss of appetite, lethargy and impaired concentration is depression (Mental Health Foundation, 2016). According to the study by Saelim (2003), it was shown that the unwanted pregnancy women who

decided to terminate pregnancy have significantly higher depression than the women who carried to term pregnancy; and depression was correlated with women age and gestational age, but more depression were not because of older age or higher gestational age. Depression was also associated with body image. According to an analysis of 22 studies by Coleman (2011), a 110% increased risk of experiencing depression was found in abortion, and the rate of depression was 37%. Suicidal thoughts or intentions have been reported among approximately 60 percent of all women who have had either spontaneous or induced pregnancy terminations. Of these, the findings show that 28 percent have reported having attempted suicide with half of this group having made two or more suicidal attempts (Reardon, 2016).

Risk Factors Related to Psychological Sequelae

According to the American Pregnancy Association Promoting Pregnancy Wellness (2016), the following traits have been reported to make women more likely to have negative emotional or psychological reactions to the termination of pregnancy:

1. Previous emotional or psychological issues. Prior history of mental health conditions, history of child abuse and neglect, sexual assault, and intimate partner violence are the factors most strongly associated with experiencing adverse mental health outcomes after abortion (Advancing New Standards In Reproductive Health, 2018).

2. Coercion, force or persuasion to terminate a pregnancy. The factors correlated with negative feelings in response to pregnancy terminations are the abortion of a planned or otherwise meaningful pregnancy, perceived pressure to have an abortion from family members and others, insufficient social support and particular personality characteristics that have a tendency to make people more susceptible to the effects of certain stressors (e.g., low self-esteem, a pessimistic outlook, low perceived control) (Major et al., 1998).

3. Religious beliefs and moral or ethical that discourage or forbid pregnancy termination. The essence of the Buddhist ethics is synthesized in the first five moral precepts compulsory for all Buddhists. The first of these precepts is the most important one and it refers to the interdiction of killing not only human beings but also animals,

regardless their size. Considering the embryo a fully human being, Buddhism considers abortion an infringement of this essential moral precept (Damian, 2010).

4. Pregnancy termination during later stages of pregnancy. According to Steinberg (2011), a critical review of research about psychological experiences of women having later abortions (second trimester or beyond) were evaluated with respect to the claim that later abortions harm women's mental health. Factors may increase the chances of mental health problems among women having later abortions. The experience of fetal movements or stigma, for example, may differ between women having earlier and later abortions and may contribute to women's psychological adjustment. Women having later abortions may be unable to conceal their pregnancies, and thus the stigma associated with later abortions may differ from that associated with earlier abortions.

5. Insufficient or no family/peer/spousal/partner support. The terms of women without support from significant others or their partner, negatively perceived spousal or couple relationships have been found to be correlated with increased psychological morbidity stemming from a termination of pregnancy. Other factors such as living alone, insufficient emotional support and negative changes in spousal/couple relationships have been asserted as risk factors for psychological distress following the termination of a pregnancy (Canário et al., 2011).

6. Pregnancy termination prompted by genetic or fetal anomalies. By law, a pregnancy can be induced for saving the mother's life and a baby's well-being.

The American Psychological Association Task Force on Mental Health and Abortion in the 2008 report (as cited in Elliot Institute, 2016b) recommended about risk factors of reactions to women to have negative emotional after pregnancy termination which focus on coping. Firstly, adoption of coping strategies involving avoidance and denial. According to Schibalski et al. (2017), avoidant stigma coping may bring harmful effects, potentially exacerbating pre-existing psychological distress and undermining social networks. Secondly, low level of perceived coping ability concerning pregnancy termination. According to the study by Major, Cozzarelli, Sciacchitano, Cooper, and Testa (1990), a correlation has been found between perceived spousal/partner support and a woman's adaptation to having undergone a termination of pregnancy. Thus, women

who perceive high levels of family/peer/ spouse/partner/social support tend to report greater self-efficacy in coping skills, but perceive low levels of social support have reported greater difficulty in adaptation during the post-pregnancy termination period than both women who opted for non-disclosure of their pregnancy termination and those who perceived full family/peer/spouse/partner support.

In conclusion, the negative psychological reactions after pregnancy termination can be created from various factors such as previous emotional or psychological problems, force or persuasion to terminate a pregnancy, religious beliefs, moral or ethical, later stages of pregnancy, insufficient or without support, and non-elective (therapeutic or coerced) termination of pregnancy. In Thailand, sociocultural, religious, and legal issues on abortion strongly influence post-termination women's mental states. As a consequence, the women employ several coping strategies to go through their experience.

Part C: Coping with Pregnancy Termination

After pregnancy termination, the women have to deal with both of physical and mental problems. In the third part of the literature review, the content consists of 2 topics: 1) coping strategies, and 2) support for women with pregnancy termination.

Coping Strategies

As aforementioned, termination of unwanted pregnancy leads the women to experience many negative feelings, possibly resulting in emotional and psychosocial problems. To survive, the women employ several ways to cope with their painful feelings. 'To cope with' refers to 'to deal with and attempt to overcome problems and difficulties' (Merriam-Webster, 2019c). In this study, coping means dealing with the negative feelings developed from the experience of pregnancy termination. The focus was on coping strategies the women employed. That is, implicit or explicit actions of the women which were performed to manage their negative feelings were explored.

Coping mechanisms are any efforts directed at stress management (Stuart, 2013) The intentional behavioral and psychological efforts of a person are referred to as coping strategies aimed at enduring, taking control of, mitigating or minimizing triggers or stress or distressful situations (Taylor, 1998). Lazarus and Folkman (1984) define coping

strategies as the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events (Lazarus & Folkman, 1984). In this study, coping strategies refer to the implicit and explicit actions performed by the women to manage their negative feelings developed by pregnancy termination. Coping strategies are reviewed based on the concepts of coping mechanism and coping strategies.

According to Stuart (2013), coping mechanism can be constructive or adaptive and destructive or maladaptive. Positive coping leads to adaptation, which is characterized by a balance between health and illness, a sense of well-being, and maximum social functioning (Williams & Boyd, 2005). Coping mechanisms can be divided into 3 categories: problem-focused, cognitively-focused, and emotion-focused. The details are as follows (Stuart, 2013):

1. Problem-focused coping mechanisms involve tasks and direct efforts to cope with the threat itself. These mechanisms are thoughtful, deliberate attempts to solve problems, resolve conflicts, and gratify needs. Examples of these reactions can be confrontation and seeking advices to remove and overcome obstacles to satisfy needs. Compromising is another method performed to change one's usual way of thinking about things, substituting goals, or sacrificing aspects of personal needs. In biological stress, withdrawal behavior, such as smoking cessation, can be performed to remove oneself from the source of the threat.

2. Cognitively-focus coping mechanisms are employed to control the meaning of the problem and thus neutralize it. These methods include positive comparison, selective ignorance, substitution of rewards, and devaluation of desired objects. According to Rice (1999), cognitive restructuring is subtle method of attacking stressor whereas problem-solving method is employed to completely eliminate a stressor. In cognitive restructuring, one examine thought patterns that are negative, self-defeating, and self-limiting. This method also requires some outside help in viewing one's thoughts.

3. Emotion-focus mechanisms are employed to moderating emotional distress, including ego defense mechanisms. Defense mechanisms are employed to diminish emotional stress (Stuart, 2013). Examples are as follows (Stuart, 2013; Videbeck, 2017):

Compensation: Making up for a perceived weakness to maintain self-respect.

Denial: Avoidance of disagreeable realities by refusing to recognize them.

Displacement: Shift of emotion from a person or object to another.

Intellectualization: Excessive reasoning to avoid disturbing feelings.

Introjection: Incorporating other values into their own ego structure.

Projection: Attributing intolerable wishes or emotional feelings to another person.

Rationalization: Offering a socially acceptable explanation.

Repression: Involuntary exclusion of a painful thoughts from awareness.

Suppression: A conscious counterpart of repression.

In terms of defense mechanism, Vaillant (2011) describes it as healthy- unhealthy continuum to help individual in coping with stressful situations. Healthy coping includes 1) sublimation: gratification of primitive needs that are unconscious by society's standards adverse consequences, 2) altruism: the gaining of gratification by being of genuine service to others, 3) humor, 4) suppression, and 5) anticipation coping can be dissociation, reaction formation, displacement, repression, fixation, regression, intellectualization, undoing, acting-out passive-aggressive behavior, hypochondriasis, fantasy, compensation, identification, projection, distortion, and denial. The judicial use of mechanism may go along the way toward reliving pain and discomfort.

Based on a qualitative study by Sekudu (2001), it was found that women who had induced abortion coped with their experience based on the general defense mechanism of rationalization, repression, and compensation.

1. Rationalization: With this defense mechanism the women gave reasons for having an abortion in order to go on with her life, with minimized emotional stress.

2. Repression: The woman was not aware of any negative feeling as though the abortion never happened-a mechanism of denial, which may be end up not in touch with reality.

3. Compensation: When the woman becomes pregnant soon after her abortion, she may reinforce her belief that abortion is right or carry the baby to term to serve as a substitute for the aborted baby.

Coping can be dynamic depending on time and context. Strasrynska (1999) conducted a qualitative study focusing on coping strategies. They described coping with induced abortion experience as “restoring wholeness-tending the garden,” consisting 3 stages as follows:

1. Stage one: Surviving the struggle. Once the pregnancy was terminated, the struggle to protect themselves from condemning judgments continued, leaving several women with limited opportunity for grieving and healing. This stage consists of four phases: 1) making a choice: challenging a joint decision, taking stock, validating the option, 2) approaching the inevitable: taking action, letting emotions surface, settling the internal debate: establishing readiness, 3) enduring the inevitable: creating a comforting fantasy, being on guard, and 4) moving on: continuing on the path, shrouded in secrecy, grieving in darkness (running away from sadness feeling the loss).

2. Stage two: Beginning the process of healing: the “power of love” recovering the unresolved experiences, putting the “little ghost” to rest shining the light: breaking away from the shadows.

3. Stage three: Becoming whole: looking for common ground, comparing to others, connecting with others (exploring new meanings), harvesting: acknowledging benefits (recognizing persona1 achievements and favorable, personal attributes, sharing and celebrating).

Theoretical and empirical evidence on coping in general rather than in specific emotions is described aforementioned. Particular coping strategies are those with loss or sadness, shame and stigmatization, as well as guilt. Religious coping is another method which is highly powerful. Coping with loss is grieving. Sadness is having experienced an irrevocable loss. Rando (1984) describes 6 tasks of grieving: recognize the realities, emotionally react, recollect and re-experience through reviewing memories, relinquish of no turning back, readjust, and reinvest. Worden (2008) views 4 grieving tasks: accepting the reality, working through the pain of grief, adjusting to an environment that has changed because of the loss, and emotionally relocating that which had been lost and moving on with life. Disenfranchised grief is grief over a loss that is not or cannot be acknowledged openly, mourned publicly, or support socially (Videbeck, 2017). Women

with pregnancy termination likely experience this form of grief because their loss involve social stigma.

Coping with shame and stigmatization can be avoidance, referring to emotional distancing or the minimization of the shaming event through hiding from reminders of the event. Shame resilience is another method of coping with shame, a process that transforms an individual's ability to have strong and meaningful relationships with others (Brown, 2006, 2007), through combating the feelings of powerlessness, feeling trapped, and feeling isolated and increasingly feeling more connected, more power, and freedom from shame. One qualitative study found that post-abortion women coped with shame through worthiness by meaning making, grace, forgiveness, and honesty (Chavier, 2015). On the contrary, avoidant stigma coping may bring harmful effects, potentially exacerbating pre-existing psychological distress and undermining social networks (Schibalski et al., 2017).

Coping with quilt is more likely associated with problem-focused coping than coping with shame (Yi & Baumgartner, 2011). Guilt includes a feeling of tension between what one should have done and what one has done, thus providing motivation to repair the fault (Tangney & Dearing, 2002). Guilt from pregnancy termination is related to the concern that a mother has hurt her baby and to the resulting desire to repair such mistakes with their dead and future baby. In Thailand, Ratchukul (1998) found that a woman after abortion was philanthropy charity devoted to fetus in order to reduce guilt and sin, which helped them feel better. If women's experiences could be understood and they received care and support as they needed after abortion, this might help them to overcome these difficulties and had less psychological problems in the future (Chaloumsuk, 2014).

Religious coping is the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances (Ano & Vasconcelles, 2005). Religious coping is crucial in extremely stressful situations that limit and deplete them of personal and social resources (Pargament, Ano, & Wachholtz, 2005) because it enhances self-esteem and influences perception (Maton, 1989). Since pregnancy termination is perceived as a sin and stigma, religious coping is possibly the common method. In addition, religious coping is moral-focused, which is suited to moral wrongdoing in killing a baby.

Empirical evidence about coping mechanism in particular to pregnancy termination is shown in the qualitative study in 24 women with induced abortion by Stålhandske et al. (2011). The authors used the terms of coping strategies instead of coping mechanism and they found four different existential strategies. The found coping strategies with pregnancy termination were not limited to emotion-focused coping and ego defense mechanism. Instead, the coping was likely related to problem-focused and cognitively-focused coping as well.

1. Detachment strategy refers to a woman's attempt to keep a distance between herself and her pregnancy as a means of protection from hard-to-handle emotional impacts. According to a number of women who had undergone pregnancy terminations, the time spent waiting for an impending termination of pregnancy is difficult due to feelings that ongoing fetal development made their detachment from the pregnancy more complex. Many women have also mentioned the significance of compartmentalizing their feelings about an unwanted pregnancy from their attitudes about planned pregnancies in the future. In such cases, the detachment strategy does not emphasize the fetus and fetal development. Rather, the strategy emphasizes pregnancy as a whole.

2. Defining strategies refer to a person's ability to make a meaning of events or apply experiences to the person's world view, both of which are aimed at making pregnancy termination morally acceptable. For some women, consideration of pregnancy and fetal development is linked with the women's overall perception of the world around them and their world views. In the situation of an unplanned pregnancy, many women are confronted with making morally definitive choices about the values they hold. Thus, the aforementioned set of circumstances can cause conflicting ideals such as individuality and reproduction, or fidelity and motherhood. For example, although some women feel ready to adopt the maternal role, but are uncertain about the paternity of their unborn children. Thus, these women may find allowing the pregnancy to go to term unfeasible for their personal situations.

3. Social strategies involve sharing personal experiences with significant others with the aim of gaining acknowledgment and acceptance in discussing their pregnancy terminations with family/peers/spouses/partners. This strategy is essential for most women. In sharing their experiences in a friendly, non-judgmental setting, the women

sensed acceptance and less isolation, particularly when they were given the chance to recognize that pregnancy termination experiences are common among most women. Thus, women can implement social strategy to cope with existential questions.

4. Symbolic strategies involving physical "descriptions" of experiences in the form of signs, facial expressions, gestures and other symbols aimed at coping with the emotional impacts of pregnancy termination. Though symbolic or ritual and diverse in nature, the aforementioned strategies are key components of the stores of women who have had either spontaneous or induced terminations of pregnancy. Some women intentionally create or implement symbolic or ritual strategies for coping with distressing experiences. In contrast, other women report rather common activities as being symbolically significant because the activities are done in a way that distinguish them from the ordinary activities.

In summary, coping strategies refer to the means and the implicit and explicit actions of the women which are employed to overcome their negative feelings after their pregnancy termination experience. The strategies may be emotion-focused, cognitively focused, or problem-focused coping. This study focused on coping strategies. More importantly, social support is believed to improve coping strategies.

Support for Women with Pregnancy Termination

In this study, support was explored based on the concept of social support. As we known that the ways people cope with stressful situations depending on the resources available to them such as social support and social network (Lazarus & Folkman, 1984). Social support is indicated as an important environmental coping resource of an individual (Lazarus & Folkman, 1984). Social support is a multidimensional concept involving positive interpersonal relationships that a supporter aims to promote well-being of a receiver (Hupcey, 1998). House (1981) defined social support as an interpersonal transaction involving the provision of resources such as emotional concern, instrumental aid, or information. Adequacy of social support is directly related to severity of psychological and physical symptoms reported by individuals, and that social support also represents a buffer between stressful life events and psychological distress. Social

support is believed to improve coping strategies, whereas the belief that support is available can lead to the perception of situations as less stressful (Lakey & Cohen, 2000).

Schefer and colleague (1981) have classified social support into 3 types: 1) emotional support, such as attachment, reassurance, and being able to rely on and confide in a person, 2) informational support, such as information, advice, and feedback, and 3) tangible support, such as direct help or aid, loans and gifts, services, or taking care. Formal support can come from organizations in terms of services provided by professional, trained employees, typically paid for their work. Informal support includes the support provided by family, friends, colleagues, neighbors, and community members. Women often seek informal support from relatives and friends.

Aside from social support as the external forms of coping resources, there are various internal coping resources which function as the protective factors of coping. These internal resources include spiritual beliefs, problem-solving skills, social skills, material assets, knowledge and intelligence, and strong ego identity (Stuart, 2013). Spiritual beliefs can serve as a basis of hope and coping efforts under the most adverse circumstances (Stuart, 2013). Many spiritual and religious beliefs help persons cope with stress because these beliefs are employed with issues of living (Halter & Varcarolis, 2014). Spirituality and religion are often used interchangeably but spirituality goes beyond religion, and religion is an organized system of beliefs and practices focusing on higher power the governs the universe (Shives, 2008).

Empirical evidence in relation to support for women with pregnancy termination is considering. Shortly after the pregnancy termination, the presence of a support person in the recovery room was perceived in a positive manner by women and support people (Veiga et al., 2011). Canário and colleague (2011) studied 50 women with different etiologies of abortion and 15 partners. They found that at one and six months after abortion, social support provided by the partner was a key aspect in the psychological recovery after abortion, particularly for women with high coping resources. A feminist study of 12 Thai women with unwanted pregnancy termination and 11 partners showed that the women expected their partner's caring in 6 ways: assisting pregnancy termination, not abandoning, caring heart by heart, expiating, basic care need, and financial care (Chatchawet, 2009).

According to the study by Major and colleague (1990), a correlation has been found between perceived spousal/partner support and a woman's adaptation to having undergone a termination of pregnancy. Thus, women who perceived high levels of family/peer/ spouse/partner/social support tended to report greater self-efficacy in coping skills. As a result, this improved self-efficacy has been found to be a predictor or psychological adaptation, but not a predictor of actions taken as a result of physical discomfort. Furthermore, who told family members/peers/spouses/partners about pregnancy terminations, but perceived low levels of social support have reported greater difficulty in adaptation during the post-pregnancy termination period than both women who opted for non-disclosure of their pregnancy termination and those who perceived full family/peer/spouse/partner support.

The terms of women without support from significant others or their partner, have been found to be correlated with increased psychological morbidity stemming from a termination of pregnancy. Other factors such as living alone, insufficient emotional support and negative changes in spousal/couple relationships have been asserted as risk factors for psychological distress following the termination of a pregnancy (Canário et al., 2011). Included among the factors correlated with negative feelings in response to pregnancy terminations are the abortion of a planned or otherwise meaningful pregnancy, perceived pressure to have an abortion from family members and others, insufficient social support and particular personality characteristics that have a tendency to make people more susceptible to the effects of certain stressors (e.g., low self-esteem, a pessimistic outlook, low perceived control) (Major et al., 1998). Positively perceived spousal/partner relationships, the ability to depend on a spouse/partner in future situations, a high perceived degree of spousal/partner support in making the decision to terminate a pregnancy has been found to be associated with more positive reactions following the termination of a pregnancy (Major et al., 1990).

In summary, women, especially in the countries where abortion is illegal, who undergo pregnancy termination suffer alone because of stigma surrounding this issue. Even though the feeling of relief and maturation can occur after the experience of pregnancy termination. Some women feel relief because they can solve unwanted pregnancy problem, but many women have negative feeling such sadness, guilt, shame,

sinfulness, stigmatization, anxiety and so on because they fear their stories will be disclosed and the effects to their future life. As mentioned before, termination of unwanted pregnancy leads the women to experience many emotional and psychosocial problems since this act is legally, socially, culturally and religiously disapproved. To survive, the women employ several ways of coping and need various supports from lay people and nurses. The concept of coping with the pregnancy termination experience is demanding and complex that is summarized from extensive literature review. This study focused on coping strategies and support based on the women's experience.

The unavailability of mental support and mental care services lead to unfair treatment for women with pregnancy termination since these services respond only to the women's basic needs. Women are not granted the rights to give their voices to anyone around them. Feminist perspectives are employed to understand women's experiences in coping with pregnancy termination without gender bias in order to improve the women's well-being. However, it is unclearly known "what their feelings are, how they survive and go through it, and what kinds of help they need." Feminist research is obviously suited to obtain the answers. Feminist perspectives on this issue are employed to understand the women's experiences, aiming to empower the women to understand their painful experience.

Part D: Feminist Perspectives on Pregnancy Termination

This part focuses on influence of gender values, particularly in Thai context, on psycho-emotional responses and healing in post-termination women. The debate on legitimization of abortion is not the point but abortion disapproval is discussed as the influencing factors based on feminist perspectives. New insights from different angles can help more clearly understanding the women's capacity and struggles and the ways to enhance their healing processes. The content starts with ideology of motherhood, gender inequality in pregnancy termination, and women's rights to healthcare access. At the end, broader aspects of religions and morality, as well as laws are described.

Ideology of Motherhood

Mothers staying home and acting as the main carers of their children is an ideal. (Stockey-Bridge, 2015). In Thai society, a mother is the most important patron which her children are obligated to gratitude her when they are grown up. There is a strong belief that a mother is so important that she is the one who gives life to her children, raises them, and nurtures them. Motherhood is equated with femininity which guarantees children's well-being; and considered the most significant for a woman. Women's natural abilities and capabilities, or maternal instinct, are dismissed when a woman decides not to have a child or has a child out of wedlock. (Leskošek, 2011). It is worse in pregnancy termination because motherhood is totally destroyed. Abortion is considered to be a life-destroying act that counts as a serious bap (sin or demerit) in Thai culture. According to Johnson (2015), as killing an unborn child psychologically scars the mother; a woman should "Be At Least a Little Sad" about the abortion. If a woman's interactions, religious upbringing, or abortion ideology dictate post-abortion grief and remorse, she might actually subject herself to hazards. The abortion experience can be conceptualized as running a gauntlet, stated Johnson (2015).

Empirically, a study in Chile revealed that women became real women through motherhood exist; and anti-abortion debate was strongly connected to the discourse on motherhood and the natural body (Kohlmark, 2012). The ideology of motherhood leads an abortion woman becomes a bad mother and a cruel woman, devastating her sense of self. It is not surprised that the woman still feels ashamed, self-blamed, and depressed although her unwanted pregnancy problem has been solved.

A woman is placed on high responsibilities to be a good mother but she has no rights to control her life and body, as well as to choose pregnancy termination when she is not ready to bear a child. This is a double standard and unfair treatment for the woman. Although abortion is disapproved, an abortion woman still needs empathetic understanding and console instead of blaming and stigmatizing.

Gender Inequality in Pregnancy Termination

According European Institute for Gender Equality (2019), gender inequality means legal, social and cultural situation in which sex and/or gender determine different rights and dignity for women and men, which are reflected in their unequal access to or enjoyment of rights, as well as the assumption of stereotyped social and cultural roles. The term of unwanted pregnancy and unwanted pregnancy termination both of men and women have to share the responsibility together. However, woman with pregnancy termination felt unfairly treated in Thai society.

Based on a feminist study of Thai couples by Chatchawet (2009), messages of gender bias were found when an unwanted pregnancy was terminated. Women were the one who carried pregnancy; therefore, all suffering and stigma from pregnancy termination belonged to the women, allowing men to be irresponsible. This came from the higher privileges of manhood over womanhood in sexuality, such as a man had rights and freedom to have sex but a woman was obligated to control her sexual desire, to respond to a man's needs, and to be responsible for pregnancy. Actually, sex and pregnancy was mutual between a woman and a man, and both the woman and the man were responsible to all consequences, including pregnancy termination. In this study, it was also found that a man should provide care to a woman when pregnancy was terminated. In addition, a woman felt that her partner also deserved to feel as guilty as her. This study implies that an abortion woman feel unfairly treated as she is being a woman who is subordinate to a man.

Women's Rights to Healthcare Access

Women's rights are the fundamental human rights that were enshrined by the United Nations for every human being on the planet nearly 70 years ago. These rights include the right to live free from violence, slavery, and discrimination; to be educated; to own property; to vote; and to earn a fair and equal wage (Global Fund for Women, 2019).

Many obstetricians and gynecologists in Thailand are not willing to provide abortion services due to the current restrictive law, their personal beliefs, or religious

reasons (Chinthakanan et al., 2014). They should be educated about the amendment of the medical regulation and abortion service, as well as the right of women to access comprehensive abortion care (Chaturachinda, 2014). Even though abortion services are unavailable for women who have no medical indications, they still have the rights to quality healthcare services following the abortion for complication prevention, as well as physical and mental recovery. Their rights to healthcare access should not be violated from the judgment of their misconduct in abortion. An injured criminal still has the rights to have a surgery. Healthcare services for an abortion woman should be provided similarly to a criminal on the basis of human rights. Sadly, health care practice for post-abortion women is emphasized on complication and further pregnancy prevention. Mental care enhancing the women's healing process is very limited. In academic settings, the research topic of therapeutic abortion is preferred rather than illegal abortion, remaining the lack of knowledge and practice guidelines for this marginalized group. Hopefully, this study will contribute to the respect of the women's rights to quality healthcare services.

A post-abortion woman can access to health care when she has complications and go to hospital. Since abortion is a stigma, some women with complications refuse health care services. They may not realize the necessity of mental care. They prefer to keep their abortion in a secret and heal by themselves alone. The women have to conceal their pain and grieve in silence without support, interfering their grieving process and possibly leading to depression. Johnson (2015) states that the women have the rights to grieve openly. In other words, they have the rights to access to mental care services. Another way of increasing mental care accessibility is dissimating messages through websites by women's organizations. For example, the Children by Choice Organization (2007) provides information about coping with abortion, such as telling, acknowledging and addressing negative feelings, identifying strengths, dealing with spiritual questions, etc. However, these kinds of messages are slightly available in the Thai language and context.

Religions and Morality

A religion is a set of spiritual beliefs about two key aspects of life as follows 1) concern with the ultimate meaning of human existence., and 2) an identification with a supernatural power beyond the limits of the human and natural worlds (UNESCO, 2010).

The term of morality is an informal public system applying to all rational persons, governing behavior that affects others, and has the lessening of evil or harm as its goal (Desh, 2011).

Approximately 95% of Thais are Buddhists with the Theravada school. Abortion is religiously perceived as a sin and therefore prohibited because a human life starts at a very early gestational age. Abortion is killing and sinful. This religious belief strongly influences why most Thais do not accept abortion for unwanted pregnancy (Chinthakanan et al., 2014). Through childbearing and maternity, a woman marks her status within the Buddhist moral orders and ensures her spiritual salvation through the action of her children. Abortion thus interferes the karmic cycle of birth and death by not allowing the rebirth of a being. In, so doing, Buddhism teaches that a woman will inevitably suffer karmic retribution for her action. Within this view, women must recognize the higher moral value of acceptance of a pregnancy rather than selfish concerns (Whittaker, 2004). Some religious rituals and practices, such as releasing birds and fish, doing merits, and offering dedicated to the monks, are helpful when they function as redeeming their karma. Buddhists believe in suffering as a natural thing, and we need to accept it and try to endure it. In addition, The Four Noble Truths is Buddha's teaching how to get rid of suffering, consisting of 1) suffering or "Dukkha," 2) the origin of suffering or "Samudaya," 3) the truth of the cessation of suffering or "Nirodha," and 4) the truth of the path to cessation of suffering (Adams, 2013)

In Thailand, religious beliefs, and moral or ethical views that conflict with abortion are very serious factors for women with a higher probability of having a negative emotional after abortion. Women's experiences of abortion may vary as a function of their religious, spiritual, and moral beliefs and those of others in their immediate social context. Religiosity and religious beliefs are likely to shape women's likelihood of having an abortion as well as their responses to abortion. Women who belong to religious groups that oppose abortion on moral grounds, such as Evangelical Protestants or Catholics, may be more conflicted about terminating a pregnancy through abortion (Major et al., 2009).

In Buddhism, life begins since conception. Termination pregnancy or abortion is certainly forbidden and morally wrong. The stigmatization after undergoing an abortion, appears to be derived from the religious, ethical and moral values held by the majority of

Thais (Chunuan et al., 2012). The stigma is also associated with illegal abortion (Cohen, 2009). Unwanted pregnancy and abortion is not accepted by Thai society (Mahawan, 2013). Women may be aware of the illegality and believe that abortion constitutes a serious Buddhist sin. The reason is that abortion is considered to be a life-destroying act that constitutes a serious Buddhist sin/demerit. It carries karmic consequences not only for the mother who will be reincarnated into a less auspicious life, but also for the aborted fetus that is understood to have missed an opportunity to be reincarnated to improve its karmic status. Many women cited fear of bap (Buddhist demerit) as the reason they chose to continue with an unplanned pregnancy (Whittaker, 2002). However, the Buddhist has a different attitude in situations when the fetus is diagnosed with severe physical or mental disabilities: the handicap is a manifestation of the child or parents' karma and therefore abortion is unacceptable. Another reason for this attitude is the humanitarian one (Damian, 2010).

Law and Pregnancy Termination

According to the abortion law in Thailand, it is governed by the provisions of sections 301 to 305 of the Thai penal code of 13 November 1956. Under the code, the performance of abortions is generally prohibited (Thailand Lawyer Online, 2018). Abortion is illegal accepted when performed by a medical practitioner in circumstances considered necessary when the pregnancy endangers the woman's health or conception had occurred during a sexual offense such as rape or incest (Chinthakanan et al., 2014). A woman who causes her own abortion or allows any other person to procure her abortion is subject to up to three years' imprisonment and/or payment of a fine not exceeding 6,000 baht. However, illegal abortion services outside hospitals are provided by non-physician practitioners (Phaumvichit & Chandeying, 2012), and sometime by skilled persons hiddenly. None-legitimization of abortion does not only control women's reproductive life but it creates a negative attitudes of society on abortion. In spite of legal abortion in some western countries, negative messages and mental health problems of the women still occur.

In summary, rather than conventional health models, the experiences of women following pregnancy termination are explored through feminist perspectives that focus on the oppressive conditions indicated as emotional responses toward pregnancy

termination, coping in order to overcome their emotions, and support to improve effectively coping. Based on feminist perspectives, the concepts of ideology of motherhood, gender inequality, women's rights to healthcare access, religions, morality, and law are applied in understanding the phenomenon of interest. In this study, feminist standpoint theory by Harding (1995) advocates the use of women's experiences to generate research methodology which will be described in the next chapter.

CHAPTER 3

Methodology

Feminist standpoint theories were the philosophical underpinning of this study. These theories guided research methodology and procedures for describing the experience of Thai women following pregnancy termination in terms of the ways which they overcome their struggles and support which they obtained and expected.

Philosophical Features of Feminist Research

According to Harding (2004), standpoint theory emerged in the 1970s and 1980s as a feminist critical theory about relations between the production of knowledge and practices of power. Standpoint theory is presented as a way of empowering oppressed groups, of valuing their experiences, and of pointing toward a way to develop an oppositional consciousness. It presents itself as a philosophy of science, an epistemology, and a methodology or method of research, appearing to conflate or even confuse fields standardly kept distinct. It frames these disciplinary projects within a feminist social theory and a political strategy, though standardly it is presumed that these fields can and should be kept immune from social and political elements. It claims mainstream, purportedly only descriptive and explanatory, theories about science and even within science are also perhaps always normative, and that this is so even when they achieve maximally accurate description and explanation (Harding, 2004).

According to Ardovini-Brooker (2002), standpoint theory assumes that systems of privilege are less visible to those who benefit the most and who control the resources that define the dominant cultural beliefs such as whites, males, heterosexuals, and so on. Standpoint feminists believe that it takes the standpoint of the oppressed groups such as people of color, women, and homosexuals, to recognize systems of oppression and privilege. However, this standpoint is not accepted blindly. Systems of oppression also shape the consciousness of the oppressed. Therefore, standpoint feminists must construct

knowledge that reflects the experiences of both the dominant and subordinate groups in order for that knowledge to spawn liberation (Ardovini-Brooker, 2002).

Harding (1995) suggests three distinguishing features as criteria for the best feminist research that make feminist distinctive from conventional research. Each feature is applied into the research methodology. Firstly, feminist research focuses on and analyses gender issues critically by asking how gender difference accounts for women's oppression and how gender beliefs provide lenses through which researchers view the world. In the country where pregnancy termination without any medical indications is illegal and immoral, a woman who terminates her pregnancy without any medical indications has to take the blame for violating the norms (Ratchukul, 1998). In healthcare system, prevention of unwanted pregnancy is substantially attempted. However, the large number of pregnancy termination still exists but health services for post-termination women is neither widely available nor accessible. In fact, getting pregnancy is not by only a woman and she unlikely wants to terminate her pregnancy if there are other alternatives. Unfairly, the woman is assigned into a subordinate group and have no locations in society and healthcare sphere. This injustice shapes the women to live in the submissive manners. In this study, feelings, coping strategies, and support from the women's experience were explored to uncover their oppressive conditions. In addition, the researcher's beliefs on the existing gender-biases in this issue were used to understand and analyzed their oppressive conditions.

Secondly, in contrast to conventional research based primarily on the lives of men in the dominant race, class, and culture, feminist standpoint theory advocates the use of women's experiences to generate research problems, hypotheses and concepts that guide research (Harding, 1995). Women's perspectives on their own experiences also serve as a resource for designing the research project and constructing knowledge that is not on women but rather for women. In this study, the dearth of particular and comprehensive healthcare services for the post-termination women and the lack of clear bodies of knowledge in relation to this issue led the researcher to raise research questions about their feelings and coping strategies to deeply understand their difficulties and capacities. In addition, for the women's benefits and justice, the support they actually obtained and expectantly desired were explored. The gained and non-gendered bias knowledge would

help for improving healthcare services for these women group. That is, the research questions were not on the women but rather for the improvement of these women's lives. Another point is that the generated knowledge was primarily from the women's direct experience rather than from the existing frameworks and theories, or from the oppressors. The obtained findings would be authentic understanding.

Lastly, feminist inquiry requires a reflexivity practice in which a researcher is placed on the same critical plane as the researched through an explicit situating of a researcher in the research (Harding, 1995). Egalitarian cooperation between researchers and women allows the women to talk from their own interests rather than from the researchers' desired focus (Hall & Stevens, 1991). A number of tools are available to the feminist interviewer in the task of establishing non-hierarchical relationships: sharing experiences and giving advice; revealing personal details; stating one's research goals; opening up spaces for reflection and interpretation; providing the opportunity for long term contact through the creation of friendships; and establishing a conversation in a comfortable environment (Lyons & Chipperfield, 2000). In the present study, the women's condition was disapproved by society whereas the researcher was a doctoral student. This different position might unease and hinder the women from expressing their stories. Non-hierarchical and reciprocal relationship between the researcher and the participants was produced throughout the study, especially in the interview sessions because of the reason to reduce the difference between the researcher and the participants by using demeanor, not denouncing, beneficence, and avoidance exploitation. One method of non-hierarchical and reciprocal relationship is sharing the researcher's feelings and experience that researcher took care of women after pregnancy termination in the hospitals after the interviews as requested by the participants with the precautions of controlling or dominating the participants' stories. In addition, giving some appropriate helps and reasonable assistance were performed under the researcher's abilities. Some advices and mental support after the end of the interviews, if requested by the participants were provided in order to avoid exploitation.

Another technique is consciousness-raising, which the researcher strengthens the women's roles in construction and production of their stories in the non-bias manners (Cook & Fonow, 1990). The women were invited to tell their experience without any

judgment. Since the women had internalized the negative attitudes about pregnancy termination, their perspectives around this issue were inevitably controlled and distorted by those unfair beliefs. To liberate the women from those biases, the researcher raised reflexive questions to encourage the women to view their storied in the fairer angles.

In summary, feminist standpoint theory by Harding (1995) is appropriate to explain reality of phenomenon of the study because of three important reasons. Firstly, gender difference accounts for women's oppression. As we known that Thai society strongly disapproves abortion from law and religion. Women are highly aware of the illegality and obviously believe that abortion constitutes a serious Buddhist sin. As a result, termination of unwanted pregnancy is a social stigma which is assigned to only women but men are not. Secondly, Harding (1995) has presented women's experiences to generate research problems, hypotheses and concepts that guide research. In this study, the generated knowledge was primarily from the women's direct experience rather than from the existing frameworks and theories, or from the oppressors. Finally, feminist inquiry requires a reflexivity practice in which a researcher is placed on the same critical plane as the researched through an explicit situating of a researcher in the research. Non-hierarchical and reciprocal relationships between the researcher and the participants, and reflexive questions were used in order to raise consciousness of the women from negative awareness to positive awareness which lead to emerge new non-biased knowledge.

Methodology Features of Feminist Research

The methodology of this study was based on Harding's feminist standpoint theory as aforementioned. To sum up, in this study, the researcher has explored the oppressive conditions indicated as feelings in responses toward pregnancy termination, which are shaped by gender-biased values in Thai context. Their coping strategies and support were also unfairly shaped by the negative attitudes surrounding this issue. The experience shared by the women were the primary source of data and highly valued rather than the researcher's worldviews or existing distorted knowledge.

Non-hierarchical and reciprocal relationships between the women and the researcher were developed in order to empower the women to tell their stories openly. Sharing the researcher's feelings and experience as requested by the women were done

because they were viewed as active and unexploited participants, and they could both give and take from the research project. While sharing, the researcher was precautious about directing or controlling the participants' stories by sharing the similar things and avoiding introducing new things. For example, after the participants told about their feelings after making mistakes and asked about the researcher's feelings, the researcher told about her feelings similar to the participants' feelings. After one participant told about some rituals and asked the researcher, the researcher shared her experience about meditation and some teachings of Buddha similar to hers. If the participant asked before telling her story, the researcher invited her to tell firstly and the researcher would share later.

Assistance under the researcher's ability were provided if needed to ensure that the research did not oppress the participants. For example, the researcher gave some advices and mental support to some participants after the completion of the interviews. Some participants who were very poor were given with some clothes and food after they were glad to have them.

In a reflexivity practice, the researcher always examined the researcher's perspectives and social locations as a middle-class, professional nurses, without direct experience of abortion, and tried not to direct and distort the women's stories.

Consciousness-raising was conducted through raising reflexive questions to have the women reconsider their experience from positive and productive perspectives, instead of internalizing unfair sociocultural values as usual. New and fair insights were gained through these research procedures based on the framework of feminist standpoint theories as aforementioned.

Research Methods and Procedures

Following feminist philosophy and methodology, research design, participant recruitment, research instruments, data collection and analysis procedures, trustworthiness, and protection of human subjects were planned and performed.

Research Design

The experiences of women in coping with pregnancy termination were described through qualitative feminist research based on Harding's feminist standpoint theory.

Participants Recruitment

A purposive sampling technique was used to recruit the participants. The eligible participants in this study were Thai adult women in the reproductive age living in Nakhon Nayok province. The selected province is an area where the researcher is familiar with and easily accesses to the participants. The inclusion criteria were as follows:

1. Thai woman aged 20-44 years.

2. Having experience in terminating pregnancy without medical indications at least 10 years ago for the last termination.

3. Willingness to share experiences concerning pregnancy termination with the researcher.

4. Ability to communicate in the Thai language.

Who were purposively selected next was based on the emerging data. Women with severe physical, for example, having severe symptoms of illness history (severe hypertension and cannot control, and have headache), severe infection and having fever, weakness, nausea, and vomiting, or mental problems such as severe stress and anxiety (decreasing of concentration, palpitation, and arrhythmia), or women whose participation would lead them to potential danger were excluded. In this study, no one was excluded.

The participants were initially approached by invitation letters and announcement in six hospitals in Nakhon Nayok province.

1. In terms of invitation letters, the researcher requested for cooperation from nurses to give an invitation letter (see Appendix A) to every woman who were admitted at a postpartum unit or those who visited out-patient units for follow-up such as an obstetric and gynecological out-patient unit, and a well-being clinic. In the letter, the information of research project was provided such as the topic of research, name of major advisor, the research objective, inclusion criteria, and the participants' contribution. The researcher's telephone number was also provided in the letter in order that the women contacted the researcher.

2. For the announcement, flyers (see Appendix B) with the project information and invitation were distributed to women who came to visit at a postpartum unit, an obstetric and gynecological out-patient unit, and a well-being clinic in the hospitals. The researcher's telephone number was given in the flyers. The flyers were also posted as a notice on the announcing boards at the units mentioned above.

After giving an invitation letter and announcement about two months, the first eligible participant contacted the researcher. Thirteen women contacted the researcher via telephone. On the telephone conversation, they were asked about the inclusion criteria. All of them were eligible and interested in the project. After that, the personal contact was made to meet in person and more written information were given to them (Appendix C). The details were also verbally explained. The researcher emphasized that the primary aim of this study was to listen to their experiences in pregnancy termination with the hope that they felt free to share with the researcher. Issues of confidentiality and privacy were discussed. Verbal informed consent was obtained from all participants and recorded in the form with the signature of the witness (Appendix D). One participant withdrew from the project after one interview session due to moving far away and lost contact. Therefore, 12 participants remained in the project.

In qualitative study, participant number should be sufficient until the point of data saturation. Data saturation occurs when data are redundant and there is no additional information. The major concern in qualitative research is the richness of information. Therefore, the number of participants is not a determinant of research significance (Simkiss, Edmond, Bose, Troy, & Bassat, 2016). In making plans for a time-frame and budget for the present study, the researcher estimated the number of participants by

reviewing previous studies most closely matching to this study within a range of 12-20 participants (Chatchawet, 2009; Komon, 2010; Ratchukul, 1998). In this study, the data are saturated after the completion of data collection and analysis of 12 participants.

Research Instruments

Research instruments in this study included the researcher, interview guides, MP3 recorder, and a demographic data sheet.

The researcher. In qualitative researcher, the researcher is an important instrument to collect and analyze data (Holloway & Galvin, 2017). The researcher is the part of the study because researcher is the observer, interviewer, or interpreter, and participation in the inquiry; and also has the potential to add the richness of data collection and analysis (Strubert & Carpenter, 2011). The researcher was prepared to conduct the qualitative research in order to ensure that the research procedures were carried out smoothly and that the aims of study were achieved. The researcher has taken 2 credit course about qualitative research, and practiced with the advisors in conducting interviews and focus groups for 98 hours.

The professional experience of the researcher in midwifery was also be helpful in understanding the issues surrounding pregnancy termination. The researcher is Thai Buddhist woman and the age is forty-six years old, married, and has two children. The researcher finished bachelor degree from Boromarajonani College of Nursing, Udon Thani, and graduated with a master's degree in family nursing, faculty of nursing, Khon Kaen University. After that researcher has been a lecturer of Maternal-Child Nursing and Midwifery Nursing department from 2001 to present. And more importantly, the researcher has teaching experience about abortion in theoretical section, and caring women after abortion in practical section. On the other hand, the researcher does not have direct experience in unwanted pregnancy termination, but the researcher has friends and cousins who have induced abortion because of unwanted pregnancy. The researcher has taken care of the women with the feelings that they underwent pregnancy termination because they had no choices. In addition, they deserve fair treatment. Then, the researcher acknowledges that the researcher's background, experiences, and attitudes are brought into the data collecting and interpretation.

An interview guide. The interview guide of the study (see Appendix E for the Thai version) was developed from review literature and discussion among dissertation advisory team. There were 4 broad issues, which were approved by the advisory committees.

1. Please tell me the stories about your pregnancy termination.

2. How do you feel about your pregnancy termination?

3. What do you do to go through your experience after pregnancy termination?

4. What kinds of support did you obtain and expect in going through your experience after pregnancy termination?

Examples of probing questions included the following:

1. What made you feel that way?

2. What else do you feel?

The researcher attentively listened to the participants without interruption or judgment. Uncomfortable feelings were also assessed. In addition, reflexive questions were raised aiming to empower the participants to critically review their oppressive conditions.

Examples of reflexive questions included the following:

1. What suggestions would you like to make to other women who have had the similar experiences?

2. What support the women who had the similar experiences deserve to?

Audio recorder. An MP 3 recorder was used to record all of interviews. It can assist the researcher to engage in lengthy in-depth interviews and more accurate transcription.

A demographic data sheet. A record form was used to obtain the characteristics of all participants. The data included the following: 1) personal characteristics such as

age, race, educational level, occupation, income, number of family members, and history of health problems, and 2) information about pregnancy termination, such as, gravida, parity, gestational age, time-frame, reasons given, methods used, complications, and treatments. The sheet is shown in Appendix F.

Data Collection Procedures

The steps of data collection were as follows:

1. The research was conducted after receiving approval from the Research Ethics Committee of the Faculty of Nursing, Chiang Mai University (Appendix G), from the ethical committee of one hospitals, and permission from five hospitals. The documents about the hospitals are not shown to keep anonymous.

2. The researcher met with the nursing directors of the hospitals to provide more information and seek for cooperation. The nurses in post-partum units, out-patient departments for post-abortion follow-up, and well-baby clinics were contacted to assist with recruitment by giving the women the invitation letter and flyers. The flyers approved by the Research Ethics Committee of the Faculty of Nursing, Chiang Mai University, were distributed and posted in post-partum units, obstetric and gynecological out-patient units, and well-baby clinics in order to invite eligible women to contact the researcher.

3. The women who obtained invitation letters or flyers, and had the interest contacted the researcher by telephone. They were asked about inclusion criteria. After that meeting was arranged to provide information about the research and their contributions. The participants' rights to refuse and withdraw from the study was also explained. Written information was also provided. The participants who agreed to participate in the study were asked for a verbal consent in order to assure confidentiality. In this process, there was a witness who signed in the recording form. Then, the time and place for interviews were discussed based on the convenience and privacy. It was planned that each interview was last 60-90 minutes. It required 2-4 interview sessions for each participant. From the study, the interview sessions were 40-90 minutes long. Each participant was interviewed for 2-3 times.

4. The in-depth interviews were conducted in a private place, mostly in the participants' cousin homes, and the researcher's home without interruption to protect the participants' confidentiality and privacy. Each interview started by inviting the participants to tell their stories and making broad statements or asking open-ended questions such as "Please tell me the stories about your pregnancy termination." After that they were invited to tell about their feelings, the ways they managed their feelings, the support they obtained and expected. Probing questions were used to obtain sufficient data, with depth, breadth of interpretation and meaning or complete description of the experiences being studied.

5. In terms of non-hierarchical relationships, the researcher shared some feelings and experience during the interviews as requested by the participants with the precautions of controlling or dominating the participants' stories. From the study, the researcher shared feelings and experiences with four participants after the interviews. The researcher also had some similar negative feelings to the participants when the researcher made mistakes. Some religious rituals performed by the researcher which were similar to the participants were also shared. Some opposite points of views were not told to the participants in order not to confusing them. Some appropriate and reasonable assistance under the researcher's abilities were provided if required by the participants. The researcher gave some advices and mental support after the end of the interviews. Some cloths and food were given to some participants who wanted them. The relationships may not be discontinued, depending on the participants' preference. These kinds of relationships were aimed at avoiding exploitation in addition to obtaining equity, sincerity, and empowerment. The researcher treated them as her friends or cousins. The researcher avoided expressing herself as a nurse or health worker by not wearing a nurse uniform. The researcher introduced herself as a doctoral student, who wanted to learn from them. As a consequence, a close relationship between the researcher and participants was developed and they voluntarily told their sensitive stories openly.

6. After each interview, field notes and reflexive journal were recorded. Field notes are recorded about the behaviors, activities, events and other features of the setting under observation (Cohen & Crabtree, 2006). The researcher wrote down a few words or short sentences to help recall the information from the participants' statements observations taking place during the interviews. A reflective diary is provided the

rationale for decisions made, instincts and personal challenges the researcher experiences during research (Houghton, Casey, Shaw, & Murphy, 2013). A reflexive diary was written during the process of data collection and analysis to critically examine the researcher's beliefs, feelings, and thoughts. This reflexive account helps the researcher to be aware what is known, what the researcher needs to know, and how the researcher proceeds to enhance her understanding. The example of reflexive journal, field notes are shown in Appendix H.

7. Since there was no note-taking during the interview, an MP3 recorder was used to record the interviews with the permission from participants. Audio-recording was transcribed verbatim within one week.

8. The interviews were terminated when no new data surfaced. Five participants were invited to review the tentative findings in order to validate the findings in the process of member checking. No contradict opinions were found.

9. A money of 100 bath was given to all participants at the end of each interview. Transportation expenses were also provided.

10. Data about participants' characteristics were assessed by using the demographic data sheet. In addition, some personal data found during the interviews were also recorded.

Data Analysis Procedures

Data collection and analysis were conducted simultaneously. Narrative analysis methods were employed for data analysis. According to Sosulski, Buchanan, and Donnell (2010), narrative analysis focuses on the participants' personal, community, institutional relationships, as well as their suggestions for local and societal change. The study privileges the participants' interpretations by examining their actual language and symbolic meaning, and presents an overview of the connections the participants make as they weave their stories into the whole narrative construction. The dialogue among the researcher team members is discussion of the text on 3 levels: 1) the literal meaning of the women's speech as they describe, 2) the symbolic meaning, and 3) the researchers' understanding of the sociocultural environment that connects themes across interviews or

in the literature (Sosulski et al., 2010). After that data and themes are compared across cases or aggregated to demonstrate trends and variation. The present study involved a total of five narrative analysis stages mostly based on Sosulski et al. (2010) aforementioned.

. In all five steps of data analysis, feminist perspectives on pregnancy termination were employed to understand the participants' experiences. Their experiences were analyzed by considering the concepts of ideology of motherhood, gender inequality, women's rights to healthcare access, religions, morality, and law, which led them to be oppressed and to emancipate themselves from their oppressive conditions.

The detail of five steps of data analysis is presented below. The example of step 1-3 of data analysis, and all stories of individual participants are shown in Appendix I. The final results are provided with thick description in Chapter 4.

Step 1: Initial coding (literal meaning of women's stories). The researcher read the transcripts and listened to the audio recordings at the same time in order to check the accuracy of individual transcripts. In addition to the transcripts, the researcher also reviewed the field notes and reflexive diary, looking for and highlighting repetitive terms or phrases used by the women to relate or illustrate the women's experiences within individual contexts. Codes were assigned to the women's meaningful narrates.

Step 2: Symbolic coding (symbolic meaning). After step 1, the researcher sought symbolic meaning concerning the reasons provided by the women for the occurrence or unique significance of the events described by the women.

Step 3: Categorizing and generating themes. The researcher non-linearly categorized preliminary and symbolic codes, looking for socio-cultural contexts linked with the aforementioned categories and searching for sub-themes in the data obtained. The data were then categorized, while the correlations among the data categories were re-framed.

Step 4: Describing individual narratives. At this stage, the researcher recorded the detailed descriptions offered by each participant in writing based on the order of events and codes obtained from steps 2 and 3 which were employed by the above

descriptive approaches, and aided the researcher in identifying the general complex pattern and the right underlying links to be submitted to the analysis.

Step 5: Structuring. The women's narratives about their pregnancy termination experiences were comprised all of the women's stories in the form of individual accounts. Next, the researcher simultaneously analyzed all of the codes and descriptions obtained from individual participants in order to determine common themes and structure in the participants' stories. As a means of focusing on the aforementioned narratives, the researcher classified the core data themes, namely, coping with pregnancy termination, and gender influence.

Trustworthiness

According to Lincoln and Guba (1985), the strategies to establish trustworthiness consist of four strategies such as credibility, transferability, dependability, and confirmability.

Credibility. Credibility can be enhanced when researchers describe and interpret their own behavior and the experiences of participants (Lincoln & Guba, 1985). The procedures for achieving credibility are member checking and peer debriefing. In member checking, the main points of each interview were summarized together by the participant and the researcher at the end of each interview. The participants' previous interview transcribing was checked before the next interview. The tentative findings including categories, subthemes, and themes were checked the validity by five participants.

In terms of peer debriefing, one expert and three advisory committees were discussed and examined the process of recruitment and data collecting. They also focused on human rights and psychological harms because it is the sensitive topic. Tentative findings were also discussed and suggested. After the process of peer debriefing, the researcher received suggestions for revising the results of the study.

Transferability. Transferability is determined by fittingness, understanding, generality, and control. Thick description is deep, dense, detailed accounts of data, which enable someone interested in transferring to possibly conclude the result (Lincoln & Guba, 1985). In this study, the researcher provided information about the participants'

background. Explanations on the generated themes and subthemes were provided with some participants' excerpts.

Dependability. Dependability or reliability is judged as auditable. The reliability of the data elicited is dependent upon the appropriateness and ability of the researcher's methodology, skill and interpretations of the data (Lincoln & Guba, 1985). In this study, the researcher practiced interviewing skills. Data analysis, finding, and interpretation were audited by the advisory committee throughout the process of the study.

Confirmability. Confirmability means the degree to with the findings determined by the participants and the context of the study and not by the biases of the researcher (Lincoln & Guba, 1985). This process was performed by the researcher using reflexive journal in order to reflect on, tentatively interpret, and plan data collection, which include all events that happened in the field, personal reflections in relation to the study in this study. The researcher used reflexive journal to decrease bias during the data collecting process. The researcher recorded her ideas, feelings, or opinions about her impression and her thoughts in reflexive diary. The reflexive journal was written continuously throughout the data collecting and data analysis which reflected on all situations, subjects, ideas, and thoughts.

Protect of Human Subjects

The research proposal was submitted for approval by the Research Ethics Committee (REC) of the Faculty of Nursing, Chiang Mai University (Appendix G). Permission to proceed was also obtained from the ethical committees of the selected hospitals. The researcher did not directly access to confidential information of women from medical records. Invitations letters and flyers were provided to women who were admitted or the visitors at postpartum unit or those who visited out-patient units for follow-up. The researcher requested for cooperation from nurses to give an invitation letter and flyer to every woman. The researcher did not meet the eligible women in person during the recruitment process, but used telephone for conversations in order to protect the identity. They were asked about inclusion criteria. The other sensitive information about pregnancy termination was not asked. After the women insisted to participate in, the researcher contacted them and described the research objectives and procedures in

person. Written information (Appendix C) was also provided. Participants were informed of their rights to refuse certain questions and withdraw from the study at any time. Verbal consent with the present of the witness was obtained from all participants. The details of the oral consent and the witness were recorded in the form (Appendix D). There were thirteen had participated in the study. Only one woman withdrew from the study after one interview session due to moving far away and lost contact.

The in-depth interviews were conducted in a private place chosen by the participants, including participants' cousin homes to protect the participants' confidentiality and privacy. Confidentiality was assured to each participant by using code numbers on the interview transcripts. The audio recordings were deleted after the completion of the transcribing. The transcription interviews were destroyed immediately after the study is completed. The interview transcripts and MP3 recorder were kept in locked locker. All participants' information was kept accessible only by the researcher.

If any of the participants felt upset or uncomfortable, the researcher provided mental support after each interview. There were four participants expressing strong upset and obtaining mental support by the researcher. No one had mental illness needing medical attention. Some appropriate and reasonable assistance were provided only when requested by the participants. A money of 100 bath was given to the participants after finishing at the end of each interview for expressing the researcher's gratitude. Transportation expense was provided.

CHAPTER 4

Findings and Discussion

This study aimed to describe coping with pregnancy termination among Thai women. The chapter is divided into 3 parts: part 1-participants' characteristics, part 2-structure of coping, and part 3-discussion.

Part 1: Participants' Characteristics

There were 12 participants who were Thai adult women in the reproductive age living in Nakhon Nayok province. The participants age was 28-44 years (Mean=39.4, SD=5.4), which six participants were 20-40 years old. Most of them were Buddhists (91.7%), and only one was Catholic (8.3%). Three participants had bachelor degree, and the others had lower education. All of them were employed. The average monthly income of the participants was 12,167 bath (Range=5,000-30,000, SD=7345). A half earned 10,000 bath/month or less. Most of them had insufficient incomes. Ten participants were married (83.3%), two were divorced, and one was single. Mostly, family members were 4-6 persons. Only one participant had no children. Nine participants had no illness whereas three participants reported physical illness. The detail is described in Table 1.

Considering participants' characteristics of pregnancy termination, eleven participants (83.3%) underwent one termination. One participant did four times termination. The total number of pregnancy termination was fifteen time. Among 15 pregnancy termination times, four incidents were terminated their pregnancies at 18-20 weeks of gestational age and the remaining was at 4-10 weeks. Duration between the last pregnancy termination and the participation in this study ranged from 10 to 26 years, which their illegal acts were expired. Two pregnancy terminations were conducted by unskilled persons. Nine incidents were conducted with the reasons related to irresponsibility of husband, lesser wife, and divorce. The methods of pregnancy termination were varied and similar to those used for therapeutic abortion. There were three participants who had complications from

pregnancy termination such as severe vomiting, severe abdominal pain, hypermenorrhea, and infertility. The details are described in Table 2. Characteristics of individual participants were summarized in Table 3.

Table 1

Demographic Data of the Participants (n=12)

Demographic Characteristics	Frequency	%
Age (years) (Range=28-44, Mean=39.4, and SD=5.4)		
20-30	1	8.3
30-40	5	41.7
41-44	6	50.0
Nationality		
Thai	12	100.0
Religion		
Buddhism	11	91.7
Cathoricism	1	8.3
Education		
Primary school	4	33.3
Junior high school	2	16.7
Senior high or vocational school	3	25.0
Bachelor degree	3	25.0
Employment		
Tailor	1	8.3
Employee	4	33.3
Merchant	5	41.7
Government officer	2	16.7

Table 1 (cont.)

Demographic Characteristics	Frequency	%
Adequacy of incomes		
Inadequacy and having debt	8	66.7
Adequacy but no spared money	4	33.3
Marital status		
Single	1	8.3
Couple	10	83.4
Divorce	1	8.3
Number of marriage		
0	1	8.3
1	6	50.1
2	4	33.3
3	1	8.3
Number of family members, including the women		
3	5	41.7
4	5	41.7
6	2	16.6
Number of children		
0	1	8.3
1	2	16.7
2	7	58.4
3	1	8.3
5	1	8.3

Table 2

Pregnancy Termination Characteristics (n=12)

Characteristics of Pregnancy Termination	Frequency	%
Number of pregnancy termination (n=12)		
1	11	91.7
4	1	8.3
Years of pregnancy termination experience (n=12)		
(Range=10-26, Mean=15.7, and SD=5.9)		
10-15	7	58.5
16-20	2	16.6
21-25	2	16.6
> 25	1	8.3
Gestational age at pregnancy termination (weeks) (n=15)		
(Range=4-20, Mean= 10.2, and SD=5.8)		
4-7	4	26.8
8-10	7	46.4
11-17	-	-
18-20	4	26.8
Persons conducting termination (n=15)		
Self conducting	6	40.1
Skilled persons	7	46.5
Unskilled persons	2	13.4
Methods of pregnancy termination (n=15)		
Curettage	3	20.0
Medical pill	3	20.0
Vaginal suppository	4	26.5
Intravenous oxytocin	1	6.7
Antiprogesterones & Curettage	2	13.4
Vaginal suppository & Curettage	1	6.7
Internal irrigation	1	6.7

Table 2 (cont.)

Characteristics of Pregnancy Termination	Frequency	%
Reasons of pregnancy termination (n=15)		
Studying	3	20.0
Having enough children	2	13.3
Having many children & financial problems	1	6.7
Lesser wife or divorce	2	13.3
Irresponsible husband	2	13.3
Irresponsible husband & financial problems	4	26.7
Severe morning sickness	1	6.7
Complications after pregnancy termination (n=15)		
None	8	53.2
Severe vomiting & severe abdominal pain	1	6.7
Hypermenorrhea & infertility	1	6.7
Severe abdominal pain	4	26.7
Hemorrhage	1	6.7

Table 3

Data of 12 Individual Participants

Code[a]	Age (years)	Rel[b]	Ed[c]	Emp[d]	Income bath/ month)	MS[e]	Number of children	Number of pregnancy termination	GA at pregnancy termination (weeks)	Methods of pregnancy termination	Years of last pregnancy termination	Complications	Reasons of pregnancy termination
P1	39	B	BD	M	7,000	M	5	1	6	Intravenous oxytocin	13	-	Having many children and financial problem
P2	44	C	PS	M	6,000	D	3	1	20	RU 486 & curettage	26	Severe vomiting and severe abdominal pain	Lesser wife
P3	44	B	PS	T	5,000	M	2	1	10	RU 486	10	Severe abdominal pain	Irresponsible husband
P4	28	B	BD	Gov	12,000	M	1	1	4	Vaginal suppository	10	Hyper menorrhea and infertility	Studying

Table 3 (cont.)

Code[a]	Age (years)	Rel[b]	Ed[c]	Emp[d]	Income Bath/ month)	MS[e]	Number of children	Number of pregnancy termination	GA at pregnancy termination (weeks)	Methods of pregnancy termination	Years of last pregnancy termination	Complications	Reasons of pregnancy termination
5	37	B	SH	E	9,000	M	2	1	8	Curettage	10	-	Severe morning sickness
P6	31	B	JH	E	5,000	M	2	4	18, 8, 6, 18	Vaginal suppository, Internal irrigation	13, 11, 10, 10	Severe abdominal pain, hemorrhage	Irresponsible husband and financial problem
P7	43	B	PS	M	18,000	M	2	1	8	Curettage	24	-	Divorce
P8	43	B	SV	M	30,000	M	2	1	4	RU 486	20	-	Having enough children
P9	44	B	SV	M	12,000	M	2	1	8	RU 486	10	-	Having enough children
P10	44	B	PS	E	10,000	M	2	1	8	Curettage	17	-	Irresponsible husband

Table 3 (cont.)

Code[a]	Age (years)	Rel[b]	Ed[c]	Emp[d]	Income Bath/ month)	MS[e]	Number of children	Number of pregnancy termination	GA at pregnancy termination (weeks)	Methods of pregnancy termination	Years of last pregnancy termination	Complications	Reasons of pregnancy termination
P11	38	B	BD	Gov	20,000	M	1	1	20	RU 486 & Curettage	18	-	Studying
P12	38	B	SV	E	11,000	S	-	1	8	RU 486	10	-	Studying, lesser wife

Note. [a]P = Participant; bRel=Religion; B=Buddhism, C=Christian

[c]Ed = Education, cPS=Primary school, JH=Junior high school, SH=Senior high school, SV=Senior vocational school, BD=Bachelor degree

[d]Emp =Employment; M= Merchant, T= Tailor, Gov=Government officer, E= Employee

[e]MS=Marital status; M= Married, S= Single, D=Divorce

Part 2: Structure of Coping with Pregnancy Termination Among Thai Women

The researcher has assimilated and summarized the structure of coping with pregnancy termination among Thai women from their experiences through feminist perspectives. At the beginning, the participants felt relieved for solving their pregnancy problems. However, at present, most of them still had the feelings of wrongdoing. Their experiences were ten years ago or longer, which their acts were legally expired. Unfortunately, their stressful feelings still existed, which one participant developed such strong feelings that she heavily cried while telling her story. Their feelings were rooted from social, moral, religious, and legal disapprovals of pregnancy termination in Thai society whereas some countries approve it and those women do not feel so wrong.

Based on liberal feminism perspectives, which emphasize on liberties and rights (Im, 2007), the women are viewed as the ones who have the rights to control their body and reproductive functions. Accordingly, in this study, pregnancy termination to solve the women's problems was seemingly acceptable but the consequences on the unborn baby was controversial in terms of their rights to be born. The women had to accept the consequences of their wrongdoing but it should be limited to some extent. Through socialist feminism, which emphasizes on special position of women (Im, 2007), their long-term and tremendous feelings of suffering from wrongdoing was interpreted as an oppressive condition since they were stereotyped and stigmatized as the cruel and bad women and mother. Consequently, they had to carry their mistakes so long and some bad things happening to their life were perceived to be related to their wrongdoing.

Through Marxist feminism, which emphasizes on the origins of women's oppression (Im, 2007), the origins of the women's feelings of suffering were analyzed through the ideology of motherhood. It was found that their feelings of suffering developed from their beliefs that pregnancy termination was killing or hurting their own baby, and preventing their baby from being born, which were stronger than those to protect their baby's life by allowing the baby to be born in the bad circumstances.

Based on basic liberties and rights, it was interpreted that the women attempted to emancipated themselves and to live their life free from suffering through taking responsibility for their wrongdoing. They accepted their mistakes rather than blaming

someone else. They took responsibility for their own sense of values by keeping their stories secret and preventing themselves from restigmatization. Importantly, they sought forgiveness from their dead baby mostly through religious beliefs and rituals. They also took responsibility of their own life by living their life in a better way, such as not repeating the mistakes, and not being stuck in the past. Although they were wrong, they lived their life in the active and productive ways. Their positive and productive sides needed to be replaced with the stereotypes of being a cruel mother.

Since there was no social position of these women, to go through their suffering, they did not dare to seek for mental support from health personnel. Most of the support they obtained were religious beliefs and rituals, which they sought by themselves. Some support was obtained from their family. Because of the lack of professional support, they substantially suffered for a long period of time. This was an unnecessary suffering. When they were empowered to suggest some support, their need was just understanding them with empathy, no condemnation. Through essentialist feminism, which emphasize on different men and women (Im, 2007), they were asked to critically analyze women's and men's responsibility on pregnancy termination. They suggested that men should share responsibility. According to basic rights to assess to health care services, they suggested the availability of mental and obstetric healthcare services suited to the women's nature in order to facilitate their body's and mind's recovery.

In conclusion, the women following pregnancy termination was oppressed by gender biases on pregnancy termination and led them to develop unnecessary long-term feelings of suffering from their wrongdoing. They liberated themselves through taking responsibility for their wrongdoing in productive manners by accepting their mistakes, protecting their self-values, seeking forgiveness, and empowering themselves. Religions and their family were the main sources of support. Fairly, not only understanding them but men's sharing of responsibility and healthcare services were also suggested by the women. In response to three study objectives about feelings, coping strategies, and support, four themes emerged as the structure of coping with pregnancy termination. They included 'the feelings of suffering from wrongdoing,' 'taking responsibility for wrongdoing,' 'obtaining of support,' and 'expecting support,' The findings are summarized

in Table 4 and the definitions of each theme and subtheme are provided in Table 5-7. The details are explained later using participants' statements with the following symbols:

'You're crazy' means participant's statements as someone talked to her.

… means unrelated statements are excluded;

--- means informant stopped talking or faltering;

[crying] means informant's action as crying;

(How?) means the researcher talked to the participant as "How?"; and

(P10(1)/P12/L205-209, 213) means informant number 10; the statements are on Page 12, Line number 205-209, 213 in the transcripts.

Table 4

Structure of Coping with Pregnancy Termination Among Thai Women

Themes	Subthemes
The feelings of suffering from wrongdoing	The feelings of being wrong: sad, guilty, sinful, stigmatized, shameful, and anxious
	The feelings of being haunted: senses of illusive pictures, sound, or touches
	The feelings of being failed in life: difficulties, obstacles, and no progress
Taking responsibility for wrongdoing	Accepting one's mistakes
	Protecting self - values
	Seeking forgiveness
	Empowering oneself
Obtaining support	Religious support
	Family support
Expecting support	Just empathetic understanding
	Men's sharing of responsibility
	Health services

Table 5

Definitions of Theme and Subthemes about Participants' Feelings

Theme and Subthemes	Definitions
Theme: The feeling of suffering from wrongdoing	The women's feelings of suffering developed from the perception about pregnancy termination as making mistakes in terms of destroying or killing their own baby, or stopping a baby from being born as expressed through the feelings of being wrong, being haunted, and being failed in life.
Subtheme 1: The feelings of being wrong	The women's feelings of sadness, quilt, sinfulness, stigmatization, shame, or anxiousness developed from the perception of doing wrong with their unborn baby.
Subtheme 2: The feelings of being haunted	The women's feelings of craziness, confusion, fear, or unhappiness developed from having the senses of illusive pictures, sounds or touches of their dead baby.
Subtheme 3: The feelings of being failed in life	The women's feelings of failure, including having difficulties and obstacles, being unprogressive, in their life as perceived due to their mistakes in committing pregnancy termination.

Table 6

Definitions of Theme and Subthemes about Participants' Coping Methods

Theme and Subthemes	Definitions
Theme: Taking responsibility for wrongdoing	The women's coping method employed to amend their mistakes in terminating their pregnancy by taking responsibility through accepting their mistakes, protecting self-values, seeking forgiveness, and empowering themselves.
Subtheme 1: Accepting one's mistakes	The women's acceptance of their own mistakes in terminating their pregnancy without putting the blame on others.
Subtheme 2: Protecting self - values	The women's actions in taking responsibility for their own self-values by keeping their stories about their pregnancy termination as a secret.
Subtheme 3: Seeking forgiveness	The women's actions in taking responsibility for their baby by seeking forgiveness from their dead baby in order to emancipate themselves from sins and bad *Karma*, to obtain the peace of mind, and to pray for the baby's rebirth to a new better life., through various religious beliefs, practices, and rituals.
Subtheme 4: Empowering oneself	The women's attempts and actions in taking responsibility for their own life by making themselves to be powerful through learning from their mistakes, not being stuck in the past, becoming stronger, and improving their life in a better way.

Table 7

Definitions of Themes and Subthemes about Participants' Support

Themes and Subthemes	Definitions
Theme 1: Obtaining support	The support which the women search for and obtain for enhancing their management with their feelings of suffering from wrongdoing, mostly derive from religions, and followed by family.
Subtheme 1: Religious support	Religious beliefs, practices, and rituals that help the women overcome their feelings of suffering, especially to obtain forgiveness from their dead baby.
Subtheme 2: Family support	Physical and mental support from the family members, primarily by their mother and secondarily by their female relatives, that help the women go through their feelings of suffering.
Theme 2: Expecting support	The support which the women do not obtain nor request for, but if the support is available, their desires are just empathetic understanding, men's sharing of responsibility, and health services.
Subtheme 1: Just empathetic understanding	The most desired support by just understating the women's situations and necessities in terminating their pregnancy without condemning and disapproving them.
Subtheme 2: Men's sharing of responsibility	The responsibility which men should share with the women in terminating their pregnancy.
Subtheme 3: Health services	The availability of mental and obstetric health services for facilitating the women's physical and mental health recovery.

Part 2A: Feelings after Pregnancy Termination:
The Feelings of Suffering from Wrongdoing

At least five participants (P4-6, P11-12) said that they felt relieved shortly after they terminated their pregnancy. The feeling resulted from their problems, such as being a student, being too young to have a child, were solved as seen in some participants' statements:

> *"I can study. The problem is gone. It's relieving that I can solve the problem and then I can go to school. I think it's the solution, kind of relieving from becoming the social problems."* (P11(1)/P12/L205-206)

> *"I felt relieved. I could still enjoy and have fun with my friends. I still hung out, like yeah, the problem was gone. I didn't have to think about it anymore. It was a relief. No more problems and burden with the child that would have been born like this. Adolescents. I thought like an adolescent would."* (P12(1)/P5/L88-89)

Importantly, in the long run and until the present, pregnancy termination was strongly believed to be severe wrongdoing, leading the participants to develop the feelings of suffering, called 'the feelings of suffering from wrongdoing,' as evidenced from the following statements:

> *"I felt I did something wrong to him/her (the baby). I didn't think that doing it would relieve me from burden. I felt guilty all the time. That day should have never happened to me. If it hadn't happened to me, my life wouldn't have become like this."* (P1(1)/P12/L202-203)

> *"I mean I knew I was wrong for doing that to him/her (the baby)"* (P8(1)/P12/L208)

> *"After it was done...it was like I had done something wrong. The wrongest thing in my life."* (P2(1)/P8/L128)

> *"It felt uncomfortable and guilty. I felt that I couldn't undo the situation. What can I do? Oh! it was great suffering."* (P5(1)/P18/L335-336)

Most of their feelings of suffering were rooted from their beliefs about their wrongdoing that they destroyed their unborn baby, killed their baby, or stopped the baby from being born as seen in these statements:

> *"It was like I killed a person. If born, (the baby) could have grown and walked. I have thought about it that (the baby) could have grown and walked, but I killed him/her before he/she was born."* (P10(1)/P5/L69-70)

> *"(Crying) I didn't want to live, to be honest. I felt really sad. I felt sorry for the baby. It's hard to be born as a human. It takes many lifetimes to be born as a human, and I destroyed it. I stopped it from being born into a human. It will take many lifetimes to reincarnate. That's what I think and it makes me really sad."* (P1(1)/P9/L151-153)

> *"I cried and cried a lot, thinking this shouldn't have happened to me. It was my baby but I don't give birth to it."* (P8(1)/P4/L58)

Their strong feelings were also greater when their unborn baby was already formed as a person, as noticed from the baby's movement. They said: *"It's really sad. It was four months already and it was already formed."* (P2(1)/P8/L130) and

> *"I felt hurt and sad. The baby was still moving in front of me and I felt really sad."* (P6(1)/P2/L29)

At the time of the interviews, although ten years or longer had passed since the experience of pregnancy termination, their suffering still existed. Various suffering feelings were expressed and could be categorized as 'the feelings of being wrong,' 'the feelings of being haunted,' and 'the feelings of being failed in life.'

The Feelings of Being Wrong

The above statements indicated that the participants felt wrong and obviously expressed themselves as feeling guilty and sad, especially when they believed they cruelly hurt their baby. Additional statements indicating guilt are as follows:

"I feel so guilty to the baby that I shouldn't have done it. Then I look at my child here, looking at children around me, thinking if it was alive, it would be around this age." (P1(1)/P7/L121-122)

The participants, both Buddhists and Catholic, suffered from being sinful which was experienced when their wrongdoing violated their religious beliefs about killing or hurting someone, especially their own child. These are some of their statements:

"It's like I am sinfully condemned from what I did. It's like murdering." (P5(2)/P31/L571)

"It's like I killed a person, stopping it from being born. This is a sin." (P9(1)/P3/L36)

"I felt uncomfortable, too. It was like I did wrong, sinful things like that. It was sinful because it hurt someone." (P9(1)/P2/L29)

"In Christianity, killing is considered as a sin, in the same way as Buddhism. Taking life is like a double sin." (P2(1)/P15/L269)

In addition to directly killing or hurting someone, a sin was also assigned to the one who assisted in misconducts as seen in the following statements:

"In my opinion, it's like I have intentionally killed a person. The person who took me there was also sinful. It's like I carry this sin with me until I die." (P11(1)/P11-12/L199-200,202)

Their sin was always present and not erasable. This means they suffered from a stigma. These are some of their expressions:

"If I did something bad and it remains in my heart, I will keep thinking that this is a stigma." (P10(1)/P18/L336-337)

"I have done a bad thing. No matter what I do, I can't erase this sin from me. But I know that it can never be erased. Like erasing ink with an eraser, it's impossible. I don't believe that it can be erased. At least the stigma remains in my mind until

I die." (P2(1)/P5/L83-84) *..."It will be a stigma in my mind until the day I die. It's impossible. I may be able to forget it for a while but it will stick to me like a scar. It's a scar that can never be erased from my life…When doing something wrong, as far as I can remember, do I still remember it now? I do, but I only (remember) what day (I did it). It will pop up in my head."* (P2(1)/P16/L289-291)

Wrongdoing also led the participants to feel ashamed and attempt to conceal it as a secret. One participant said, *"I keep it as a secret because having an abortion is wrong in Buddhism. I don't want people to know. I feel ashamed that I did something terrible."* (P9(1)/P14/L261-262)

The last feeling found in the participants was being anxious. Shortly after pregnancy termination, one participant felt so worried and anguished that she could not maintained her daily activities. She narrated:

"I'm so worried all the time that I can't do anything. When I think too much, I don't want to see anyone. I don't want to talk to anyone. I just want to lie still. Sometimes I feel like I don't want mornings to come. I just want to lie still, not seeing anybody. It's like this when I'm worried too much. I don't want to go to bed because morning will come after I go to bed." (P10(1)/P20/L355-359)

Two participants were also anxious about their future baby. They were afraid that their wrongdoing might cause something wrong to their future babies. They said:

"That's why I am worried of the outcome of my baby. I don't know much and I was scared. But since I decided to keep it, I want it to be healthy. I always ask the doctor about every pregnancy, whether it is a boy or a girl, if things are OK with them. I don't want any bad Karma in my babies… I am worried that they might be disabled. I am worried that I myself may not be able to give birth; they won't come out, and I would be the cause of unhealthy babies." (P6(1)/P25/L458-460)

"I was afraid that the Karma would fall on these two (babies). I hoped they would come out perfectly. I hoped the Karma would not fall on my babies." (P2(1)/P12/L206-208)

In summary, a strong belief in misconducts of pregnancy termination primarily led the participants to feel wrong and further develop the feelings of sadness, guilt, sinfulness, stigmatization, shame, and anxiousness.

The Feelings of Being Haunted

As aforementioned, suffering was experienced by the participants on the beliefs in their own misconducts. There was another feeling of being haunted by the dead baby, which developed as they believed that the dead baby would get even with the mother who harmed him/her. Accordingly, the dead baby kept following the participants and made them have hallucination. As a consequence, unhappiness was expressed as seen in these participants' experience:

> *"It's like the baby is following you all the time. I am not happy. He/She haunted me all the time and asked why I harmed him/her. It is a deceptive picture in my head all the time. When I think of the incident, I can't do anything. It's haunting me all the time."* (P1(1)/P7/ L117-118)

> *"Now I often feel pain in my neck. Sometimes I feel like he/she is sitting on my neck or something like that. I turn around to see if there is anyone on my neck. When I get this pain, I think about the Karma I have done or something like that."* (P11(1)/ P12/ L216-217)

Another participant heard some hallucinating sounds of a baby crying. She also dreamed about a baby. She felt as if she was losing her mind. She recounted:

> *"When I get back home, sometimes I hear things. It's like I am haunting myself. Sometimes I think I hear a noise, like a crying baby. When I close my eyes and about to fall asleep, I dream about a baby. I'm alone at home and it might just be my own craziness. It might be nothing but I dream about a baby, I think. Sometimes I hear a baby crying. It doesn't matter night or day. It happens. Maybe I was just crazy."* (P6(1)/P11/L199-201)

In addition to illusive pictures and sounds, one participant felt being touched or interacted by the dead baby. She also heard a baby shouting at her. She felt as if she was going crazy, confused, and scared. She expressed:

> *"I feel that the baby touches me and feels me. I don't want to talk to anyone about this. They must think that I'm crazy. The first time I felt it was when I was sleeping. It was after I had finished working and I was so tired. I didn't have a shower and I was in my towel. I heard a noise calling, Mommy! Mommy! wake up, it's time to take a shower. Something pulled my hands. I was wondering to myself if it was a dream or a ghost. I was so scared then."* (P3 (1)/P6/L96-98)

> *"One day I forgot to turn off the TV, he/she turned it off for me. Before leaving, he/she told me he/she was leaving; he/she wouldn't be with me anymore. It was a dream that didn't seem like a dream. When these things happen, it doesn't feel like a dream."* (P3(1)/P3/L53-54)

Some participants felt being haunted in their dreams, as indicated by these statements:

> *"Now it seems like the baby often visits me in my dream, scolding at me, asking me why I couldn't have raised him. (crying)"* (P2(1)/P2/L22)

> *"I used to dream…A baby came crying near my house."* (P9(1)/P4/L53)

The Feelings of Being Failed in Life

The participants felt that they were living with difficulties, confronting with various obstacles, and having no progress in their life due to their wrongdoing. Their wrongdoing brought bad things to their life in return, as evidenced by these statements:

> *"I never get ahead with anything I do."* (P10(1)/P12/L201)

> *"Nothing gets progressive. Everything seems to get stuck. I thought my life would be better, but then it was like something is blocking it. I start to feel better, for a short while, but then I feel stuck again. I totally believe that it affects everything in my life."* (P12(1)/P5/L69-70)

"I think it's very sinful. That's why everything in my life has failed. It's the consequence of that deed, I think. That's why things have become like this, hardship." (P1(1)/P4/L50-52)

In addition to her own life, one participant revealed the failure to her whole family:

"It's like I ruined everybody in the family. It was not only me, but the people who went with me were also in trouble. My parents got sick. My mom has diabetes and my dad has cancer. My siblings were all in debt. They had a fight with their partners and don't live together now, living without money. They all now live with my mom. My sister came with me to the clinic, so she's in trouble now. …We are struggling. It all affects the whole family." (P5(1)/P8/L139-141)

Some participants also related their failure to their bad Karma as they said:

"*I never progress in anything I do. I used to earn a lot of money, about 7-8 thousand a day. But now nothing gets developed. Being a business owner seems good but doesn't make you rich. I think that people with abortion don't progress anywhere... I think this is the law of Karma. What goes around, come around and it happened so often. It was my mistake. I lend them stuff, but never get it returned. This must be the Karma from the abortion."* (P10 (1)/P1/ L201-204)

"I have done it so, except paying for my Karma, what can I ask for? In Christianity, they say killing others results in failure and adversity. It's like having no respect for parents." (P2(1)/P4/L55-56)

In conclusion, following pregnancy termination, the participants initially felt relieved for solving their problems of unwanted pregnancy. Mostly, their beliefs about their misconducts in terms of destroying or killing an unborn baby, and stopping a baby from being born, led them to experience the feelings of suffering from wrongdoing in the long run. Their suffering was expressed as 'the feelings of being wrong,' leading them to further feel sad, guilty, sinful, stigmatized, shameful, and anxious. 'The feelings of being haunted' was another one experienced by some participants as the baby's revenge or *Karma* retribution. They sensed some illusive touches, pictures, or sounds, leading them to feel like going crazy, confused, scared, and unhappy. In addition, 'the feelings of being

failed in life' was experienced, making them feel like living with difficulty and failure in their own life or their family. To manage their undesired feelings of wrongdoing, the participants employed various methods, and attempted to move on with their lives.

Part 2B: Coping Methods Employed with Pregnancy Termination: Taking Responsibility for Wrongdoing

The participants dealt with their painful feelings mainly by taking responsibility for their wrongdoing. In taking responsibility, the cause of a particular action or situation, especially a harmful or unpleasant one is accepted rather than denied, and the person takes responsibility is the one who deals with (Cambridge Advanced Learner's Dictionary & Thesaurus, 2019). In this study, the participants's taking resonponsibility was the coping method employed to amend their wrongdoing as evidenced in these statements:

> *"For this pregnancy termination, I made the decision by myself, without consulting anyone. I bought the abortion pills by myself. So, I am not going to blame anyone but myself for making such decision. I will take all the responsibility for doing it and let all the Karma fall on me only, not on my child. I wish my child will be born healthy, not handicapped."* (P1(3)/P2/L22-25)

> *"So, I didn't consult my family, not even my husband, about abortion. So, I think I will take all the responsibility for what I have done. I will not blame anyone but myself for this wrongdoing. I have made a huge mistake to my child. I took the chance to be born to this world from him."* (P2(3)/P2/L42-45)

In taking responsibility, the participants started with accepting their mistakes. As their mistakes might diminish their self-values, the participants took responsibility to protect their own self-values by keeping their stories as a secret. To be responsible for their acts in harming the baby, they sought forgiveness from their dead baby. Additionally, they were responsible for their life by empowering themselves.

Accepting One's Mistakes

In healing their suffering by taking responsibility, the participants started with accepting their wrongdoing rather than denying it or blaming someone else. Their acceptance of their mistakes led them feel guilty. These are their expression:

> *"I realize that I have made a mistake to him/her (the baby) ... I feel guilty all the time. I shouldn't have done it or been in that situation."* (P1(1)/P12/L202)

> *"I felt like I was the one who did wrong. I felt dizzy and could not see anything."* (P5(1)/P1/L7)

> *"It was wrong. My answer is still the same that it was wrong. I didn't want (to do something wrong). What I did was wrong. If 'sin' didn't exist, I wouldn't be guilty. But I am here at my home, sins and merits do exist. So I am guilty."* (P12(1)/P17/L302-303)

However, accepting their wrongdoing led the participants to accept the consequences of their actions. This acceptance assisted them feel better as evidenced in these statements:

> *"Now I admit it. Once I admit it, it's like I no longer exist. I allow whatever to happen. I will not let myself into problems. I just realize what I have done and admit the consequences. This allows me to feel better mentally."* (P3(1)/P4/L57-58)

Some participants became detached from and let go of their mistakes, as stated by this participant: *"I kind of 'Plong.' I let it go with Karma."* (P1(1)/P7/L113). They could not undo what they had done. This method, called '*Plong*' (ปลง), made them feel better. Accepting their own mistakes helped the participants take responsibility to themselves and their dead baby.

Protecting Self-values

Wrongdoing in terminating their pregnancy brought the feeling of shame, causing them to see themselves as tainted and worthless. To be responsible to their own self, the participants protected their self-values by keeping their pregnancy termination as a secret.

"I keep it as a secret because having an abortion is wrong in Buddhism. I don't want people to know. I feel ashamed that I did something terrible." (P9(1)/P14/L252)

"I didn't want to tell anyone. It was---what do they call it?---a bad thing, right?. It was a sin for myself too. It was bad to say, 'Hey I had an abortion or something like that.' Hearing it, people would think, 'Oh, shit this person did this kind of things to her own baby.' So I didn't want to tell anyone about it. I'd better not." (P8(1)/P5/L86-87)

"I didn't talk about it. I didn't because it was a bad thing. It was a sin so I didn't want to tell anyone. I didn't talk at all, even to my mother." (P3(1)/P21/L381)

"Women who undergo abortion hide it because they don't want anyone to know about their mistakes. I think it is not good. No one would want to have an abortion. It's true that the woman is the one who kills the baby but other people do not know her reasons. But people label the person who has an abortion as bad, or something like that." (P4(1)/P10/L172-174)

In addition to telling no one about their stories, the participants also sought no help from others to avoid being blamed. Having their own reasons for pregnancy termination was also another mean to relieve their sense of self-devaluation. These are their statements:

"I didn't ask for any advice from anybody because I've already known well. If I had asked them, they would have blamed me for why I had done that." (P1(1)/P18/L327-330)

"I didn't talk about it because I don't know how I would mention it to anyone. I was afraid that they might say it was a sin and Karma or something like that. I already knew it was bad but I had my reason for doing it." (P3(1)/P13/L239-240)

In addition to be responsible for their self-values, the participants were also be responsible for their acts in harming their baby.

Seeking Forgiveness

Making a mistake towards their own baby led the participants attempt to take responsibility to their own baby initially by accepting their wrongdoing with the feelings of being wrong, such as guilty, as aforementioned, and then taking actions to deal with the dead baby, including making an apology to the dead baby, asking for forgiveness from the dead baby, as evidenced from these statements:

> *"Until now, I always feel guilty. I apologize to him/her (the baby) all the time."* (P2(1)/P2/L17)

To attain forgiveness, some participants gave their dead baby the reason on their goodwill for stopping their baby from being born during the critical conditions, as one participant said:

> *"I kept telling 'Mum is sorry. How do you live your life if I die early? Who will take care of you?' Anyway, I couldn't rely on his dad because I snatched him from someone else and when it is time, he has to go back."* (P2(1)/P7/L114-115)

Some participants tried to do the right things, such as providing help, support, and advices or others, in order to get forgiveness and the good things in return. For example, one participant advised some women not to terminate their pregnancy. Another participant donated baby clothes and stuff to other people.

> *"It's like, yeah, I know I have made a mistake and I will try to do the right thing. So, I might be forgiven or something like that."* (P7(1)/P11/L188)

> *"I try to do good deeds, so that I can resolve my sin. I have told someone who was about to do it. I told her to fight for her baby. I stopped her from doing it. She also has a lot of problem like me. I told her not to do it. It's not good. I was trying to convince her, telling her that I know the consequences and they are not good. It badly affects your life. And she keeps her baby."* (P1(1)/ P11/ L187-188)

> *"I like to buy things for a newborn baby. Anything, diapers, baby bottles or anything for a newborn. You see they don't have money, and I have money. So I want to give."* (P5(2)/P8-9/L141-142)

Aside from making apology and giving reasons to the dead baby, and doing good deeds, many religious rituals were performed and dedicated to the baby, aiming that the baby would reborn, have a new better life, and seek no revenge on them, further leading the participants obtain forgiveness in return, feel better, have the peace of mind, and have no bad luck. The rituals included making merits (*Tam-boon* ทำบุญ), offering food (*Sai-bat* ใส่บาตร) or religious essentials (*Sung-ka-tan* สังฆทาน) to monks, pouring dedication water (*Kruad-nam* กรวดน้ำ), praying, chanting, meditating, confessing, swearing, giving alms (*Tam-tan* ทำทาน) by setting birds and fish free, and getting sprinkled with holy water (*Rod-Nam-Mon* รดน้ำมนต์). These are some of their actions and their wishes.

> *"Once in while, I would make a great merit, and dedicate the merit to the baby. I offer religious essentials to the monks and build Buddha image for the temple. I think what I did would make me feel better, for the peace of mind."* (P10(1)/P12/L209-210)

> *"I always make merits and dedication like this. Go to the temple, pour dedication water and miss him/her all the time. It the peace of mind, right? Today, as I offered food to a Buddhist monk, I prayed and wanted him/her to get that merit and seek no revenge on each other."* (P10(1)/P18/L330-331)

> *"Sometimes I go to a ritual to remove bad luck, give alms, set birds and fish free to remove bad luck so that a baby won't hold a grudge. I also get sprinkled with holy water and I feel better afterwards."* (P8(1)/P14/L249-250)

One participants also had the wish for themselves in terms of liberating themselves from sins by ordaining as a nun, as she narrated:

> "*I think I am free from my sin. I was in a really bad state. Then I went to ordain, so my life has become better. I pray and meditate a lot."* (P7(1)/P5/L69)

One Buddhist participant resolved her sins through the ritual of '*Kae-Karma*' (แก้กรรม means setting oneself free from bad Karma by chanting the particular mantra called

'*Panyak*' (กาฬยักษ์) which is used particularly for abortion and killing. She explained what she did as follows:

> *"Panyak Prayer is a chant for a Karmic retribution in case of abortion or killing, whether you intentionally or unintentionally kill. There will be a lot of people where the chant is taking place. It gives such a shrilling sound. I join the chant so that I can resolve my sin. The chant lasts about half a day. It aims toward forgiveness. There are ceremonial thread, small pieces of red and white fabric amulet and small sacred dolls. I did everything. Anything to resolve my sin, I did them all."* (P5(1)/P20/L354-356)

A Catholic participant used confession, chanting, and swearing to reduce her sense of sin, as she narrated:

> *"The confession is like giving promises that you won't commit a sin again. We pray and then repent our sin. Then we talk to the priest, swearing that we won't commit any sins again. The priest will give us some chants. This doesn't mean that the sin will go away. It is just a method for people to accept one another in order to live in the society. It's like a strategy to make you feel better. The heavy sin will be resolved if you pray a lot."* (P2(2)/P22/L409-411)

Some participants joined in the *Dharma* path. A Buddhist participant turned herself to *Dharma* using the "Four Noble Truths." *Dharma* or Buddha's teaching led her to accept her mistake, stay with the present, and forgive herself. She told:

> *"I turn to the Dharma lesson. If I didn't study Dharma, I would sit around feeling sorry for myself and keep blaming myself. When things get worse, you start blaming yourself, just because you have made a mistake. I study Dharma lessons to stay with the present, not the past. This suffering causes another suffering. We should stop the occurrence of suffering. If we learn to accept the truth that we are the cause of this suffering, we would be surrendered. And I surrender to the fact that I made a mistake. I don't think that ending the pregnancy is the way to end all suffering, but I use the Four Noble Truths."* (P3(2)/P11/L207-209)

In conclusion, taking responsibility of wrongdoing with their own baby led the participants attempt in many ways to obtain forgiveness from their dead baby. They wished to obtain the peace of mind, to liberate themselves from sins and bad *Karma*, and to have a baby be reborn with a new better life with no revenge. Their actions included making apology and giving reasons to the dead baby, and providing some tangible support to others. Additionally, several religious rituals dedicated to the baby were performed. Another way of coping with the feelings of suffering from wrongdoing was taking responsibility for their own life by empowering themselves.

Empowering Oneself

The participants accepted and were responsible for their misconducts. They attempted to keep their stories as a secret to protect their self-values. They seek forgiveness and emancipated themselves from sins and bad *Karma*. Although their wrongdoing brought them trouble and difficulty in their life, they were not passive and never surrendered to their suffering. Instead, they learned from their painful experiences as a life lesson; as a result, they became more mature, and stronger. They were not stuck in the past, but rather, improved their life in a better way. One participant stated:

> *"I decided that I wouldn't do it again. If you feel like me, like sad or depressed, I want to say you can't undo the past. It's all gone and it was a mistake. You can't turn back time, but you have to move on. You can learn from the lesson and don't let it happen again."* (P1(1)/P21/L373,384-385)

Learn as a life lesson. Some women accepted that they should not have undergone pregnancy termination, as one participant admitted: *"It's like I killed a person. So it's bad. If I could turn back time, I wouldn't have done it."* (P10(1)/P9/L151) Another participant mentioned that her mistakes taught her. At that time, she was deprived of contemplation and considered only the short-term consequences. She narrated:

> *"It teaches me at the same time that I should think carefully. I made a mistake. At that time, I didn't think carefully. I only thought about how I would get myself out of it. I couldn't take it anymore. I only wanted to get the baby out when I had an abortion. I felt as if I was dying. I was so tired. I couldn't take it anymore. The*

only thing on my mind was to get the baby out. I didn't think about the consequences. As I told you, when this really happened to me, I now realize how it feels to kill a person." (P5(1)/P22/L397-399)

The significant lesson learned was that they would not repeat their mistakes. They would not terminate their pregnancy again. Some of them said:

"Things go by and I have to move on, be a new person, and make sure it will not happen again. I won't make a mistake again. I won't hurt a life that should have been born." (P2(1)/P8-9/L143)

"I used to say if I got pregnant again, I would keep the baby. I would hold on. No matter what, I would hold on. I used to say I did it. Mother (I) made a mistake. I thought about many things. I thought to myself, if the baby's coming, then let it come. I would hold on." (P5(1)/P1-2/L12-13)

However, one participant (P6) terminated more than one pregnancies. This implied that learning not to repeat mistakes was not easily successful and took much time. She said that at that time she was too young to know birth control methods and the alternatives of unwanted pregnancy. Fortunately, she accepted that pregnancy termination was wrong and at present she firmly insisted on not committing it again.

Not to be stuck in the past. In addition to learning not to repeat mistakes, the participants also attempted not to be stuck in the past and to keep going on with their life. The reasons were that they could not get back to amend their past.

"My life must go on. I don't want to be stuck in the past. I need to work to make money and to think about my family. This will pass. I need to stand up and fight for my family." (P12(1)//P20/L353-354)

"It is the same as stream of water that has passed by. It means nothing can be brought back. Everyone has their own duty and their own task. Who will be stuck with the past all the time? At least they have to do their own routines like it is time to take a bath, have a meal. Therefore, this makes them think of other things

because our thought won't return to the same thing all the time." (P2(2)/P24/L440-442)

"We have to strive against all problems and obstacles. Whatever we did in the past, we couldn't fix it. We have to keep ourselves up because we can do it." (P1(1)/P22/L399)

Be stronger. Some women raised their consciousness from negative to positive awareness. This led them to strengthen themselves, as stated by one participant, *"Time will pass. I don't want to think about it and feel bad about it. I need to be strong."* (P5(2)/P50/L925) Some power was derived from their self-thoughts about their valuable life, especially for their family and loved ones.

"Try to forget it. Otherwise, you will be immersed in the past, right? Now I don't feel sad anymore because I've already done my best." (P7(1)/P13/L226)

"I am stronger. My mind is not sensitive with the past. I am not tearful or think that I can't live a life. I live my life as usual and continually do my duty best each day. We have to live with it. Make a living as normal." (P1(2)/P12/L225-226)

"I have to move on and stay strong. My life is very valuable. I have to make contributions to people around me, and my mother. I have to take care of my mother, my children and others, and (do things that are) useful. I keep on doing good deeds. I don't do bad things or something like that. Then, one day, my life might become a little better. I might be able to escape from that moment and get over it." (P1(1)/P21/L390 -392)

"Because the time passes by, this makes my heart stronger. I am not getting weak because of that anymore. I don't think of him to make me painful again. Make your mind stronger. If you had spoken about this last year, I would have cried. But not today." (P5(2)/P50/L925-926)

Improve one's life in a better way. When they were strong and valuable, they had enough strength and energy to do good and productive things, and further improve their life in a better way.

"Life has to go on. You need to think about the future." (P2(1)/P6/L93)

"Life has to go on. I'm doing my best each day." (P4(1)/P8/L129)

"Be awaken and do better for tomorrow… look ahead for the future." (P12(1)/P14/L241)

It can be seen that the participants were active in surviving their suffering experiences from wrongdoing. They empowered themselves through the following coping methods: 'learn as life lesson,' 'not to be stuck in the past,' 'be stronger,' and 'improve one's life in a better way.' Prior to 'empowering oneself,' they initiated with 'accepting their mistakes,' then 'protecting self-values,' and 'seeking forgiveness.' The participants put much effort and employed many means by themselves to go through it. It was interesting to explore what kinds of support they obtained and desired.

Part 2C: Support After Pregnancy Termination: Obtaining Support and Expecting Support

In terms of support the participants obtained, the theme of 'obtaining support' with its subthemes of 'religious support,' and 'family support' were emerged. Considering support the participants expected, the theme of 'expecting support' and its subthemes of 'just empathetic understanding,' 'men's sharing of responsibility, and 'health services,' were found.

Obtaining Support

When an unwanted pregnancy is brought to an end, a woman is perceived as violating the sociocultural norms of motherhood and legal regulations. The participants internalized these judgments. They developed suffering and silently lived with psychological pain. Accordingly, they sought and obtained plenty of strength and support from religions. Support from their family was also obtained.

Religious support. In managing the feelings of suffering, religions were found to be the main source of participants' support. What made the participants highly counted on religions were described in term of the nature of religious support in the women's context. When a person has done something wrong to someone, he/she will feel relieved

if those inflicted persons forgive him/her for his/her mistakes. This manner is unlikely applicable to fetus homicide which the woman accepts herself as the cruel killer of her own baby. The baby is already dead and unable to express forgiveness to the mother in the reality. Therefore, religions were helpful for the women to attain forgiveness by counting on faith and power of religions in the abstractive ways. Religious support helped them obtain the peace of mind and liberated themselves from sins as aforementioned. Accordingly, religious support functioned as the resources for emotion-focused coping for immoral wrongdoing.

The power of religions was believed to be so strong that the participants were able to connect to her baby and ask for forgiveness, although the baby might not hear, as one said,

> *"I sometimes make merits, offering food to monks. I pour dedication water and told my baby that I am sorry. I made a mistake. Please forgive me. We talk to each other. I don't care whether my baby hear me or not."* (P5(1)/P8-9/L143-144)

Religions were believed to be powerful for making a wish come true. As aforementioned, some participants wished the religious rituals they performed would allow their baby to be reborn, have a new better life, seek no revenge on them, and make them feel better. The belief in reincarnation or rebirth also assisted the participants feel less guilty for stopping the baby from being born, as evidenced from these statements:

> *"Feel like the merit has been reached. I feel he has forgiven me and doesn't want revenge. He will be reborn, something like that."* (P3(1)/P5/L68)

> *"Prayed and meditated, I send all merits to the baby, wherever he/she is. Wish he/she gets the entire merit I've been making all day. I send the feeling of pleasure and wish the baby has a contented heart and is pleased with the merit. Hope his/her life and spirit will be better, wherever he/she will be in the next life, whatever form he/she may be. This has made me feel happy."* (P3(1)/P25/L468-470)

In addition to the resources for emotional-focused coping, which were powerful, religions were believed to be substantially available and accessible support, as one participant explained about religious rituals:

"It was the only one remaining channel at that moments in lessening my feelings of guilty. It helped reduce sins I had committed. And it was easy to reach because it is our culture. We thing about it at first. It is easier than going to the hospitals. We don't need to wait for a long queue. We can go anytime we want to." (P11(3)/P2/L184-186)

There was the method of chanting the mantra called '*Panyak*' (ภาณยักษ์) for a *Karma* retribution aimed particularly toward abortion and killing as aforementioned (P5(1)/P20/L354-356). This implied that there might be many women who sought religious support following pregnancy termination.

In some rituals, they needed some religious places, such as temples and churches, and religions-related persons such as monks, priests, liaisons, and churchwardens. These resources were available and affordable. Another participant explained about religious rituals in terms of convenience, confidentiality, privacy, and no control.

"We can do anytime. If we want to do, we can do by ourselves. If we think it helps we feel better, we will do. We don't need to tell anyone. We don't need to follow anyone's orders." (P1(3)/P6/L152-153)

In terms of confidentiality and privacy, she further explained:

"I prefer making merits rather than telling my stories to anyone. Because abortion is a private matter and it should be only us who know about it. Don't let anyone know. Making merits to the monks does not disclose our matters." (P1(3)/P7/L184-185)

She did not consider religious rituals as foolish things, as she said:

"I don't feel like foolish. I didn't go to see fortune tellers. And I didn't loss much money. I paid as I could afford. For example, I bought infant milk and offered it to the monks." (P1(3)/P7/L186-187)

Another participant added in terms of culture, Buddhism, and personal beliefs.

"I have made merits since I was young. It is not foolish. It is culture for Buddhists. It is a personal belief." (P11(2)/P3/L197-198)

In terms of the nature of religion support, religions functioned as emotional support which were very essential for the participants since they were substantially powerful, available, accessible, confidential, and self-directed. The participants were not required to disclose their secret stories to anyone. The participants could direct themselves without being under control by anyone.

Religions are a broad issue. In addition to the issue of the nature of religious support, the forms of religious support were analyzed to deeply understand the women's experience. As emotional support, religions in this context was related to religious beliefs, rituals, and doctrine. Religious beliefs were carried out through various religious rituals. The beliefs in sins and bad *Karma* from killing a baby brought about a *Karma* retribution or the negative consequences. Many religious rituals were thought out and performed by themselves to reduce their sins and bad *Karma* to some extent. One Buddhist participant (P5) believed in '*Kae-Karma*' by chanting whereas a Catholic participant used confession, chanting, and swearing to reduce her sense of sin.

In terms of religious doctrine, only one participant (P3) explained that joining *Dharma* path or following Buddha's teaching was performed to obtain the peace of mind. She turned herself to *Dharma* using the "Four Noble Truths." *Dharma* or Buddha's teaching led her to accept her mistake, stay with the present, and forgive herself.

Family support. Some participants disclosed their secret to the close ones and then they obtained support from them. Most supporters were primarily the mothers, and secondarily their sisters or aunts, who provided mental and physical support, advices, good caring, and protection.

"Mom and aunt often bought food to nurture me." (P4(1)/P6/L104)

"For me, when I disappeared from home for one week, my mum always protected me and offered an excuse. She told my teacher that I ran away from home. That

time I felt sorry and cried to my mum. Eventually, my family gave the greatest support. My mum took and helped me solve that problem." (P11(1)/P2-3/L27-28)

"Lately I talked to my sister or my mother only when I had problems. They advised that I have to go on and keep fighting... They did not want to make me feel worse. They said what's done is done. Nothing can be done to fix it. They just said that. It's like they gave me encouragement and told me to keep moving forward and continue fighting. If I didn't fight, how could my child live? They wanted me to try to sustain my life and not to commit suicide or do anything bad. Don't do like some people who do bad things after a mistake, like that." (P1(1)/P18/L333-335)

"That time my mum took care of me, when I was not feeling well. I stayed at home all day so my dad asked why I didn't go to school. My mum told dad that I was very sick." (P11(1)/P4-5/L66-68)

"*The thing that my mum did for me at that time seemed very protecting. She felt guilty because she told the teacher that I ran away with a guy. I got back to school by myself and had to face the teacher who nagged me about that."* (P11(1)/P11/L184-185)

One participant received good mental and physical care from her husband.

"(He) cared for me physically, about diets, taking me to a toilet or other stuff because I did not have much strength since I lost a lot of blood. Psychologically speaking, yeah, I made a mistake and I can start over again. I don't have to feel sad. Don't think too much. With consolation, I feel better." (P9(1)/P9/L152-153)

Considering the importance of family support, especially for their mind, the participants needed their family to understand them without judgment, and also to give them love and to comfort them. They suggested:

"Mentally, I think family is really important. Family needs to give support. People do things with their own reasons. I just wish that family would accept the action and will not blame the person for making a mistake. Family should understand

and find the solutions. My dad can accept the situation and it won't happen again. There is no need to blame, to find the reasons why it happened." (P11(1)/P27/L502-503)

"Family is the only support that I want. I want love from them. But my family is not so close. They don't love each other. All I want is love from my family. Family is so important. When you have problems, you just want to come home for support. But all I get is blame. Society is not as important as family. Society can be like friends. Sometimes I get support from my friends, but support from home is much better." (P12(1)/P17/L308-309)

Expecting Support

The support the women obtained were from religions and family. Health personnel was unlikely approachable. One participant said: *"I don't need help from anyone at all"* (P3)/P15/L274). Interestingly, the other participants did not initiate their requests for help while revealing their experience. The main reason was that they were the ones who chose to make terrible mistakes. Their mistakes were illegal, disapproved, morally wrong, and violated social norms. In addition, it was considered a private matter. Therefore, they judged themselves to have no rights to obtain help. Asking for help might also bring some difficulties. They wanted to conceal their stories in order to prevent themselves from being ashamed and blamed. One participant expressed:

"I think it's the same with anybody. You wouldn't need any help if you were in my situation. It's my personal matter. Nobody forced me to do it. I did it myself. The doctor would help with bleeding, of course. He/She knows what I had done. You don't want to tell the doctor, but of course they know. This thing is illegal. If you tell the doctors, they will report to the police." (P4(2)/P13/L224-225)

The participants were invited to respond to the question: if help was available, what kinds of help they would suggest, and if their loved ones were in the same situations as them, what forms of support they would suggest to help them go through it. The following was their suggestions:

Just empathetic understanding. Many participants mentioned that they just needed to be understood with empathy and compassion, not to be blamed or condemned.

They just needed someone to understand that they did not intend to make mistakes. They terminated their pregnancy because it was necessary. They wanted to solve their problems. Each of them had their own reasons that those who were not in the same situation as them could not understand. They did not want anyone to use their past mistakes to further judge them for everything. What they asked for was to stop blaming them repeatedly. These are their requests and reasons:

> *"People don't want to reveal their life stories. I wish people would understand mine. I wish they understand my reasons and my action, not just blaming me. But please just look at the reasons and give me some advice. We can't undo the past, but we can prevent the problem."* (P1(2)/P5/L82-83)

> *"I don't want help from anybody. Just don't blame me. Just wait and see whether my behavior would change or not; whether I am really a bad person or not; whether I'm not a responsible person or not. But just don't blame me."* (P3(1)/P15/L274-275)

> *"The thing I would like most is love and understanding from family. Do not blame when that person makes mistakes. Family is the most important. When there are problems, our family should be the best place to encourage us. Society is not as important as family. Sometimes, a group of friends can cheer us up. But eventually, we have to come home."* (P12(1)/P17-18/L308,310,311-318)

> *"I would like our family to accept whatever we've done. It is not a wrong thing but sometimes it is necessary to do. When the problem occurs, it should be accepted and family should help solve it together. … If the family can accept that it is necessary to do such a wrong thing and accept one's own decision and reason, the problem will be reduced. Don't blame or yell but encourage and support, no need to find out the cause, why they did."* (P11(1)/P27-28/L502-514)

Men's sharing of responsibility. Some participants felt unfairly treated. It was only them to take responsibility on their wrongdoing whereas men were free. If it was possible, they needed society to have men share their responsibility as evidenced in these statements:

"I know I make a mistake, but we both are wrong. We both make a mistake. It should be good times and bad times together. But I am the only person taking the blame. I want to tell you that it's not only women. Society only blames women that we are slut. We are bitches and we don't use any protection. That's what they said. I just want them to rethink. It's not only me. It's both our mistake. We both should use protection. I know I am wrong. My boyfriend is also wrong, but he does not take the blame because he is selfish. I just want the society to rethink, not just blame the women." (P12(1)/P9/L160-162)

The reasons given by the participants included 1) a man plays a part in causing pregnancy; therefore, it is not only a woman to be blamed, and 2) when a pregnancy is unwanted, both the man and the woman should solve problems together. These are some of their critiques and suggestions:

"Society only blames women. Only women are wrong. Men actually have a part in it. They should also take responsibility. You can't get pregnant alone. Men also have a part in this. When there is a problem, society only blames women. Men should also take the blame. A couple should communicate and find ways to solve the problem. Women are the ones who give birth, so that's why the society blames only women when there's an abortion happening. Men can't get pregnant, so it doesn't affect them much. But they are also wrong. I don't think it's right to just blame women. Both should take responsibility." (P1(2)/P9/L148-150)

"It's not only women's duty to prevent this kind of thing, but men as well. Society doesn't really see the real cause, but only sees the problem. Women are the ones who get pregnant. It's only women who do the action, but they don't actually see the real cause, which is men. When something like this happens, no one talks about men. They should also take responsibility." (P11(1)/P15/L275-276)

"I know I make a mistake, but we both are wrong. We both make a mistake. It should be good times and bad times together. But I am the only person taking the blame. I want to tell you that it's not only women. Society only blames women that we are slut. We are bitches and we don't use any protection. That's what they said. I just want them to rethink. It's not only us. It's both mistake. We both should

use protection. I know I am wrong. My boyfriend is also wrong, but he doesn't the blame because he is selfish. I just want the society to rethink, not just blame the women." (P12(1)/P9/L160-162)

"Social values has been giving the wrong definition of being a mom and a woman 'being aware.' As a women, you have to love your child, you shouldn't kill your own child. Men don't have uterus. What would happen if they have one? What if men have abortion, would they be blamed? Society condemns a woman because she is the one who is pregnant. Everybody just put the blame on women. Both are actually wrong, but women are the ones who take the sin. Women are the only ones who make decision to solve the problem. Just think about it. If it was men, would they be blamed by the society? But it is impossible for men to get pregnant. You don't experience the situation, so you don't understand. I've been through a lot and now I understand that there is always a reason. I have the right to think, but I can't stop the society from blaming. I can't stop people from thinking." (P2(2)/P12/L209-216)

Health services. The procedures and consequences of pregnancy termination brought some health problems that required recovery. Suffering from their severe mistakes left them with various long-term psychoemotional problems, such as sadness, guilt, sinfulness, stigmatization, shame, and anxiousness. Being haunted by the dead baby and being failed in their life were also experienced. Obviously, the participants attempted to manage their feelings of suffering by independently and actively seeking plenty of religious support and obtaining some family support. However, they still needed more support to help them recover from both body and mind wounds.

To restore their mind, participants needed their family support as aforementioned. One participant experienced some illusive touches and voice from her dead baby. She thought she was crazy and had no one to talk to. She said:

"I feel that the baby touches me and feels me. I don't want to talk to anyone about this. They must think that I'm crazy. The first time I felt it was when I was sleeping. It was after I had finished working and I was so tired. I didn't have a shower and I was in my towel. I heard a noise calling, Mommy! Mommy! wake up, it's time to

take a shower. Something pulled my hands. I was wondering to myself whether it was a dream or ghost. I was so scared then." (P3(1)/P6/L96-97)

This implied that she needed mental healthcare from health professionals. Congruently, a few participants suggested the need for professional help by healthcare providers. If it was available, they suggested mental healthcare services and female healthcare providers. Their suggestions were as follows:

"There should be a psychologist to restore their mind. Help them live with the present moment, not get stuck in the past. Help them have courage to fight and move on to the future, so they will not make the same mistake again." (P1(1)/P6/L101-102)

"It's kind of stressful after the abortion. It's like different kind of stress, so the psychologist should understand what level the stress is. Some people can take it, some can't. Psychologists, they know how to make us feel better. If there was this type of clinic, we would attend. It should be set up in a general hospital first. There are only men's practitioners in some hospitals. We feel embarrassed to talk to them. The obstetricians should be females though. They should have more understanding as a woman. It doesn't matter if the psychologist is male or female, but a woman would be better. It is easier to talk to." (P11(1)/P28/L538-540)

In addition to mental care, one participant suggested obstetric care. She also suggested the services and providers to be sensitive and appropriate for women's issues. She stated:

"There should be mental healthcare. There should be a psychologist to give support and strengthen our mind to get over this. Psychiatrists, psychologist, they have good words. For health, there should be a care clinic, located in a secured area. This kind of thing is embarrassing. Skilled obstetric practitioners and equipment are available. All personnel should have ethical codes and leave everything inside the clinic. If they should be suspended from work. There should be regulations for all the staff. That's how things should be because there are some women who feel ashamed to go to the hospital." (P2(2)/P15/L265-267)

It can be seen that most of the support the participants obtained were religious support and followed by family support. In their situation, they did not ask support from others. However, if support was available, they suggested just understanding them without blaming and condemning them. If possible, men should share responsibility on pregnancy termination issues. If support by healthcare providers was available, they needed the support that could help them restore their body and mind. This means mental and obstetric care services that are appropriate for this sensitive issue and women's natures were suggested.

In summary all findings, the experiences of pregnancy termination led the participants to feel suffering from their wrongdoing, further develop the feelings of being wrong, being haunted, and being failed in their life. To manage their suffering, the participants took responsibility for their mistakes, initially by accepting their mistakes and then sought forgiveness to liberate themselves from sins and bad *Karma*, mostly through religious rituals. In the responsibility to their self-values, they attempted to keep their stories as a secret to protect their self-values. In addition, they also took responsibility to themselves by empowering themselves through learning from their mistakes, not being stuck in the past, becoming stronger, and living their life in a better way. To go through their suffering, they sought plenty of religious support and some support from their family. If it could be made available, they suggested the following: just empathetic understanding them and men's sharing of responsibility. In addition, mental and obstetric care services were suggested for their mind and body recovery.

Part 3: Discussion

Coping with pregnancy termination among Thai women was found to be 'taking responsibility for wrongdoing' in response to 'the feelings of suffering from wrongdoing.' Aside from taking responsibility, sources of obtained support and expectantly desired support were emerged. These findings are discussed based on empirical evidence and existing knowledge to elaborate the results.

The Feelings of Suffering from Wrongdoing

Shortly after pregnancy termination, the women felt relieved because their problems have been solved. This finding similar to the studies by Foster et al. (2012; 2015), Mahawan (2013), and Pregnancy Advisory Centre (2018). However, long-termed mental health problems remained, which in this study is called 'the feelings of suffering from wrongdoing.' This suffering lasted for more than ten years, indicating by the highly traumatized experiences at the time of interviews. In the survey of postmenopausal women, the risk of experiencing a depressive mood in daily life was increased with increasing number of induced abortion (Wie et al., 2019) but it is hard to make conclusion in the present study.

Considering the severe mental problems as mental disorders, it was unlikely that termination of an unwanted pregnancy increased the risk on long-term common mental disorders; but it might increase the risk of recurrence among women with a history of mental disorders (Ditzhuijzen, Have, Graaf, Lugtig, & Volleberg, 2017). Interestingly, there is a case reported in the news website indicating that a woman who terminated her pregnancy still felt traumatized and had alcohol problems and depression although it was almost 30 years ago (Bell, 2016). Another case performed pregnancy termination 10 years ago and needed medical treatment for depression (Lekgetho & Taolo, 2017). Long-term effects on mental well-being should not be overlooked.

The topic for discussion is the foundation of women's suffering from wrongdoing. Aside from legal and social disapproval, pregnancy termination is the serious violation of a child rights to be born and to live, which these rights are rooted from the religious and moral regulations and strongly indicative of human being's value (Pananakhonsab, 2011).

Abortion is controlled through a moral issue stemming from religious beliefs (Andersen, 2006). Another issue is preborn humanness or which point the life begins. If pregnancy is terminated at the time of the life has already begun, the termination is certainly the killing. The more advanced gestational age, the more depression was reported by the post-termination women (Saelim, 2003), which might be related to the perceived baby's living.

The participants in this study internalized the legal, social, religious, moral, and ethical norms and regulation aforementioned as evidenced by the beliefs in destroying or killing the baby, and preventing the baby from being born. Because of this, the participants considered their action as making serious mistakes to their own baby, leading them to experience various suffering feelings.

A woman has the rights to control her body. Accordingly, the rights to terminating a pregnancy will be approved if it is the mean to protecting the woman's life. The participants who gave some necessary reasons of their termination felt relieved. It is controversial which one between the woman's rights and the child's rights is greater protected. In Thai society, women's rights to their body is less discerned (Pananakhonsab, 2011). The results of this study have supported this attitude as shown in the strong feelings of wrongdoing even though they performed the termination with their necessity.

Motherhood is a feminine trait assigning a woman to give birth, to protect and nurture her child. Maternal role is reflected by attractive young women who are married and looking forward to bringing a precious new life into the world. The family ideal is an ideology-one assumes that motherhood is women's major roles as all-loving, kind, gentle, and selfless (Anderson, 2006). Considering womanhood, a woman is stereotyped to be polite, gentle, religious, and aware of other feelings (Brannon, 1996). To discourage termination of pregnancy, photographs of warm, affectionate, attractive young mothers are often contrasted by photographs of broken, bloody, distorted fetus-victims of abortion in Thailand (Whittaker, 2004). Once a pregnancy is terminated, it indicates the killing of her own child, which is strongly internalized as the loss of the both senses of womanhood and motherhood (Neyer & Bernardi, 2011). According to various violations of legal, social, moral, ethical, and feminine norms and regulations, the women inevitably experience serious suffering along with many painful feelings.

Several negative and introvert feelings were experienced by the participants. In general, women likely have emotional feelings and expression (Unger & Crawford, 1996). Women are also likely better in dealing with their own and others' emotions (Baron-Cohen & Wheelwright, 2004). Sensuality, all about feeling one's self, is a feminine energy trait in terms of leading the women to be aware of their inner world, learn from it, and be heard and understood by the outsiders (Gifford & Mallory, 2015). Similarly, the participants acknowledged their feelings developed from their wrongdoing and tried to make amends of their mistakes. Certainly, their suffering feelings were expressed, heard, and understood through this study.

The feelings of being wrong. Because of the feelings of being wrong, the participants felt sad, guilty, sinful, stigmatized, shameful, and anxious, which is similar to those in the literature review on negative feelings after pregnancy termination by Komon (2010), and Pingprasert (1991). They found that the women who had the experiences of illegal induced abortion had such negative feelings as guilt, shame, suffering, anxiety because they feared their stories' disclosure and the effects to their future life.

Sad refers to unhappy, usually because something has happened that one does not like (Collins English Dictionary, 2010), or the response to loss (Leventhal, 2009). In unwanted pregnancy, the women thought that abortion was the loss (Ratchukul, 1998). In this study, a woman felt really sad and sorry for their own undesirable mistakes and the cruel consequences on their own baby. The similar feeling of sadness is grief, which was experienced in the women with perinatal loss (Sriarporn & Liamtrirath, 2014), and therapeutic abortion due to fetal anomaly (Chaloumsuk, 2013; Kanchanapusit et al., 2009; Kreetiyutanont et al., 2014). Disenfranchised grief in abortion can lead the women to develop depression due to inability to process the grief (Johnson, 2015) as evidenced in the studies by Coleman (2011) and Saelim (2003), and also to have suicidal thoughts or attempts (Reardon, 2016). In the present study, sadness was also obvious and lasted for many years, probably because no one obtained mental post-termination counseling.

Guilt develops when a person thinks that he/she does something wrong to some persons (Harstade et al., 2012). In the present study, guilt was experienced, which was also found in Coleman's study (2008), due to making mistakes toward themselves and

their babies. Guilt also came from disappointing the family (Sujiinnaprum, 2011). Other feelings found similar to the previous studies were shame (Johnson-Hanks, 2002; Komon, 2010; Pingprasert, 1991; Shehan et al., 2003), and sinfulness (Lerdmensewong & Francis, 1998; Sirithanawutichai et al., 2008; Whittaker, 2001). Feeling guilty, signifying a sense of unworthiness, is likely experienced by women due to socialization that women should get along with others, not hurt anybody's feelings, and take care of loved ones (Greenberg, 2017). Shame and guilt are likely concurrent and they are based on moral self-awareness (Tangney & Dearing, 2003). Pregnancy termination is morally wrong and then further produces the feelings of guilt and shame.

Under Buddhism and Catholic doctrine, killing is considered as a sin. In Buddhists' view, termination of pregnancy interrupts the flow of the *Karmic* cycle of birth and death by impeding the reincarnation of another living creature with unavoidable consequences for women who engage in this practice. Women who opt for termination of pregnancy are subject to *Karmic* penalties for both mothers and aborted fetuses (Whittaker, 2004). While women who terminate pregnancies are likely to face unfortunate reincarnation to a lower status, aborted fetuses whose chance for elevated status through reincarnation has been thwarted. The strong feelings of sinfulness among women might be related to socialization in that women are kind and religious.

Goffman (1963) described stigma as an attribute that is deeply discrediting, reducing the possessor from a whole and usual person to a tainted, discounted one. Abortion is a stigma because it is the violation of female ideals of sexuality, motherhood, personhood to the fetus, legal restrictions, and dirty or unhealthy (Norris et al., 2011). In the present study, a stigma was attached to the women because of various violation similarly to the aforementioned. However, from the women's perspectives, they likely related their feeling of stigmatization with sin and violation of religious doctrine, which some believed the stigma could not be erased and would attach to them until they died. This finding is congruent with the previous study. That is, Thai women with pregnancy termination were faced with stigmatization frequently because it linked with moral, ethical and religious values (Chunuan et al., 2012).

The feelings of being haunted. In the present study, some participants used to feel haunted by the dead baby. They experienced illusive pictures, sounds, touches, or in their

dreams. A study about the haunting fetus in Taiwan found that a fetus-ghost was believed to frighten and bring tremendous troubles to the parents, especially the mother; and they had to performed some rituals (Moskowitz, 2001). In the present study, the participants felt that they were crazy, confused, scared, and unhappy. These feelings were liked the symptoms of illusion and hallucinations. According to Tuttle (2006), a hallucination is false sense perception, or a perception without an object whereas an illusion is a mistaken sense perception. In addition, it could be related to post-traumatic stress disorder (PTSD). PTSD is a mental health condition that's triggered by a terrifying event; and symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event (The American Psychiatric Association, 2011). Guilt and shame are relevant features of PTSD as evidenced in the study among women who experienced violence (Beck et al., 2011). The present study supports this finding.

The feelings of being failed in life. From the present study, women felt about their pregnancy termination as a wrong Karma related to a life-destroying act that constitutes a serious sin or demerit, as a result, they felt very guilty. In addition, the failure in life, including financial problems, divorce, accidents, sickness, and so on, were believed to be the outcomes of their actions according to the law of Karma. Terminating a pregnancy is believed to disrupt the *Karmic* cycle of birth and death by impeding the birth of a fellow human being (Whittaker, 2001). Karma penalties leave the participants with some bad things happening to their lives. They related their failure in life with their cruel wrongdoing, especially if they did not attempt to amend their mistakes. The study in Taiwan also found that a fetal-ghost brought the parents such many difficulties that they needed to performed some rituals to make their lives be better (Moskowitz, 2001). Two non-Buddhists cases reported in the news also revealed substantial hardship in their lives (Bell, 2016; Lekgetho & Taolo, 2017).

Taking Responsibility for Wrongdoing

Women dealt with their painful feelings of wrongdoing by the main methods of taking responsibility for their wrongdoing, consisting of 4 particular methods of accepting their mistakes, protecting self-values, seeking forgiveness, and empowering oneself. It is recommended 7 steps of taking responsibility for wrongdoing: acknowledge internally, confess to another, admit to victim, declare understanding, erect a boundary, give time,

and be accountable (Hammond, 2017). Similarly, in the present study, the participants obviously acknowledged their wrongdoing internally and externally. They confessed to their baby as the victim, through some rituals in Buddhism and Catholicism. They also quite understood their wrongdoing actions in terms of harming or killing the baby, and preventing the baby to be born. Considering 'erect a boundary,' the women demonstrated a grasp of the potential future consequences for any further pregnancy termination. Rather than feeling relieved immediately after confession, the participants spent much time to go through the feelings of wrongdoing. Some participants believed their wrongdoing has never been erased. Finally, the women were accountable in insisting not to terminate their pregnancy again.

The issue of women's responsibility is discussed next. Society places the heavy burden of reproductive responsibility on women. This gender bias is stemmed from biological functions of women in bearing a child and women's roles as mothers. Additionally, male ways of moral reasoning emphasize on rules, rights, universality, and impartiality whereas female ways of moral reasoning emphasize on relationships, responsibilities, particularity, and partiality (Jaggar, 1992). An ideology of motherhood as all-loving, kind, gentle, and selfless (Anderson, 2006) and womanhood as polite, gentle, religious, and aware of other feelings (Brannon, 1996) also shapes women to behave in a good manner and to be the responsible person. Women tend to be aware of their inner world, learn from it, and then be heard and understood by the outsiders (Gifford & Mallory, 2015). Women's position is inner and private world. Therefore, in the present study, the women took personal instead of social responsibility. That is, they dealt with their own suffering by themselves rather than targeted at societal levels or social institutes. Their responsibility was likely moral-oriented since their wrongdoing was killing or hurting someone, which is immorally wrong. Consequently, they carried out their moral responsibility mostly by seeking forgiveness.

Accepting one's mistakes. In the acceptance of their own wrongdoing acts, some participants also accepted it as the law of Karma in order to detach from their own mistakes and regret. They could not undo what they had done but let go their mistakes. This method, called as '*Phuong*' (ปลง), made them felt better and obtained the peace of mind.

In healing their suffering, women started with accepting their wrongdoing rather than denying it or blaming someone else. Taking moral responsibility of their wrongdoing led the women to accept the consequences and feel better. More importantly, the women tried to correct their mistakes.

Protecting self-values. The women tried to protect their self-values by keeping their stories as a secret and unlikely seeking help to avoid blaming. Having their own reasons for pregnancy termination was also another mean to relieve their sense of self-devalue. These methods were used for coping with their feeling of stigmatization and shame. Similarly, bipolar disorders patients with higher levels of self-stigma were more likely to endorse the use of secrecy and withdrawal in stigma coping; and stigma-reduction intervention should be arranged during the early stage of bipolar disorders and targeted at various dysfunctional stigma coping (Au, Wong, Law, & Wong, 2019). However, avoidant stigma coping likely has harmful effects, potentially exacerbating pre-existing psychological distress and undermining social networks (Schibalski et al., 2017). Avoidant coping strategies among impulsive buyers would be predominantly associated with shame through mental disengagement, resignation, and blaming others (Yi & Baumgartner, 2011). In the present study, blaming others was unlikely mentioned. One participant believed that her mother who facilitated her in pregnancy termination was also believed to have sin. However, after reflexive questions were raised, many participants considered men should take responsibility and also be blamed.

Seeking forgiveness. The participants sought forgiveness from their dead babies in order to liberate themselves from sins and Karma and to obtain the peace of mind through various religious beliefs, practices, and rituals. Self-forgiveness is one method that people might work through their perceived wrongs (Hall & Fincham, 2005) by the acceptance of responsibility and the release from self-condemnation. Self-condemnation, prolonged shame, and being stuck in regret, have been associated with negative outcomes such as depression, maladjustment, and global negative self-evaluations (Cibich, Woodyatt, & Wenzel, 2016). It is a common assumption in moral philosophy that there is nothing to forgive unless the person has deliberately done wrong to another person (Gamlund, 2011), whereas blameworthiness is considered a necessary condition for forgiveness. In pregnancy termination, although the participants really did not want to

end their pregnancy if there were other alternatives, they intended to do it, and their wrong actions brought out severe harms to their baby. Accordingly, they could not escape from self-blame, which further led them to seek forgiveness.

Empowering oneself. Empowerment represents the culmination of two components: 1) agency as the ability to define and act upon goals, and 2) resources, such as education and household circumstances, enable women to exercise agency (Kabeer, 1999). Women in the present study acquired themselves to be powerful by learning from their mistakes, not being stuck in the past, being stronger, and improving their live in the better ways. The women learnt lesson from their experiences that they should not have done or repeated the pregnancy termination. Furthermore, they tried to live their life in the better ways, for example, taking good care of their child and family, working hard, because their lives were valuable, especially for their loved one. These coping methods were similar to those of young ethnic minority parents from low-income communities who experienced stigma and discrimination (Conna, Figueiredoa, Shererb, Mankerianc, & Iverson, 2018). Their coping methods included developing a positive self-concept as a person and worth, finding the benefits or lessons learned from early parenthood, and viewing parenthood as a major motivator for actively initiating life changes. These forms of coping are productive and problem-focused, likely due to the perceived guilt. Congruently, in impulsive buyers who experienced guilt and shame, problem-focused coping strategies would be predominantly associated with guilt whereas avoidant coping strategies would be predominantly associated with shame (Yi & Baumgartner, 2011). Accordingly, women should not be stereotyped as emotional, emotional focused, and passive.

The women also tried not to be stuck in the past since they could not get back to amend their past. They raised their consciousness by thinking of their own duty and their own task that they have to do. They strengthened themselves. They were strong and valuable. They owned enough strength and energy to did a good and productive things and further improved their life in a better way. Women's power and strength is also potential force in the community that can provide nourishing, supporting other people, and making differences for their communities (Kesselman, McNair, & Schniedewind, 1995). The women in this study did not have opportunity to dedicate themselves to their

communities. However, their contributions to this study in helping us understand their lives will be the initial step in moving forward to develop quality healthcare services for these women.

Obtaining Support

The participants obtained plenty of psychoemotional support from religions. Support in the forms of tangible, physical and mental support, was obtained from family. Unfortunately, from their perception, they were never been given support by healthcare providers.

Religious support. The women relied mostly on religions in taking responsibility for their wrongdoing, especially by the mean of seeking forgiveness. To obtain forgiveness, most of the participants performed various religious rituals. The rituals allowed the participants to acknowledge their mistakes and confessed to their baby internally by self-talk about what they had done wrong to the baby and how they felt guilty. They had not to disclose their secret to anyone. The ones to whom they told their stories were the monks who would not bring them any troubles. Their self-values were still protected through this coping support. They could also choose what, how, and when to perform the rituals. Privacy, confidentiality, and a sense of self-control in performing religious rituals are the strong positive sides suited to the women in this stigmatizing condition. It was found that mastery and perceived control were positively associated with psychopathology in women and men (Taylor & Stanton, 2007). However, women may be exploited and cheated by someone who offered them performing rituals as also evidenced in the Taiwanese's study on a fetus-ghost (Moskowitz, 2001). However, no participant complained about this exploitation.

Religion is the very powerful support for healing processes of severe moral wrongdoing and committing a sin. Spirituality/religion can facilitate resilience by providing solace, calm, hope, facilitating adaptive psychological processes, and provided a buffering effect against mental distress (Rosmarin, Pirutinsky, Appel, Kaplan, & Pelcovitz, 2018; Weber & Pargament, 2014). Buddhism has provided a unified symbolic system to interpret and organize day-to-day and social lives (de la Perriere, 2017; Schober, 2011). Belief in Karma and reincarnation enabled the women to accept their

wrongdoing and dedicated merits to their dead baby, hoping their baby to be reborn and themselves to obtain peace of mind. The principal beliefs on Karma and reincarnation may factor into self-management and self-efficacy (Klunklin & Greenwood, 2005).

Both in the United States and worldwide, some religious beliefs are the core of sexist ideologies that maintain women's subordination in the home but some religious beliefs are powerful source of liberation and social movement because the beliefs rests on a strong faith in justice, fairness, and equality (Andersen, 2006). However, religious beliefs are not applicable to reproductive issues. Religion depresses women's reproductive rights and abortion rights. It was found that Buddhism consistently had a significant negative correlation with abortion policy (Forman-Rabinovici & Sommer, 2018). Optimistically, religious disapproval of abortion is a mean of controlling unwanted pregnancy and neglected child. Moreover, some religious beliefs, rituals, and doctrine are also the mean of reducing suffering developed from undergoing abortion.

Family support. Along with plenty of religious support, the participant also obtained support from their family, mostly their mother and female relatives. Previous studies indicate that spouse's or partner's support was very helpful for their mental adaptation (Canário et al., 2011; Major et al., 1990). The women who had doula support, companionship during the procedure, reported positive experiences (Chor, Lyman, Tusken, Patel, & Gilliam, 2016; Veiga et al., 2011). However, in the present study, the participants unlikely mentioned on their partners' support possibly due to most of them had relationship problems. When they were encouraged to reconsider about the contributions of their partners, they requested men to share responsibility in this issue, which is similar to the study by Chatchawet (2009).

Expecting Support

The participants expressed no need of support since they made mistakes and their actions were wrong which might further put them in more troubles. However, when they were asked if the support was available, they suggested about 'just empathetic understanding,' 'men's sharing of responsibility,' and 'health services.'

Just empathetic understanding. Which support the participants needed the most was just understanding them with empathy for their undesirable and unwilling wrongdoing. They all fully accepted their mistakes and really wanted to amend as much as they could. They felt overwhelming. They were so guilty that they could not tolerate more blaming. Seeing oneself as having poor moral character may lead to diminished self-esteem and a sense of helplessness (Janoff-Bulman, 1979). On the contrary, expressing empathetic understanding might strengthen them to change in the positive ways. It is hard to control blaming messages sent out through media while gender-biased social norms of abortion still exist. Mental support by family and healthcare providers are the alternatives.

Men's sharing of responsibility. Initially, the participants felt that they were the only ones who committed transgression, and the ones who should take the blames. Women's experience is highly value for understanding why and how they are oppressed and how to liberate them (Lincoln & Guba, 2000). Termination of unwanted pregnancy is obviously an oppression of a woman through giving total responsibility to her since she is the one who carries a baby inside her womb, excluding men's responsibility although he is the one who makes pregnancy occur. The woman is blamed and stigmatized for the abortion without asking her partner why he does not stop the abortion. These oppressive and bias attitudes are internalized by the woman, making her develop self-blame. However, when they were raised their consciousness about men's responsibility in reproductive issues, they could think in other angles. Thai is, sexual relationships, conceiving a baby, being parents, and nurturing children were all mutual acts between men and women. The both have to take responsibility when there were somethings wrong. It is not the women who take the blame. One mean was that the women expected their partner's caring in 6 ways: assisting pregnancy termination, not abandoning, caring heart by heart, expiating, basic care need, and financial care (Chatchawet, 2009). Both women and men have to be treated equally. However, negative attitudes are also constituted in health personnel, leading them to treat the woman in an unfair manner.

Health services. The participants felt traumatized physically and mentally needing to recover. During the terminating procedures, the participants had a lot of concerns about their safety and fear since the procedures were perceived to be harmful and frightening.

They also needed the performers to be sensitive to their situations and highly strict with confidentiality. Doula support, especially spouse or partner, is also advantageous (Chatchawet, 2009; Chor et al., 2016; Veiga et al., 2011). Counseling before and after the procedures are crucial but it is hard to provide in case of non-therapeutic abortion. Post-termination counseling might be provided only if the women are admitted to the hospitals due to complications. Post-termination check-up and family-planning services can be another route for counseling. Anonymous counseling through telephone, social media, and websites are available in some countries. The lists of available counseling resources should be provided.

Effective counseling can provide emotional support and guidance by a trained person in an environment that is conducive for openly sharing thoughts, feelings, and perceptions. There were nine practices used in emotional care for stigmatized and sensitive health issues, including abortion: self-awareness assessments, peer counseling, decision aids, encouraging active client participation, supporting decision satisfaction, support groups, internet-based support, telephone counseling, and public artistic expression (Upadhyay, Cockrill, & Freedman, 2010). One study found that phone-based postabortion support services appeared to stigmatize and pathologize abortion with some mental disorders; and increasing awareness of and access to existing nonjudgmental, nondirective postabortion services appears warranted (LaRoche & Foster, 2015).

Gender-sensitive approach is suited to the care of post-termination women. The main principles of gender-sensitive care include: people have a right to access physical, sexual and emotional safe services; effective care is responsive to people's lived experiences and their particular needs, preferences, identities and circumstances; women and men may experience mental health issues differently (Health.vic, 2018). In caring post-termination women, their emotional feelings will not be exaggerated as mental disorders. Their stories are attentively and non-judgmentally listened. These women are not stereotyped and blamed repeatedly as cruel mothers and bad women, instead, they are moral and responsible to their actions. They are not labelled as sinfulness but they are the ones who attempt to correct their mistakes. They are not passive but they are powerful to live better lives. Some rituals performed are viewed as powerful support rather than

irrational or ridiculous things. A partner also participates in the caring process to support each other. Support from their loved ones is assessed and enhanced.

To sum up, the experience in terminating pregnancy without medical indication led the women to have the feelings of being wrong, being haunted by the dead baby, and being failed in life. The women coped with these feelings through taking responsibility for their mistakes by accepting it as *Karmic* penalties rather than blaming others. They kept their stories in secret to protect their self-values. They sought forgiveness from their dead baby to liberate themselves from sins and to obtain peace of mind mostly through performing religious rituals. Finally, they empowered themselves by learning form their mistakes in order not to repeat it, not being stuck in the past, becoming stronger, and improving their lives. To go through this long suffering, the women obtained plenty amount of religious support and some support from their family, no support from healthcare providers. If help available, they suggested just understanding them without condemning, men's sharing of responsibility, and health services for their body and mind recovery, through gender-sensitive and accessible healthcare services. This study based on feminist perspectives provided similar findings to existing knowledge in terms of the oppression of unnecessary long-term suffering, the women's capability to manage their suffering although they were treated subordinately. Feminist movement has a long way to go to attain equal and fair treatments in healthcare sectors, to help the women live better.

CHAPTER 5

Conclusions and Recommendations

This chapter consists of three parts. The first part illustrates the conclusions of the study. The second part comprises limitations of the study. The recommendations are described in the third part.

Part 1: Conclusions of the Study

The objective of this study was to understand coping with pregnancy termination among Thai women. The participants of the study were 12 adult women during the reproductive age who lived in Nakhon Nayok province and experienced pregnancy termination without medical indication. They were 28-44 years old (Means=39.4, SD=5.4). The majority were Thai Buddhists. Only three participants graduated at the bachelor degree, the rest had lower education. Most of the participants were employed with insufficiency incomes for their living expenses. Their experience of pregnancy termination ranged from 10 to 26 years. Eleven participants committed pregnancy termination once, only one committed 4 times, with varieties of reasons, and mostly by skilled persons.

Feminist qualitative research was conducted to understand the experiences of Thai women in coping with pregnancy termination. The participants were recruited by a purposive sampling technique from 6 hospitals in Nakhon Nayok province. The in-depth interviews, and non-hierarchical relationships building were conducted in order to attain deep understanding of women's experiences. The researcher shared her feelings and experience at the end of the interviews as requested by the participants. Some appropriate and reasonable assistance under the researcher's abilities were provided if required by the participants. Each participant was interviewed in the private room for 2-3 times. Each interview session lasted 40-90 minutes.

The interview was started by inviting the participants to tell their stories and by making broad statements or asking open-ended questions. Probing techniques were applied in order to gain adequate data, with depth, a wind range of interpretation and meaning or a full description of the experiences being studied. In addition, reflexive questions were raised aiming to empower the participants to view their lives in the fair angles. After each interview, field notes and reflexive journal were written. There was no note-taking during the interview. An MP3 recorder was used to record the interviews with the participants' permission. Audio-recording was transcribed verbatim within one week.

Narrative analysis methods recommended by Sosulski and colleague (2010) were employed for data analysis through feminist lens. The methods included: initial coding, symbolic coding, categorizing and generating themes, describing individual narratives, and structuring. Trustworthiness of the study were achieved mostly through member checking, peer debriefing, and reflexive journal.

It was found that the participants felt suffering developed from their wrongdoing. The way the participants coped with this suffering was taking responsibility for their wrongdoing to make amends for their mistakes. Taking responsibility consisted the following participants' actions: accepting one's mistakes, protecting self-values, seeking forgiveness, and empowering oneself. Along with their coping, they obtained plenty of religious support, and followed by support from their family, no support from healthcare providers. If support available, they expected just understanding them with empathy, men's sharing of responsibility, and health services for their body's and mind's recovery. The structure of coping with pregnancy termination among Thai women was found to be: 1) the feeling of suffering from wrongdoing, 2) taking responsibility for wrongdoing, 3) obtaining support, and 4) expecting support.

1. The feelings of suffering from wrongdoing. The participants' feelings of suffering were rooted from their beliefs in destroying or killing their own baby, or stopping their baby from being born. Their feelings of suffering were expressed as the following feelings: a) the feelings of being wrong: sad, guilty, sinful, stigmatized, shameful, and anxious; b) the feelings of being haunted: senses of illusive pictures, sound,

or touches leading them to feel crazy, confused, scared, and unhappy; and c) the feelings of being failed in life: difficulties, obstacles, and no progress

2. Taking responsibility for wrongdoing. The participants coped with their sense of wrongdoing through 4 methods: a) accepting one's mistakes without putting the blame on others; b) taking responsibility to their self-values by protecting their self-values through keeping their stories as a secret; c) taking responsibility to their inflicted baby by seeking forgiveness from their dead baby, mostly through various religious rituals, to liberate themselves from sins and bad Karma, to obtain the peace of mind, and to wish the baby reborn with a new better life; and d), taking responsibility to their own life by empowering themselves through learning from their mistakes, not being stuck in the past, becoming stronger, and improving their life in a better way.

3. Obtaining support. The support which the participants sought and obtained the most was religious support, mostly with the willingness to obtain forgiveness from the dead baby. Based on the participants' experience, religions were emotion-focused, powerful, available, accessible, self-directed, and self-control. The forms of religious support were beliefs, rituals, and doctrine. Another support was obtained from their family, primarily by the mothers, and secondarily by their sisters or aunts, who provided mental and physical support, advices, good caring, and protection.

4. Expecting support. The participants never requested nor obtained any professional support. However, through reflexive questioning if support were available, their expectance was just understanding them with empathy, no blaming. They also suggested men's sharing of responsibility in pregnancy termination, and health services for their body's and mind's recovery through accessible and gender-sensitive healthcare services.

Part 2: Limitations of the Study

The recruitment procedures were limited to recruit the women with high socioeconomic status. These women group might have different means of coping and sources of support. Most of the participants were Buddhists. The results might be unable to transfer to women with other religions. According to privacy and confidentiality of the studied phenomenon, consciousness-raising through reflexive questioning was elicited only from individuals' critical analysis rather than through group process analysis. The participants' changed worldview in terms of gender-equality, might be limited.

Part 3: Recommendations

The findings of the present study provided deep understanding of the experiences of Thai women in coping with pregnancy termination. The knowledge generated through research based on feminist perspectives provided greater insight from different points of views. The silent voice of these women were taken into consideration. The knowledge gained would be gender-equality based, which was fair and helpful to the women. In terms of nursing science, the found knowledge of coping with pregnancy termination in the Thai context makes contributions to nursing profession in terms of gaining empirical evidences supporting women's oppression and capacity in coping with pregnancy termination and unavailability of healthcare services for these women. It also provides some recommendation for nursing practice and further research.

Implication for Nursing Practice

The gained knowledge can be applicable in designing counseling services based on gender-sensitive approaches. The counseling should emphasize on empathetic understanding, avoiding condemnation and stereotyping. These women should be understood of their necessity in pregnancy termination. The counselors should be sensitive to their feelings of shame and guilt, and eschewing stigmatization. Various feelings, such as sadness, guilt, sinfulness, stigmatization, shame, and anxiousness, senses of illusive pictures, sound, or touches of the dead baby, and failure, should be assessed and intervened. They might have difficulty in disclosing their stories because they want

to protect their self-values. The counsellors should be highly concerned with the issues of privacy, confidentiality, avoiding stereotyping and stigmatizing.

The women are likely responsible for their wrongdoing and willing to amend their mistakes. The ways for taking responsibility employed by individual women should be assessed and facilitated. They are not viewed as passive nor incapable. Their capacity and existing resources are assessed and strengthened and incorporated into their own coping. Some rituals should be accepted as the powerful and accessible support. Their partner also participates in the counseling process to fulfil the sense of mutual responsibility. Family support should be enhanced as the sources of coping.

Importantly, the women with pregnancy termination has the rights to obtain post-termination counseling services. Their rights should be respected through the delivery of gender-sensitive services with appropriately trained health personnel. Moreover, accessibility of the services can be attained through various routes of anonymous services. In addition, the quality physical care for women experiencing all kinds of abortion should be available in all general hospitals. Then, nurses should also provide health education for physical recovery and family planning. Moreover, psychological care immediately after pregnancy termination and in the long-term should be well developed and provided for the women who are mentally suffer and created psychological illness.

In terms of nursing professionals, midwives and nurses in obstetric emergency rooms and post-abortion units have direct responsibilities to provide not only physical but also mental care. Here, mental care is not the care of women with psychiatric illness, which are provided by psychiatric nurses. Instead, it is caring for common and uncomplicated psychological problems, such as depressive symptoms, fear, anxiety, shame, guilt, anger, low self-esteem, etc., in order to prevent with psychiatric illness. If the problems are severe, the women will be referred to obstetricians or psychiatric nurses.

Implication for Further Study

Many studies on this tissue were conducted in other disciplines such as social sciences, and humanities science, which did not deeply explain health issues, and the results were hardly applicable to health practice. Therefore, exploring the experience of

women in terms of coping strategies and coping resources is very important on the ground that the deep understanding can create the effective nursing intervention programs, counseling programs, and nursing practice guidelines. These quality interventions have to meet the women's needs and fit to the women's nature. Therefore, more exploration is recommended among women with different contexts, including young women, women with early experience, and women in other religious and sociocultural backgrounds. As men should take parts in the counseling, their experience should be understood as well. Development of counseling programs based on the existing findings and women's and men's participation is also recommended. Exploration of healthcare providers' attitudes and practice is also crucial in designing the gender-sensitive programs.

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APPENDICES

APPENDIX A

Invitation Letter

(English Version)

Invitation to participate in the research project
To Thai women aged 20-44 years

I, Mrs. Paradee Prasertwong, a doctoral student from the Faculty of Nursing, Chiang Mai University, am conducting a study on "Coping with Pregnancy Termination among Thai Women" in which Associate Professor Dr. Kasara Sripichyakan is my dissertation advisory. The objective of this study is to understand coping among Thai women who experienced pregnancy termination without medical indications. The knowledge obtained from the study can be used as the basis for developing appropriate guidelines for caring the women.

This invitation letter is not given only to you. Rather, it is given to any women receiving health care services in the postpartum and family planning unites, gynecology and pediatric health units in various hospitals, and any women. I and the persons who gave you this document does not possess any of your personal information. The women meeting the following criteria are invited to participate in this study:

Thai women aged 20-44 years, Live in Nakhon Nayok, Have experience with pregnancy termination without medical indications, Communicate in Thai, and Willing to participate in this research.

If you meet the aforementioned criteria, please take some time to read a brief summary of the research project below:

1. If you participate in this study, the researcher will interview you about your experience with pregnancy termination, personal information, at least twice, but no more than four sessions. Each interview will take approximately 60-90 minutes, and all interviews will complete within a period of one month. Audio recordings will be taken

during the interviews. The interviews will be conducted in private places where only you and the researcher are present.

2. Your information will be kept confidentially. You will not be required to disclose your name and address to the researcher. In addition, during the interview, your name and identity will not be used and mentioned. Instead, only the pronoun "you" will be used every time. Moreover, audio transcription documents will not specify your name. All interview recordings will be destroyed subsequent to transcription. The interview transcriptions will be destroyed immediately after the completion of the research. Your and identity will not be described in the research report.

3. As a gesture of appreciation, you will be paid 100 baht for each interview. Travel expenses will be paid as well.

If you are interested in participating in the research, please contact me by dialing 086-6037546. In the telephone conversation, you have not to state your name and address. I will provide you some information and answers your questions to accompany your decision. If you are still interested in, I will ask for information about your qualifications along with your health problems. You can refuse to answer any questions. You can choose to not participate in this research at this point. However, if you meet all qualifications and do not have any serious health conditions that might put you in danger as you participate in the research, and you are willing to participate in the research, an appointment will be made.

If you are not willing to participate in this research, you have not to take any action. Moreover, I would like to reiterate that I and the persons who delivered this document to you have no knowledge of your personal information. All telephone conversations will be kept confidential and not disclosed. The healthcare provided at the hospital where you received this document will not be affected.

I would like to thank you for taking the time to read this document, and I sincerely hope to receive your support.

(Thai Version)

ขอเชิญเข้าร่วมโครงการวิจัย

เรียนสตรีไทยที่มีอายุอยู่ในช่วง 20-44 ปี

ดิฉันนางภารดี ประเสริฐวงษ์ นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่ ทำการศึกษาวิจัยเรื่อง “การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย” โดยมี รองศาสตราจารย์ ดร. เกสรา ศรีพิชญาการ เป็นอาจารย์ที่ปรึกษา การวิจัยนี้มีวัตถุประสงค์เพื่อเข้าใจการเผชิญปัญหาการยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์ของสตรีไทย ความรู้ที่ได้จะเป็นพื้นฐานในการวางแผนการดูแลสตรีที่ยุติการตั้งครรภ์ได้อย่างเหมาะสมและสอดคล้องกับความต้องการของผู้หญิงต่อไป

เอกสารเชิญชวนเข้าร่วมโครงการวิจัยนี้ ดิฉันมิได้เจาะจงมอบให้แก่ท่านเท่านั้น แต่มอบให้สตรีที่มารับบริการสุขภาพ ณ หน่วยหลังคลอด หน่วยวางแผนครอบครัว หน่วยนรีเวชกรรม และหน่วยสุขภาพเด็กดี ของสถานพยาบาลต่าง ๆ และสตรีอื่น ๆ ทั้งนี้ดิฉันและผู้ที่แจกเอกสารนี้แก่ท่านไม่ทราบข้อมูลส่วนตัวของท่านแต่อย่างใด การเข้าร่วมโครงการวิจัยนี้ จะเลือกเฉพาะสตรีที่มีคุณสมบัติดังนี้

หญิงไทยที่มีอายุ 20-44 ปี อาศัยอยู่ในจังหวัดนครนายก มีประสบการณ์เคยยุติการตั้งครรภ์โดยไม่มีข้อบ่งชี้ทางการแพทย์ ติดต่อสื่อสารด้วยภาษาไทยได้ และยินดีที่จะเข้าร่วมการวิจัยในครั้งนี้

หากท่านมีคุณสมบัติข้างต้น ขอสละเวลาอ่านสาระสำคัญโดยย่อของโครงการวิจัยดังต่อไปนี้

1. ถ้าท่านเข้าร่วมโครงการวิจัยครั้งนี้ ผู้วิจัยจะสัมภาษณ์ท่านเกี่ยวกับประสบการณ์ในการยุติการตั้งครรภ์ รวมทั้งข้อมูลส่วนตัว การสัมภาษณ์มีอย่างน้อย 2 ครั้ง แต่ไม่เกิน 4 ครั้ง แต่ละครั้งใช้เวลาประมาณ 60-90 นาที การสัมภาษณ์จะทำให้เสร็จภายใน 1 เดือน โดยจะมีการบันทึกเสียงในขณะสัมภาษณ์ การสัมภาษณ์จะทำในสถานที่มิดชิดและมีความเป็นส่วนตัวที่มีเพียงผู้วิจัยกับท่านเท่านั้น

2. มีการปกปิดข้อมูลของท่านเป็นความลับ โดยท่านไม่ต้องแจ้งชื่อและที่อยู่ให้ผู้วิจัยทราบ ขณะสัมภาษณ์จะไม่มีการระบุชื่อความเป็นตัวตนของท่าน ไม่กล่าวชื่อของท่าน จะใช้สรรพนาม “คุณ” แทนชื่อท่านทุกครั้ง และเอกสารการถอดเทปจะไม่มีการระบุชื่อของท่าน เทปการสัมภาษณ์จะถูกทำลายทิ้งเมื่อถอดเทปเสร็จแล้ว ส่วนบทความการสัมภาษณ์ที่ถอดเทปจะถูกทำลายทันทีหลังการวิจัยเสร็จสิ้น รวมทั้งการรายงานผลไม่ระบุให้รู้ว่าท่านเป็นใคร

3. ในการสัมภาษณ์ทุกครั้งท่านจะได้รับค่าตอบแทน เพื่อแสดงความขอบคุณ ครั้งละ 100 บาท และจ่ายค่าเดินทางตามที่ท่านได้จ่ายไป

ถ้าท่านสนใจที่จะเข้าร่วมโครงการวิจัย กรุณาติดต่อกลับมายังดิฉันที่หมายเลขโทรศัพท์ 086-6037546 โดยไม่ต้องระบุชื่อและที่อยู่ของท่านให้ดิฉันทราบ ดิฉันจะขออนุญาตให้ข้อมูลในรายละเอียดเพิ่มเติมนอกเหนือที่ระบุไว้ข้างต้น เพื่อใช้ประกอบการตัดสินใจของท่าน รวมทั้งตอบข้อสงสัยที่ท่านมี ถ้ายังสนใจที่จะเข้าร่วมวิจัย ดิฉันจะขอซักถามข้อมูลเกี่ยวกับคุณสมบัติของผู้เข้าร่วมวิจัย และซักถามปัญหาสุขภาพ ทั้งนี้ท่านสามารถปฏิเสธที่จะตอบคำถามได้ ในขั้นตอนนี้ท่านมีสิทธิ์ที่จะปฏิเสธการเข้าร่วมวิจัยได้ ถ้าท่านมีคุณสมบัติตามเกณฑ์และไม่มีปัญหาสุขภาพร้ายแรงที่อาจจะเป็นอันตรายในการเข้าร่วมวิจัย และยินดีที่จะเข้าร่วมโครงการวิจัย จะมีการนัดหมายเพื่อพบปะกันต่อไป

ถ้าท่านไม่สมัครใจที่จะเข้าร่วมโครงการวิจัย ท่านไม่ต้องทำสิ่งใด และขอเรียนย้ำว่า ดิฉันและผู้แจกเอกสารนี้ไม่ทราบข้อมูลส่วนตัวของท่านแต่อย่างใด การสนทนาทางโทรศัพท์จะถูกเก็บเป็นความลับไม่นำไปเปิดเผย ท่านจะไม่ได้รับผลกระทบจากการมารับบริการสุขภาพจากโรงพยาบาลที่ท่านได้รับเอกสารเชิญชวนนี้

ดิฉันขอขอบคุณที่กรุณาสละเวลาอ่านเอกสารนี้ และหวังว่าจะได้รับความอนุเคราะห์จากท่าน

APPENDIX B

Flyer

(English Version)

Invitation to participate in the research project
To Thai women aged 20-44 years

I, Mrs. Paradee Prasertwong, a doctoral student from the Faculty of Nursing, Chiang Mai University, am conducting a study on "Coping with Pregnancy Termination among Thai Women," aiming to understanding coping with pregnancy termination without medical indications among Thai women. The knowledge obtained from the study can be used as the basis for developing appropriate guidelines for caring the women.

This invitation is not given only to you. Rather, it is given to any women receiving health care services in the postpartum and family planning unites, gynecology and pediatric health units in various hospitals, and any women who visits these units. I and the persons who gave you this document does not possess any of your personal information. The women meeting the following criteria are invited to participate in this study:

Thai women aged 20-44 years, Live in Nakhon Nayok, Have experience with pregnancy termination without medical indications, Communicate in Thai, and Willing to participate in this research.

If you meet the aforementioned criteria, please take some time to read a brief summary of the research project below:

1. If you participate in this study, the researcher will interview you about your experience with pregnancy termination, personal information, at least twice, but no more than four sessions. Each interview will take approximately 60-90 minutes, and all interviews will complete within a period of one month. Audio recordings will be taken

during the interviews. The interviews will be conducted in private places where only you and the researcher are present.

2. Your information will be kept confidentially. You will not be required to disclose your name and address to the researcher. In addition, during the interview, your name and identity will not be used and mentioned. Instead, only the pronoun "you" will be used every time. Moreover, audio transcription documents will not specify your name. All interview recordings will be destroyed subsequent to transcription. The interview transcriptions will be destroyed immediately after the completion of the research. Your and identity will not be described in the research report.

3. As a gesture of appreciation, you will be paid 100 baht for each interview. Travel expenses will be paid as well.

If you are interested in participating in the research, please contact me by dialing 086-6037546. You have not to state your name and address. I will provide you some information and answers your questions to accompany your decision. You can choose to not participate in this research at this point. However, if you are willing to participate in the research, an appointment will be made.

If you are not willing to participate in this research, you have not to take any action. Moreover, I would like to reiterate that I and the persons who delivered this document to you have no knowledge of your personal information.

I would like to thank you for taking the time to read this document, and I sincerely hope to receive your support.

(Thai Version)

ใบปลิว/ติดประกาศ

ขอเชิญเข้าร่วมโครงการวิจัย

เรียนสตรีไทยที่มีอายุอยู่ในช่วง 20-44 ปี เข้าร่วมโครงการการวิจัย

ดิฉันนางภารดี ประเสริฐวงษ์ นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่ ทำการศึกษาวิจัยเรื่อง “การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย”โดยวัตถุประสงค์การวิจัยเพื่อเข้าใจการเผชิญปัญหาการยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์ของของสตรีไทย ความรู้ที่ได้จะเป็นพื้นฐานในการวางแผนการดูแลสตรีที่ยุติการตั้งครรภ์ได้อย่างเหมาะสมและสอดคล้องกับความต้องการของผู้หญิงต่อไป

เอกสารเชิญชวนเข้าร่วมโครงการวิจัยนี้ ดิฉันมิได้เจาะจงมอบให้แก่ท่านเท่านั้น แต่มอบให้สตรีที่มารับบริการสุขภาพ ณ หน่วยหลังคลอด หน่วยวางแผนครอบครัว และหน่วยสุขภาพเด็กดี ของสถานพยาบาลต่าง ๆ รวมทั้งสตรีอื่น ๆ ทั้งนี้ดิฉันและผู้ที่แจกเอกสารนี้แก่ท่านไม่ทราบข้อมูลส่วนตัวของท่านแต่อย่างใด การเชิญชวนเข้าร่วมโครงการวิจัยนี้ จะเลือกเฉพาะสตรีที่มีคุณสมบัติดังนี้

หญิงไทยที่มีอายุ 20-44 ปี และอาศัยอยู่ในจังหวัดนครนายก มีประสบการณ์เคยยุติการตั้งครรภ์โดยไม่มีข้อบ่งชี้ทางการแพทย์ ติดต่อสื่อสารด้วยภาษาไทยได้ และยินดีที่จะเข้าร่วมการวิจัยในครั้งนี้

หากท่านมีคุณสมบัติข้างต้น ขอรบกวนอ่านสาระสำคัญโดยย่อของโครงการวิจัยดังต่อไปนี้

1. ถ้าท่านเข้าร่วมโครงการวิจัยครั้งนี้ ผู้วิจัยจะสัมภาษณ์ท่านเกี่ยวกับประสบการณ์ส่วนตัวในการยุติการตั้งครรภ์ รวมทั้งข้อมูลส่วนตัว การสัมภาษณ์อย่างน้อย 2 ครั้ง แต่ไม่เกิน 4 ครั้ง แต่ละครั้งใช้เวลาประมาณ 60-90 นาที การสัมภาษณ์จะทำให้เสร็จภายใน 1 เดือน โดยจะมีการบันทึกเสียงในขณะสัมภาษณ์ การสัมภาษณ์จะทำในสถานที่มีความมิดชิดและมีเป็นส่วนตัวที่มีเพียงผู้วิจัยกับท่านเท่านั้น

2. ขณะสัมภาษณ์จะไม่มีการระบุชื่อความเป็นตัวตนของท่าน โดยไม่กล่าวชื่อของท่าน จะใช้สรรพนาม “คุณ” แทนชื่อท่านทุกครั้ง และเอกสารการถอดเทปจะไม่มีการระบุชื่อของท่าน ซึ่งเทปการ

สัมภาษณ์และบทความการสัมภาษณ์ที่ถอดเทปจะถูกทำลายทันทีหลังการวิจัยเสร็จสิ้น รวมทั้งการรายงานผลไม่ระบุให้รู้ว่าท่านเป็นใคร

3. ในการสัมภาษณ์ทุกครั้งท่านจะได้รับค่าตอบแทนเพื่อแสดงความขอบคุณ ครั้งละ 100 บาท รวมทั้งจ่ายค่าเดินทางให้

ถ้าท่านสนใจที่จะเข้าร่วมโครงการวิจัย กรุณาติดต่อกลับมายังดิฉันที่หมายเลขโทรศัพท์ 086-6037546 โดยไม่ต้องระบุชื่อและที่อยู่ของท่านให้ดิฉันทราบ ดิฉันจะขออนุญาตให้ข้อมูลในรายละเอียดเพิ่มเติมนอกเหนือที่ระบุไว้ข้างต้น เพื่อใช้ประกอบการตัดสินใจของท่าน รวมทั้งตอบข้อสงสัยที่ท่านมี หลังจากนั้นแล้วท่านมีสิทธิ์ที่จะปฏิเสธการเข้าร่วมวิจัยได้ ถ้าท่านยังยินดีที่จะเข้าร่วมโครงการวิจัย จะมีการนัดหมายเพื่อพบปะกันต่อไป

ถ้าท่านไม่สมัครใจที่จะเข้าร่วมโครงการวิจัย ท่านไม่ต้องทำสิ่งใด และขอเรียนย้ำว่า ดิฉันและผู้แจกเอกสารนี้ไม่ทราบข้อมูลส่วนตัวของท่านแต่อย่างใด

ดิฉันขอขอบคุณที่กรุณาสละเวลาอ่านเอกสารนี้ และหวังว่าจะได้รับความอนุเคราะห์จากท่าน

APPENDIX C

Information Sheet for Research Informants

(English Version)

The researcher invites you to join the research project titled "Coping with Pregnancy Termination among Thai Women".

Name of researcher: Mrs. Paradee Prasertwong, Ph.D. candidate, Faculty of Nursing, Chiang Mai University

Advisor: Associate Professor Dr. Kasara Sripichayakan

Research informant qualifications

You have been invited to participate in this research project because you meet the following criteria: being a Thai woman, aged 20-44 years, living in Nakhon Nayok Province, and have experience in pregnancy termination without medical indication, and being able to communicate in Thai language. Twelve persons who meet the criteria will be recruited into the research project that will be advertised in public venues, at the HRH Princess Maha Chakri Sirindhorn Medical Center-MSMC Hospital in Nakhon Nayok Province, at community hospitals, and health promoting hospitals in Nakhon Nayok Province.

Before deciding whether to participate or not, please take time to read this information sheet to fully understand all aspects of the research project. If you have any questions, please ask the researcher or the persons you feel close to. The researcher would like to emphasize that the decision to participate in this research project is voluntary. Whether you decide to participate or not, there will be no effects on you. You can refuse to participate or withdraw (withdraw consent) from this research project anytime. The details regarding consent and withdrawal are as follows:

Framework 1 The participation in this research project is voluntary.

- You **can refuse** to participate in this research project.

The participation in this research project is voluntary and is based on your decision. You can refuse to participate in this research project. If you choose not to participate in this research project, there will be no effects on you.

- You **can withdraw (withdraw consent)** from the research project anytime.

After choosing to participate in this research project, you have the right to withdraw (withdraw consent) from the research project anytime without a need to give any reason. There will be no negative effects on you. You can refuse to answer the questions if you do not feel comfortable to answer them.

If you **agree** to participate in this research project, the researcher will ask you to give an oral consent to participate in this research project without having to sign your name so as to protect your confidentiality.

Framework 2 The treatment options if you choose not to participate in this research project (if any)

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For the information related to the research project, the **background and significance of the study** is summarized as follows:

Pregnancy termination is a global concern, both in developed and developing countries, especially in Thailand. Women who terminate their pregnancy without medical indication are confronted with serious physical and psychological problems and complications, as well as financial difficulties. Due to cultural, religious, and legal reasons in Thailand, these women are not accepted by people in the society, forcing them to keep this secret to themselves and become stigmatized. This study is qualitative feminist research that aims to describe in-depth information about coping with pregnancy termination among Thai women to gain basis information that is crucial to the development of counselling models or programs to care for women after pregnancy

termination without medical indications in order to help these women effectively cope with pregnancy termination with strength.

Framework 3 Possible adverse effects of the research project

In this research project, there may be some questions that cause discomfort, frustration, concern, or stress from talking about your personal feelings. The researcher will consider your safety as a priority and you can have a break or stop the interview.

The **objective** of this research project is to understand coping with pregnancy termination among Thai women.

Framework 4 Research design

This study is *qualitative feminist research*. Data collection will be conducted using in-depth interview. Data analysis will be performed using narrative analysis.

In this research project, the **duration** required for the interview completion is approximately one month. If you decide to participate in this research project, please follow the research project schedule. (See **Framework 5**)

Framework 5 Research project schedule

1. The researcher would like to interview you about your personal information, including demographic information that consists of age, race, education level, occupation, income, marital status, number of family members, history of health problems or illness, gravidity and parity, and time since pregnancy termination.

2. The interview involves telling stories about pregnancy termination, how you felt about pregnancy termination, what enabled you to cope with problems after pregnancy termination, and what support you obtained and expected to obtain to help you through the experience of pregnancy termination.

While you are telling your stories, the conversation will be recorded. The interview will take place in a private place where there are only you and the researcher. Your convenience will be set as a priority for selecting the place, such as at your house or your relative's house. In each interview, your name or identity will not be revealed.

During the interview, the researcher will be cautious, and will use the pronoun "You" instead of mentioning your name.

3. You will be interviewed at least twice but not more than four times, depending on your convenience. Each interview will take approximately 60- 90 minutes. The interview will be completed within one month.

4. You can tell the researcher about your experience recorded in documents or materials such as diary, poems, drawings, photographs, and handicrafts. The researcher asks your permission to study from these materials and will return them to you after the data have been recorded.

The researcher has summarized risks and benefits from participating in this research project as shown in **Framework 6**.

Framework 6 Risks and expected benefits from participating in this research project

Risks and Approaches to Minimizing/Avoiding Risks	**Benefits**
- Risks In this research project, the researcher will consider your safety as a priority. Risks from participating in this research project include some questions that may cause discomfort, frustration, concern, or stress from talking about your personal feelings. **- Approaches to minimizing/ avoiding risks** If those feelings arise, you can take a break, or stop the interview about that particular topic or change the topic of the interview.	**- Direct/ Indirect benefits** 1. Although the disclosure of your life experience may cause discomfort or frustration, telling stories is a way to release your feelings and can help you feel better. Also, this gives you an opportunity to share your opinion about coping with pregnancy termination. 2. This study is qualitative feminist research with an aim to gain in- depth data about coping with pregnancy termination among Thai women, which will serve as basis data that are crucial to the development of counselling models

You are free to refuse to answer questions or withdraw from the research project anytime. After the interview, if you still have concerns, the researcher is willing to listen and answer your questions.	or programs to care for women after pregnancy termination without medical indication in order to enable these women to effectively cope with pregnancy termination with strength.

The researcher has summarized practice guidelines for situations that may occur during the research project as shown in **Framework 7**.

Framework 7 Situations that may occur during the research project

Situation	Practice Guideline
You withdraw consent during the research project.	You can notify the researcher that you wish to withdraw from the research project anytime.
During data collection, you have or change the topic	The researcher will stop the conversation discomfort, concerns, or stress.
During the conversation, you feel very terrible and need special care from psychology experts or counselling from psychiatrists.	Under the guidance of the research advisor, the researcher will assess and coordinate with the experts to provide you with immediate assistance if emergency arises.

Your data related to this research project will be kept confidential. Your name will not be shown in the demographic data form. Any materials, documents, or transcripts of the conversation will be kept confidential and will be disclosed only to the research advisor. The researcher will delete your name immediately after the completion of the interview. Some excerpts from your stories will be used, but your name or identity that can lead to knowing who you are will not be revealed. Your name will not be mentioned in any publication or presentation of the research results in any academic journal or conference. However, the Research Ethics Committee who authorizes and supervises the

research will have access to your data in order to evaluate the research data and the research processes. You have a lawful right to access your personal data. If you need to exercise this right, please notify the researcher. The benefits from this research will comply with the regulations of Chiang Mai University.

The researcher will give you 100 baht for each interview as a token of appreciation.

If you have any concerns or symptoms before or during the participation in this research project, please contact the persons in **Framework 8.**

Framework 8 Contact persons for further information

1. Mrs. Paradee Prasertwong (Researcher)	119/46 Village No.4 Saimool Sub-district, Ongkarak District, Nakhon Nayok Province 26120 Telephone: 086-6037546
2. Assoc. Prof. Dr. Kasara Sripichayakan (Advisor)	Faculty of Nursing, Chiang Mai University Telephone: 053-949093 (Office hours)
3. Research Ethics Committee	Faculty of Nursing, Chiang Mai University Telephone: 053-936080 (Office hours) or Fax: 053-894170

(Thai Version)

เอกสารข้อมูลสำหรับอาสาสมัครโครงการวิจัย

ผู้วิจัยขอเชิญท่านเข้าร่วมโครงการวิจัย **เรื่อง "การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย"**

ชื่อนักวิจัย นางภารดี ประเสริฐวงษ์ นักศึกษาปริญญาเอก สาขาการพยาบาลศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่

อาจารย์ที่ปรึกษา รองศาสตราจารย์ ดร. เกสรา ศรีพิชญาการ

คุณสมบัติผู้เข้าร่วมโครงการวิจัย

ท่านได้รับเชิญให้เข้าร่วมโครงการวิจัยนี้เนื่องจากท่านมีคุณสมบัติตามเกณฑ์ดังต่อไปนี้ คือ เป็นสตรีไทยที่มีอายุ 20-44 ปี อาศัยอยู่ในจังหวัดนครนายก และมีประสบการณ์การยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์ สามารถติดต่อสื่อสารด้วยภาษาไทย โครงการวิจัยนี้จะคัดเลือกผู้ที่เหมาะสมเข้าร่วมการศึกษาจำนวน 12 คน จากการประกาศเชิญชวนในที่สาธารณะ และจากโรงพยาบาลศูนย์การแพทย์สมเด็จพระเทพรัตนราชสุดาฯ สยามบรมราชกุมารี จังหวัดนครนายก โรงพยาบาลชุมชน และโรงพยาบาลส่งเสริมสุขภาพในจังหวัดนครนายก ให้เข้าร่วมในโครงการวิจัยครั้งนี้

ก่อนที่ท่านจะตัดสินใจว่าจะเข้าร่วมโครงการวิจัยนี้หรือไม่ โปรดใช้เวลาในการอ่านเอกสารฉบับนี้ ซึ่งจะช่วยให้ท่านเข้าใจสิ่งต่าง ๆที่ท่านจะมีส่วนร่วมในโครงการ และหากมีข้อสงสัยโปรดซักถามผู้วิจัย หรือนำไปปรึกษาผู้ใกล้ชิด ผู้วิจัยขอเน้นว่าการตัดสินใจเข้าร่วมโครงการวิจัยนี้ขึ้นอยู่กับความสมัครใจของท่าน และไม่ว่าท่านจะเข้าร่วมการศึกษาหรือไม่ก็ตาม จะไม่มีผลกระทบต่อท่านแต่อย่างใด ท่านสามารถปฏิเสธการเข้าร่วมโครงการวิจัยนี้ได้หรือท่านสามารถถอนตัว (ถอนความยินยอม) จากโครงการนี้เมื่อใดก็ได้ ซึ่งรายละเอียดการสมัครใจและการถอนตัวมีดังนี้

กรอบที่ 1 การเข้าร่วมโครงการวิจัยนี้ขึ้นอยู่กับความสมัครใจของท่าน

- ท่าน**สามารถปฏิเสธ**การเข้าร่วมโครงการวิจัยนี้ได้

การเข้าร่วมโครงการวิจัยในครั้งนี้เป็นไปโดยความสมัครใจของท่าน และขึ้นอยู่กับการตัดสินใจของท่าน ท่านสามารถปฏิเสธการเข้าร่วมโครงการวิจัยนี้ได้ หากท่านไม่เข้าร่วมการวิจัยจะไม่มีผลกระทบใด ๆ ต่อท่าน

- ท่าน**สามารถถอนตัว (ถอนความยินยอม)** จากโครงการนี้เมื่อใดก็ได้

หากท่านเข้าร่วมการวิจัยแล้ว ท่านมีสิทธิที่ท่านสามารถถอนตัว (ถอนความยินยอม) ออกจากการวิจัยได้ทุกเวลาโดยไม่จำเป็นต้องบอกเหตุผล และจะไม่เกิดผลเสียใด ๆต่อท่าน ท่านสามารถที่จะปฏิเสธไม่ตอบคำถามได้หากท่านไม่สะดวกใจที่จะตอบคำถามนั้น ๆ

หากท่าน**ยินยอม**เข้าร่วมการวิจัย ผู้วิจัยจะให้ท่านกล่าวยินยอมด้วยวาจาในการเข้าร่วมในการวิจัยโดยไม่ต้องลงชื่อไว้ เพื่อเป็นการปกปิดความลับของท่าน

กรอบที่ 2 ทางเลือกสำหรับแนวทางการรักษาในกรณีที่ท่านไม่เข้าร่วมโครงการวิจัยนี้ (ถ้ามี)

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ข้อมูลที่เกี่ยวข้องกับการศึกษา ***สามารถสรุปหลักการและเหตุผลที่มาของการวิจัย***ดังนี้

การยุติการตั้งครรภ์เป็นปัญหาที่น่าวิตกกังวลในระดับโลก ทั้งประเทศที่พัฒนาแล้วและกำลังพัฒนา โดยเฉพาะอย่างยิ่งประเทศไทย ซึ่งสตรีที่ยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์จะต้องเผชิญกับปัญหาภาวะแทรกซ้อนที่รุนแรงทั้งด้านร่างกาย จิตใจ และเศรษฐกิจ เนื่องจากเหตุผลทางวัฒนธรรม ศาสนา และกฎหมายไทยที่ส่งผลให้สตรีกลุ่มนี้ไม่ได้รับการยอมรับในสังคม พวกเขาต้องปกปิดเป็นความลับเพียงลำพังและเป็นตราบาปในใจ การวิจัยครั้งนี้เป็นศึกษาวิจัยเชิงคุณภาพแบบสตรีนิยม เพื่ออธิบายข้อมูลเชิงลึกเกี่ยวกับการเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย อันจะเป็นข้อมูลพื้นฐานสำคัญในการพัฒนารูปแบบการให้คำปรึกษาหรือโปรแกรมการดูแลสตรีภายหลังการยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์ เพื่อช่วยสตรีให้สามารถเผชิญปัญหาการยุติการตั้งครรภ์ได้อย่างเข้มแข็งและมีประสิทธิภาพต่อไป

กรอบที่ 3 ผลไม่พึงประสงค์ที่อาจเกิดขึ้นได้จากการวิจัย

- จากการศึกษาครั้งนี้ ในการสัมภาษณ์คำถามบางคำถามอาจจะทำให้ท่านเกิดความรู้สึกลำบากใจ อึดอัดใจ วิตกกังวลใจ หรือเกิดภาวะเครียดที่จะต้องพูดถึงความรู้สึกส่วนตัวของท่านเกี่ยวกับสิ่งนั้น ผู้วิจัยจะคำนึงถึงความปลอดภัยของท่านเป็นสำคัญ และท่านสามารถพักหรือยุติการให้สัมภาษณ์ได้

โครงการวิจัยนี้มี**วัตถุประสงค์** เพื่อ เข้าใจการเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย

กรอบที่ 4 รูปแบบการวิจัย

รูปแบบการวิจัยครั้งนี้เป็น *การวิจัยเชิงคุณภาพแบบสตรีนิยม* เก็บข้อมูลโดยวิธีการสัมภาษณ์เชิงลึก และการวิเคราะห์ข้อมูลจะใช้การวิเคราะห์ข้อมูลตามกระบวนการการวิเคราะห์เรื่องเล่า

การศึกษานี้ใช้**ระยะเวลา**ในการสัมภาษณ์จะทำให้เสร็จประมาณ 1 เดือน หากท่านตัดสินใจเข้าร่วมโครงการนี้ ผู้วิจัยขอให้ท่านปฏิบัติตามตารางการศึกษา (ดู กรอบที่ 5)

กรอบที่ 5 ตารางการศึกษา

1. ผู้วิจัยขอสัมภาษณ์ข้อมูลส่วนตัว ประกอบด้วย ข้อมูลส่วนบุคคล ได้แก่ อายุ เชื้อชาติ ระดับการศึกษา อาชีพ รายได้ สถานภาพสมรส จำนวนสมาชิกในครอบครัว ประวัติปัญหาสุขภาพหรือการเจ็บป่วย จำนวนครั้งของการตั้งครรภ์และการคลอด และระยะเวลาที่ได้ยุติการตั้งครรภ์จนถึงปัจจุบัน

2. ให้สัมภาษณ์ด้วยการเล่าเรื่องเกี่ยวกับการยุติการตั้งครรภ์ ความรู้สึกอย่างไรเกี่ยวกับการยุติการตั้งครรภ์ อะไรที่ทำให้ท่านสามารถเผชิญปัญหาภายหลังยุติการตั้งครรภ์ได้ และการช่วยเหลืออะไรที่ท่านได้รับและคาดหวัง

ในการที่ช่วยให้ท่านผ่านประสบการณ์หลังจากการยุติการตั้งครรภ์ ขณะเล่ามีการบันทึกเทป สถานที่มีความมิดชิด มีเป็นส่วนตัวที่มีเพียงผู้วิจัยกับท่านเท่านั้น และยึดตามความสะดวกของท่าน เช่น ที่บ้านท่าน หรือบ้านญาติท่าน ขณะสัมภาษณ์ทุกครั้งจะไม่มีการระบุชื่อความเป็นตัวตนของท่าน ผู้วิจัยมีการระมัดระวังในการสัมภาษณ์ โดยไม่กล่าวชื่อของท่าน แต่จะใช้สรรพนาม “คุณ” แทนชื่อของท่าน

3. ท่านจะได้รับการสัมภาษณ์อย่างน้อย 2 ครั้ง แต่ไม่เกิน 4 ครั้ง ทั้งนี้ขึ้นอยู่กับความสะดวกของท่าน แต่ละครั้งใช้เวลาประมาณ 60-90 นาที การสัมภาษณ์จะทำให้เสร็จภายใน 1 เดือน

4. ประสบการณ์ของท่านที่บันทึกในวัสดุหรือเอกสารต่าง ๆสามารถนำมาเล่าให้ผู้วิจัยฟังได้ เช่น สมุดบันทึก คำกลอน รูปวาด ภาพถ่าย งานฝีมือ เป็นต้น ผู้วิจัยขออนุญาตศึกษาจากสิ่งเหล่านี้ ผู้วิจัยจะส่งกลับคืนให้ท่าน ภายหลังที่ได้บันทึกข้อมูลเสร็จสิ้น

ผู้วิจัยได้สรุปความเสี่ยงและประโยชน์จากการเข้าร่วมโครงการวิจัยนี้ไว้ใน **กรอบที่ 6**

กรอบที่ 6 ความเสี่ยงและประโยชน์ที่จะคาดว่าจะได้รับจากการเข้าร่วมโครงการวิจัยนี้

ความเสี่ยงและวิธีการลดหรือหลีกเลี่ยงความเสี่ยง	ประโยชน์
- ความเสี่ยง การเข้าร่วมวิจัยผู้วิจัยจะคำนึงถึงความปลอดภัยของท่านเป็นสำคัญ ความเสี่ยงที่จะเกิดขึ้นจากการศึกษาครั้งนี้คือ คำถามบางคำถามอาจจะทำให้ท่านเกิดความรู้สึกลำบากใจ อึดอัดใจ วิตกกังวลใจ หรือเกิดภาวะเครียดที่จะต้องพูดถึงความรู้สึกส่วนตัวของท่านเกี่ยวกับสิ่งนั้น **-วิธีการลดหรือหลีกเลี่ยงความเสี่ยง** ถ้าความรู้สึกเหล่านี้เกิดขึ้น ท่านสามารถพักหรือยุติการให้สัมภาษณ์ในเรื่องดังกล่าว หรือเปลี่ยนเรื่องการสัมภาษณ์ได้ ท่านมีอิสระเต็มที่ในการไม่ตอบคำถามหรือถอนตัวออกจากการวิจัยครั้งนี้ได้ทุกเวลา ภายหลังการสัมภาษณ์หากท่านยังรู้สึกไม่สบายใจ ผู้วิจัยยินดีรับฟังและตอบข้อสงสัย	**- ประโยชน์ทางตรง/ทางอ้อม** 1. การเปิดเผยประสบการณ์ชีวิตของท่านอาจจะทำให้เกิดความรู้สึกอับอาย อึดอัดใจ แต่การได้เล่าเรื่องราวต่าง ๆจะช่วยให้ได้ระบายความรู้สึก ซึ่งจะช่วยให้ท่านสบายใจได้เร็วขึ้น รวมทั้งได้มีโอกาสแสดงความคิดเห็นที่มีต่อการเผชิญปัญหาการยุติการตั้งครรภ์ 2. การวิจัยครั้งนี้เป็นศึกษาวิจัยเชิงคุณภาพแบบสตรีนิยม เพื่อศึกษาข้อมูลเชิงลึกเกี่ยวกับการเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย ซึ่งเป็นข้อมูลพื้นฐานสำคัญในการพัฒนารูปแบบการให้คำปรึกษาหรือ โปรแกรมการดูแลสตรีภายหลังการยุติการตั้งครรภ์ที่ไม่มีข้อบ่งชี้ทางการแพทย์ เพื่อช่วยเหลือสตรีให้สามารถเผชิญปัญหาการยุติการตั้งครรภ์ได้อย่างเข้มแข็งและมีประสิทธิภาพต่อไป

ผู้วิจัยสรุปแนวทางการปฏิบัติหรือการดูแลต่อสถานการณ์ต่าง ๆที่อาจเกิดขึ้นระหว่างการศึกษาไว้ใน**กรอบที่ 7**

กรอบที่ 7 สถานการณ์ที่อาจเกิดขึ้นระหว่างการศึกษา

สถานการณ์	แนวทางการปฏิบัติ
หากท่านถอนความยินยอมระหว่างการศึกษา	ท่านสามารถแจ้งผู้วิจัยเพื่อขอถอนตัวออกจากการวิจัยครั้งนี้ได้ทุกเวลา
ขณะเก็บข้อมูลหากท่านมีความรู้สึกวิตกกังวลใจ เครียด หรือรู้สึกไม่สบายใจ	ผู้วิจัยจะหยุดการสนทนาหรือเปลี่ยนเรื่องการสนทนาในเรื่องดังกล่าว
หากท่านมีอารมณ์หรือความรู้สึกที่แย่มาก ๆ ในขณะสนทนาที่จะต้องได้รับการดูแลอย่างใกล้ชิดเป็นพิเศษจากผู้เชี่ยวชาญทางด้านจิตวิทยาและการให้คำปรึกษาหรือจิตแพทย์	ผู้วิจัยจะเป็นผู้ประเมินและประสานให้ผู้เชี่ยวชาญได้เข้ามาดูแลท่านทันทีเมื่อมีเหตุฉุกเฉินหรือมีความจำเป็นภายใต้การให้คำปรึกษาจากอาจารย์ที่ปรึกษา

ข้อมูลของท่านที่เกี่ยวข้องกับการศึกษาจะถูกเก็บเป็นความลับ โดยชื่อของท่านจะไม่ปรากฏอยู่ในแบบบันทึกข้อมูลส่วนตัว รวมทั้ง วัสดุ เอกสาร และเทปบันทึกเสียงการพูดคุยสนทนาเพื่อนำไปถอดเทปเป็นข้อความเอาไว้จะถูกเก็บเป็นความลับ ซึ่งจะเปิดเผยเฉพาะอาจารย์ที่ปรึกษาเท่านั้น และผู้วิจัยจะทำการลบชื่อในเทปเสียงออกทันทีที่สัมภาษณ์เสร็จ จะมีการยกคำพูดจากการสัมภาษณ์ของท่านบางประโยคไปอ้างถึง โดยไม่เปิดเผยชื่อหรือลักษณะส่วนบุคคลที่จะนำไปสู่การรู้จักท่าน เมื่อมีการนำข้อมูลไปอภิปรายพิมพ์เผยแพร่หรือการนำเสนอผลของการศึกษาในที่ประชุมหรือวารสารวิชาการจะไม่มีการระบุชื่อของท่าน อย่างไรก็ตามคณะกรรมการจริยธรรม ผู้มีอำนาจในการกำกับดูแลการวิจัยจะสามารถเข้าดูข้อมูลของท่านได้ เพื่อตรวจสอบข้อมูลและขั้นตอนการวิจัย ท่านมีสิทธิตามกฎหมายที่จะขอดูข้อมูลส่วนตัวของท่าน หากท่านต้องการใช้สิทธิดังกล่าว กรุณาแจ้งให้ผู้วิจัยได้ทราบ และสิทธิประโยชน์อันเกิดจากผลการศึกษาให้เป็นไปตามระเบียบข้อบังคับของมหาวิทยาลัยเชียงใหม่

ผู้วิจัยจะมอบค่าตอบแทนให้ท่านในการสัมภาษณ์แต่ละครั้ง จำนวนท่านละ 100 บาท/ครั้ง เพื่อแสดงความขอบคุณ

หากท่านมีข้อสงสัยหรือมีอาการข้างเคียงเกิดขึ้นก่อนหรือระหว่างเข้าร่วมการศึกษา ท่านสามารถสอบถามได้ที่บุคคลใน**กรอบที่ 8**

กรอบที่ 8 บุคคลที่ท่านสามารถติดต่อเพื่อสอบถามรายละเอียดเพิ่มเติม	
1. นางภารดี ประเสริฐวงษ์ (นักวิจัย)	บ้านเลขที่119/46 ม.4 ต.ทรายมูล อ.องครักษ์ จ.นครนายก 26120 โทรศัพท์ 086-6037546
2. รศ.ดร. เกสรา ศรีพิชญาการ (อาจารย์ที่ปรึกษา)	คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่ โทรศัพท์ 053-949093 (ในเวลาราชการ)
3. คณะกรรมการจริยธรรมการวิจัย	คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่ โทรศัพท์ 053-936080 (เวลาราชการ) หรือ โทรสาร 053-894170

APPENDIX D

Oral Consent Form

(English Version)

Consent to Participate in Research Project Form

(Confidential document to be used by researcher and witness only)

Research informant…….……is willing to participate in the research project titled "Coping with Pregnancy Termination among Thai Women" and has given oral consent on Date…..Month…….Year…… at (time)……. at (place)……

Signed……..…… (Researcher)

(……..)

Signed ……..….(Witness)

(……..……)

Position/relationship with informant

……

Date……Month…….……Year……..…….....

(Thai Version)

เอกสารแสดงความยินยอมเข้าร่วมโครงการวิจัย

(เอกสารปกปิดเฉพาะผู้วิจัยและพยาน)

ผู้เข้าร่วมวิจัย……ยินดีเข้าร่วมโครงการวิจัย เรื่อง “การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย” โดยได้กล่าวคำยินยอมด้วยวาจา เมื่อ วันที่…… เดือน……..……พ.ศ…… เวลา……...น. ณ……

ลงนาม……...…(ผู้วิจัย)

(……..)

ลงนาม……...…(พยาน)

(……)

ตำแหน่ง/ความสัมพันธ์กับผู้ให้ข้อมูล

……

วันที่……เดือน……พ.ศ……..

APPENDIX E

An Interview Guide

แนวทางการสัมภาษณ์

1. กรุณาเล่าเรื่องเกี่ยวกับการยุติการตั้งครรภ์
2. คุณรู้สึกอย่างไรเกี่ยวกับการยุติการตั้งครรภ?
3. คุณทำอะไรเพื่อให้ผ่านประสบการณ์หลังการยุติการตั้งครรภ์?
4. การสนับสนุนช่วยเหลืออะไรที่คุณได้รับและคาดหวังว่าจะได้รับเพื่อให้ผ่านประสบการณ์การยุติการตั้งครรภ์ไปได้?

APPENDIX F

Demographic Data Form

(English Version)

Demographic Data Form

Coping with Pregnancy Termination Among Thai Women

Part 1: Personal Information

1. Age……years.
2. Nationality [ ] Thai [ ] Chinese [ ] Others, specify.....
3. Religion [ ] Buddhism [ ] Christian [ ] Islam [ ] Others, specify.....
4. Education……
5. Occupation [ ] Unemployed [ ] Employed, specify..... [ ] Student
6. Personal Income.....(Bath/Month) [ ] Inadequacy [ ] Adequacy
7. Marital Status [ ] Couple [ ] Single [ ] Window [ ] Divorce [ ] Separate
8. Marital number.....
9. Number of family member.....
10. Number of children.....persons Male.....persons Female.....persons
11. Illness history [ ] No [ ] Yes, describe…….

Part 2: Data of Pregnancy termination

1. Number of pregnancy termination.....Gravida.....GA.....weeks
2. Years of pregnancy termination experience.....years
3. Reasons of pregnancy termination.....
4. Factors related to the decision making of pregnancy termination.....
5. Methods of pregnancy termination.....
6. Complications after pregnancy termination.....
7. The effects of pregnancy termination.....
8. Supports of women after pregnancy termination.....

(Thai Version)

แบบบันทึกข้อมูลส่วนบุคคล
การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย

ส่วนที่ 1 ข้อมูลส่วนบุคคล

1. อายุ.....ปี
2. เชื้อชาติ [ ] ไทย [ ] จีน [ ] อื่น ๆ ระบุ.....
3. ศาสนา [ ] พุทธ [ ] คริสต์ [ ] อิสลาม [ ] อื่นๆ ระบุ.....
4. ระดับการศึกษา.....
5. อาชีพ [ ] ไม่ได้ทำงาน [ ] ทำงาน ระบุอาชีพ.....[ ] นักเรียน/นักศึกษา
6. รายได้เฉลี่ยต่อเดือน.....บาท [ ] ไม่พอใช้ [ ] พอใช้
7. สถานภาพสมรส [ ] คู่ [ ] โสด [ ] หม้าย [ ] หย่า [ ] แยกกันอยู่
8. จำนวนครั้งของการแต่งงาน.....ครั้ง
9. จำนวนสมาชิกทั้งหมดในครอบครัว.....คน
10. จำนวนบุตรที่มีในปัจจุบัน.....คน เพศหญิง.....คน เพศชาย.....คน
11. การเจ็บป่วยในอดีต [ ] ไม่มี [ ] มี ระบุ……...

ส่วนที่ 2 ข้อมูลการยุติการตั้งครรภ์

1. จำนวนครั้งของการยุติการตั้งครรภ์……ครรภ์ที่……อายุครรภ์……สัปดาห์
2. ระยะเวลาที่มีประสบการณ์ยุติการตั้งครรภ์ ……..ปี
3. เหตุผลที่ยุติการตั้งครรภ์……
4. ปัจจัยที่เกี่ยวข้องในการตัดสินใจยุติการตั้งครรภ์……
5. วิธีการยุติการตั้งครรภ์……
6. ภาวะแทรกซ้อน……
7. ผลกระทบจากการยุติการตั้งครรภ์……
8. การช่วยเหลือที่ได้รับ……

APPENDIX G

Ethical Approval

(English Version)

Research Ethics Office
Faculty of Nursing, Chiang Mai University

AF 04-021

No. 012/2017

Certificate of Approval

Name of Committee : Research Ethics Committee, Faculty of Nursing, Chiang Mai University **Address of Committee :** 110 Intavaroros Rd., Amphoe Muang, Chiang Mai, Thailand 50200
Principal Investigator : Mrs. Paradee Prasertwong Doctoral Program Faculty of Nursing Chiang Mai University
Protocol title : Coping with Pregnancy Termination Among Thai Women **Research ID: 100 – 2016 ; Study Code : FULL – 039 - 2016** **Sponsor :** -

Documents filed	Document reference
Research protocol	Version 4 Date January 23, 2017
Informed consent documents	Version 3 Date December 23, 2016
Patient information sheet	Version 3 Date December 23, 2016
Instrument	Version 1 Date September 26, 2016
Principal Investigator Curriculum vitae	Version 1 Date September 26, 2016
Advertisements : (if any)	Version 3 Date December 23, 2016
Other	-

Opinion of the Ethics Committee/Institutional Review Board : Full Board Review time 11/2559 on December 26, 2016

The Ethics Committee has reviewed the protocol and documents above and give the favorable opinion

Date of Approval : January 24, 2017 **Expiration Date :** January 23, 2018

Form version 03.1 August 15, 2016

หน้า 1 ของ 2 หน้า

Progress report is required to be submitted to the Ethics Committee for continuing review

[ ] at 3 month interval
[ ] at 6 month interval
[✓] annually (in this case please submit at least 60 days prior to expiration date)

This Ethics Committee is organized and operates according to GCPs and relevant international ethical guidelines, the applicable laws and regulations.

Signed : Wichit Srisuphan

(Professor Emerita Dr.Wichit Srisuphan)

Chairperson, Faculty of Nursing, Chiang Mai University

Signed :

(Professor Dr.Wipada Kunaviktikul)

Dean, Faculty of Nursing, Chiang Mai University

GENERAL CONDITION OF APPROVAL:

1. Research Ethics Committee approval is required before implementing any changes in the consent documents or protocol unless those changes are required urgently for the safety of subjects.
2. Any event or new information that may affect the benefit/risk ratio of the study must be reported to the REC promptly.
3. Any protocol deviation/violation must be reported to the REC.
4. Review of close study report is required to be submitted to the REC.
5. Review of progress report to the REC before expiration date at 2 months.

(Thai Version)

สำนักงานจริยธรรมการวิจัย
คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่

AF 04-021

เอกสารเลขที่ **012/2017**

เอกสารรับรองโครงการวิจัย

ชื่อคณะกรรมการ : คณะกรรมการจริยธรรมการวิจัย คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่
ที่อยู่ : เลขที่ 110 ถนนอินทวโรรส ตำบลศรีภูมิ อำเภอเมือง จังหวัดเชียงใหม่ 50200
ชื่อเรื่องโครงการวิจัยเพื่อวิทยานิพนธ์ (ภาษาไทย) การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย
(ภาษาอังกฤษ) Coping with Pregnancy Termination Among Thai Women
เลขที่โครงการ : 100 - 2559 ; รหัสโครงการ : FULL – 039 – 2559
ชื่อหัวหน้าโครงการวิจัยเพื่อวิทยานิพนธ์ : นางภารดี ประเสริฐวงษ์
สาขาวิชา : พยาบาลศาสตร์ (หลักสูตรนานาชาติ)
สังกัด : คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่
ผู้ให้ทุนวิจัย : (ถ้ามี).....

เอกสารที่รับรอง	ฉบับที่รับรอง
โครงการวิจัย	ฉบับที่ 4 วันที่ 23 มกราคม 2560
เอกสารคำชี้แจงข้อมูลสำหรับอาสาสมัคร	ฉบับที่ 3 วันที่ 23 ธันวาคม 2559
เอกสารแสดงความยินยอมของผู้เข้าร่วมโครงการวิจัย	ฉบับที่ 3 วันที่ 23 ธันวาคม 2559
เครื่องมือวิจัย	ฉบับที่ 1 วันที่ 26 กันยายน 2559
อัตตประวัติหัวหน้าโครงการ	ฉบับที่ 1 วันที่ 26 กันยายน 2559
เอกสารประชาสัมพันธ์	ฉบับที่ 3 วันที่ 23 ธันวาคม 2559

กระบวนการพิจารณาโครงการวิจัย : กระบวนการทบทวนแบบในที่ประชุม (Full Board Review) ครั้งที่ 11/2559 วันที่ 26 เดือนธันวาคม พ.ศ. 2559

ผลการพิจารณา : คณะกรรมการจริยธรรมการวิจัย ได้พิจารณาแล้ว มีมติเห็นชอบให้ดำเนินการวิจัยในขอบเขตที่เสนอได้

อนุมัติ ณ วันที่ 24 เดือน มกราคม พ.ศ. 2560 มีผลถึงวันที่ 23 เดือน มกราคม พ.ศ. 2561

กำหนดส่งรายงานความก้าวหน้าของการวิจัย

[ ] ทุก 3 เดือน
[ ] ทุก 6 เดือน
[✓] ทุกปี (ในกรณีนี้โปรดยื่นอย่างน้อย 60 วัน ก่อนวันหมดอายุใบรับรอง)

คณะกรรมการฯ ชุดนี้จัดตั้งและดำเนินการตาม GCPs และแนวทางจริยธรรมสากล กฎหมายและข้อบังคับที่เกี่ยวข้อง

ลงชื่อ :
(ศาสตราจารย์เกียรติคุณ ดร.วิจิตร ศรีสุพรรณ)
ประธานคณะกรรมการจริยธรรมการวิจัย
คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่

ลงชื่อ :
(ศาสตราจารย์ ดร.วิภาดา คุณาวิกติกุล)
คณบดีคณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่

การปฏิบัติหลังจากรับรอง

1. หากจะแก้ไขเปลี่ยนแปลงในข้อมูลสำหรับผู้ป่วย/อาสาสมัคร หรือเอกสารยินยอมหรือโครงการวิจัย ต้องขออนุมัติก่อนเว้นแต่ว่าเป็นเรื่องเร่งด่วนเพื่อสวัสดิภาพของอาสาสมัคร
2. หากมีข้อมูลใหม่หรือเหตุการณ์ใด ๆ ที่อาจมีผลต่ออัตราส่วนระหว่างผลประโยชน์/ความเสี่ยงของการศึกษาวิจัย ให้รายงานต่อคณะกรรมการจริยธรรมการวิจัยโดยรีบด่วน
3. การเบี่ยงเบน/ฝ่าฝืนโครงการวิจัย ต้องแจ้งคณะกรรมการจริยธรรมการวิจัยทุกครั้ง
4. ขอส่งรายงานผลการวิจัยเมื่อสิ้นสุดโครงการ
5. หากใกล้ระยะสิ้นสุดการอนุมัติแล้ว แต่ผู้วิจัยยังดำเนินการไม่แล้วเสร็จ กรุณาส่งรายงานความก้าวหน้าโครงการวิจัย พร้อมบันทึกขอขยายเวลา โดยระบุเหตุผลความจำเป็นในการขยายเวลา พร้อมทั้งระยะเวลาที่ขอขยาย ทั้งนี้จะต้องดำเนินการก่อนที่จะสิ้นสุดระยะเวลาการอนุมัติตามที่ระบุในเอกสารรับรองอย่างน้อย 2 เดือน

บันทึกข้อความ

ส่วนงาน สำนักงานจริยธรรมการวิจัย คณะพยาบาลศาสตร์ โทร. 36080

ที่ ศธ.6593(7.15.2) / จธ. 665 **วันที่** 29 ธ.ค. 2560

เรื่อง การรายงานความก้าวหน้าและขอต่ออายุการรับรองโครงการวิจัย

เรียน นางการดี ประเสริฐวงษ์

ตามที่ **ท่าน** ได้เสนอรายงานความก้าวหน้าและขอต่ออายุการรับรองโครงการวิจัย เพื่อดุษฎีนิพนธ์ เรื่อง การเผชิญปัญหาการยุติการตั้งครรภ์ของสตรีไทย (Coping with Pregnancy Termination Among Thai Women) Study Code: FULL039-2559 รายละเอียดบันทึกข้อความ ศธ.6593 (7.15.2)/ ข. 657 ลงวันที่ 1 ธันวาคม 2560 ดังความแจ้งแล้ว นั้น

คณะกรรมการจริยธรรมการวิจัย คณะพยาบาลศาสตร์ ได้พิจารณารายงานฯ ดังกล่าว ในที่ประชุม สามัญครั้งที่ 10/2560 วันที่ 29 ธันวาคม 2560 มีมติดังนี้

1. รับทราบรายงานความก้าวหน้าโครงการวิจัย ครั้งที่ 1 ช่วงวันที่ 24 เดือนมกราคม พ.ศ. 2560 ถึงวันที่ 23 เดือนมกราคม พ.ศ. 2561

2. เห็นชอบให้ดำเนินการวิจัยต่อไปได้อีก 12 เดือน ทั้งนี้ตั้งแต่วันที่ 24 เดือนมกราคม พ.ศ.2561 ถึงวันที่ 23 เดือนมกราคม พ.ศ. 2562

จึงเรียนมาเพื่อทราบ

(ศาสตราจารย์เกียรติคุณ ดร.วิจิตร ศรีสุพรรณ)
ประธานคณะกรรมการจริยธรรมการวิจัย
คณะพยาบาลศาสตร์ มหาวิทยาลัยเชียงใหม่

APPENDIX H

Reflexive Journal (Example)

(English Version)

March 12, 2017, P2, 1st Post-interview, 1st Post-interview, 03.30-04.39 p.m.

A woman has been interviewed about her pregnancy termination. She cried a lot because it was a late pregnancy, not just only a few months. This might be a factor for her to have an excessive guilt. During the interview, she often blamed herself as if this was a stigma, marked in her life till the day she dies. Nothing can erase it. I was thinking that it seemed somehow difficult to raise the topic of Consciousness Raising since the guilty feeling is deeply rooted in her mind. However, I then felt so sad with life, sympathy and empathy at the same time. I didn't cry along with her, but tried to focus and stay calm, paying attention to her story. I needed to find out the ways to continue the interview. Moreover, I need to gain some information on the support issue. Somehow, I needed to find the way to get this information from her.

The interviewee seemed not to want any help from anyone. "I stand by my own feet, these days", that's how she said it. The interview will have to be continued in the future. Nevertheless, I gently smiled and felt impressed with how she answered some questions, with how she used her beautiful wordings. For example, she compared her feeling to a wound. I had to listen to the tape and record, "It's like a cut from a knife. Someday you look at the scare and you know where it comes from. It can't be erased, like you can't use an eraser, erasing a mark from a pen." When I get back to transcript the whole interview, I asked myself a question if I ever feel disgusted from these women, if they are so bad like how the society blamed them. The answer is 'no'. Is it because I need the research information from them? It is actually quite the opposite. The more I talk to them, the more I feel for them. I feel sympathy, and care and completely understand their situations that they all have their own reasons.

(Thai Version)

การบันทึกสะท้อนคิด (ตัวอย่าง)

12 มี.ค. 2560 P2 หลังการสัมภาษณ์ครั้งที่ 1 เวลา 15.30 น. ถึง 16.39 น.

ขณะสัมภาษณ์ผู้หญิงที่ยุติการตั้งครรภ์ เธอร้องไห้เยอะมากโดยเฉพาะ ตอนที่พูดถึงว่าสี่ห้าเดือนเป็นตัวแล้ว ไม่ใช่เดือนสองเดือน ตรงนี้คิดว่าน่าจะเป็นปัจจัยทำให้เค้าเกิดความรู้สึกผิดมากแน่ ๆ เลย เพราะตลอดการสัมภาษณ์ เธอมักจะพูดกล่าวโทษตัวเอง และบอกว่ามันเป็นตราบาป ฝังอยู่ในใจจนวันตาย ไม่มีอะไรมาลบล้างได้ คิดในใจว่า แล้วเราจะดึงประเด็น Consciousness Raising ออกมาได้ยังไงนะ ดูยากเหมือนกัน เพราะเธอมีความรู้สึกที่ฝังใจมาก แต่ในความคิดตอนนั้นก็รู้สึกว่าทำไมชีวิตมันดูเศร้าจังเลย รู้สึกเห็นใจและสงสาร แต่ไม่ได้ร้องไห้ตาม พยายามตั้งสติให้มั่น ใช้ความนิ่ง ตั้งใจฟังเค้าพูดอย่างมาก เพื่อที่ว่าจะได้หาแนวทางว่าจะถามหยั่งลึก ต่อไปอย่างไร รวมถึงประเด็น Support ซึ่งตัวเองคิดว่าจะถามเค้าอย่างไรให้ได้ข้อมูลนี้ประเด็นนี้ออกมา

เค้าพูดทำนองที่ไม่อยากได้ความช่วยเหลือจากใคร “ทุกวันนี้ก็ช่วยเหลือตัวเองก็พอแล้ว” ก็คงจะต้องไปสัมภาษณ์เพิ่มอีกในครั้งต่อไป ถ้าครั้งนี้ข้อมูลยังไม่ได้ แต่มีความรู้สึกแอบอมยิ้มคือชอบและประทับใจในการตอบคำถามที่ทำให้รู้สึกว่าคำพูดเค้าสวยงามจังเลย คือ การเปรียบเทียบความรู้สึกที่เกิดขึ้นเป็นแผลเป็นที่อยู่ในใจ เลยรีบเปิดเทปฟังและบันทึกไว้ “เหมือนมีดบาดมือ แล้วเป็นแผล วันดีคืนดีเราเหลือบไปเห็นแผลนั้น เราก็จะรู้ว่าแผลนี้มันเกิดจากอะไร หรือที่เค้าพูดว่ามันลบไม่ออกจากใจเหมือนเอายางลบดินสอไปลบปากกา” พอสัมภาษณ์เสร็จกลับมาถอดเทปทั้งหมด ได้กลับมาคิดทบทวนตั้งแต่การสัมภาษณ์คนแรกและตอนนี้คนที่สองแล้ว ถามตัวเองว่ารู้สึกรังเกียจหรือมองผู้หญิงที่ยุติการตั้งครรภ์เป็นคนไม่ดีเหมือนอย่างที่สังคมมองกันหรือเปล่า ซึ่งแปลกตรงที่ไม่มีความรู้สึกอย่างนั้นเลย จึงถามตัวเองต่อว่า เป็นเพราะเราได้ข้อมูลจากเค้าเพื่อให้งานวิจัยสำเร็จหรือเปล่า แต่ไม่มีความรู้สึกเช่นนั้น เพราะยิ่งสัมภาษณ์ไปหลาย ๆ ครั้งมันจะเป็นความรู้สึกที่เห็นใจ สงสาร และเข้าใจผู้หญิงที่ต้องยุติการตั้งครรภ์เพราะเค้ามีเหตุผลมีความจำเป็นจริง ๆ ที่ต้องทำมากกว่า

APPENDIX I

Data Analysis

The example of step 1: Initial coding

Meaningful narrates	Initial codes
"I felt I did something wrong to him/her (the baby). I didn't think that doing it would relieve me from burden. I felt guilty all the time. That day should have never happened to me. If it hadn't happened to me, my life wouldn't have become like this." (P1(1)/P12/L202-203)	Did something wrong Felt guilty
"I felt uncomfortable, too. It was like I did wrong, sinful things like that. It was sinful because it hurt someone." (P9(1)/P2/L29)	Did wrong Sinful
"If I did something bad and it remains in my heart, I will keep thinking that this is a stigma." *(P10(1)/P18/L336-337)*	Did something bad Stigma
"I think it's very sinful. That's why everything in my life has failed. It's the consequence of that deed, I think. That's why things have become like this, hardship." *(P1(1)/P4/L50-52)*	Sinful Failed Hardship

The example of step 2: Symbolic coding

Initial codes	Symbolic codes
Did something wrong	Wrongdoing of pregnancy termination
Did wrong	Wrongdoing of pregnancy termination
Did something bad	Wrongdoing of pregnancy termination
Felt guilty	Feeling guilty form wrongdoing
Sinful	Feeling sinful form wrongdoing
Stigma	Feeling stigmatized form wrongdoing
Failed	Feeling failed form wrongdoing
Hardship	Feeling hard form wrongdoing

The example of step 3: Categorizing and generating themes

Symbolic codes	Subthemes	Themes
Wrongdoing of pregnancy termination Wrongdoing of pregnancy termination Wrongdoing of pregnancy termination		Feeling suffering from wrongdoing
Feeling guilty form wrongdoing Feeling sinful form wrongdoing Feeling stigmatized form wrongdoing	The feelings of being wrong	
Feeling failed form wrongdoing Feeling hard form wrongdoing	The feelings of being failed in life	

Stories of Individual Participants

The experience of each participant is very important for understanding women in coping with pregnancy termination in her context. Stories of individual participants are described in terms of their feelings, coping methods, and support following their pregnancy termination. P and PT represent participant and pregnancy termination, respectively. The salience of each participant is described from their statements.

P1: 39 years old, married, PT=1 time about 13 years ago. . P1 is not ready to get pregnant due to economic problems. She already has two children. She has destroyed a life that was perceived as wrongdoing, as a result, she felt very sad expressing with a lot of tears and crying. Moreover, she felt that she was haunted by the dead baby. She had illusive pictures which causing her feel unhappy. *"He/She haunted me all the time."* (P1(1)/P16/L277) She accepts that it is a wrongdoing. *"I realize that I have done a mistake to him/her (the baby) ... I feel guilty all the time. I shouldn't have done it or been in that situation."* (P1(1)/P12/L202) She believes that she is sinful, and having a Karma which causes many obstacles and unsuccessfulness in her life. She uses Dharma as a spiritual anchor and as a lesson to move forward in life. She cannot undo the past. Her misconduct cannot be deleted. But what she can do is to do her best today. She has learned from the event and never thought about having a pregnancy termination again. *"...you have to move on. You can learn from the lesson and don't let it happen again."* (P1(1)/P21/L384) Nowadays, she is trying to do good deeds in order to make amends by going to the temple, praying and doing a meditation retreat so that she can send merit to her baby. *"I try to do good deeds, so that I can resolve my sin."* (P1(1)/P11/L187) She also tries not to be attached to the past and tries to pull herself up from the whirlpool of problems and lives her life. Life must be continued and she can maintain her daily life in a normal way. She has to be strong for her children. She has received support and care from her mother and her sister who always gives her advice. *"Lately I talked to my sister or my mother only when I had problems. They advised that I have to go on and keep fighting... They did not want to make me feel worse. ...It's like they gave me encouragement and told me to keep moving forward and continue fighting. If I didn't fight, how could my child live?"* (P1(1)/P18/L333-334) If health services are available,

she wants to talk to a psychiatrist who can also give advice and cares for her. She does not want to be blamed. A psychiatrist can help with the mental rehabilitation, encouraging her to move forward and not to be stuck in the past. She suggests that both men and women should altogether be responsible for unwanted pregnancy and pregnancy termination.

P2: 44 years old, divorce, PT=1 time about 26 years ago. P2 has family relationship's problem since she was a minor wife. She feels guilty for serious wrongdoing, which cannot be erased. *"After it was done...it was like I had done something wrong. The wrongest thing in my life."* (P2(1)/P8/L128) She believes that it is a sin. Morality cannot erase her sin. *"A baby was already formed," "...repent our sin,"* (P2(1)/P8/L130) *"This guilt will stay with me till I die,"* (P2(1)/P16) "As a woman, you have to love your child. You shouldn't kill your own child." She feels fear that the unfortunate Karma will cause physical impairment of her future baby. She has not received support or care from anybody. She is the only person comforting herself. She has prayed and confessed her sin, according to Christianity belief. But she thinks she just deceives herself into feeling relieved and uplifted. She uses work to forget about the past. She watches talk show on TV or listen to music and try to avoid news about abortion or pregnancy termination. Her point of view of this issue is that it is unfair for blaming women. Both men and women should be guilty. If it is possible, there should be some mental care that can motivate and strengthen her mind. *"There should be a mental health care… skilled obstetric practitioners."* (P2(2)/P15-16) There should be an anonymous abortion clinic. In addition, one must receive comfort from a family, motivating and teaching the lesson in the same time.

P3: 44 years old, married, PT=1 time about 10 years ago. P3 has once terminated an eight-week pregnancy due to an economic problem. She already has one child so she is not ready for the pregnancy. She accepts her pregnancy termination that is wrongdoing *"I make mistake by having abortion."* (P3(2)/P14/L245) Then, she feels really sad, guilty, and sinful that she has obstructed the birth of her baby, and she had the feelings of being haunted by the dead baby. *"I feel that the baby touches me and feels me. I don't want to talk about this with anyone. They must think that I'm crazy," "I heard a noise calling,*

mommy mommy wake up…if it was a dream or a ghost." Her way of solving the problem is by doing good deeds, making merit and meditating so that she can send a lot of merit to her baby. The baby then can reborn in another life. She believes in the faith of Buddhism and the teachings of the Lord Buddha. This comforts her and calms her mind, and then she can continue her normal daily life. She wished to complete her meditation retreat, cultivate her spiritual mind and reach self-enlightenment. For her mentally higher self, she will close the doorway to hell and stop the fiend, including the abortion sin. She uses the Lord Buddha and Angulimala story as an example to be in the present, to breathe and to be able to step pass this sinful feeling. After the pregnancy termination, she did not receive any help, not even from the husband. *"I don't want help from anybody. Just don't blamed me,"* She did not tell her family because she does not want to worry them. All she wants is support and encouragement, and someone who understand and does not give the blame. Everybody has his or her own reasons.

P4: 28 years old, married, PT=1 time about 10 years ago. P4 got pregnant when she was in grade 12. She perceives that abortion is wrongdoing. *"Women who undergo abortion hide it because they don't want anyone to know about their mistakes. I think it is not good. No one would want to have an abortion. It's true that the woman is the one who kills the baby but other people do not know her reasons. But people label the person who has an abortion as bad, or something like that."* (P4(1)/P10/L172-174) Her mother took care of everything, bringing her healthy food and even burying the dead baby. *"Mom and aunt often bought food to nurture me."* (P4(1)/P6/L104) However, her belly was still getting bigger. It was found out from the maternity clinic that she actually got twins. It was 8 months and survived. She does not feel sorry about the pregnancy termination because she did not do it. It was her mother who acted upon it and her mother's sin. Later her mother passed away in an accident. She broke up with her boyfriend. She somehow receives help from her relatives. She believes that she has gained everything back into her life because her mother has paid for the sinful consequence. This helps her to start a new life. *"Life has to go on. I'm doing my best each day."* (P4(1)/P7/L125) In order to make a reparation, she has to chant the *Panyak Pray*, but the monk said it was unnecessary because it was not her wrongdoing. She did not kill anybody. She then feels so certain

that she does not kill anyone. Now she is remarried. Her 10-year-old child who survived from the pregnancy termination, is growing up.

P5: 37 years old, married, PT=1 time about 10 years ago. P5 already has 2 children. She ended her pregnancy due to an excessive morning sickness. She felt sinfully because she did wrongdoing in murdering her baby. *"It's like I am sinfully condemned from what I did. It's like murdering."* (P5(2)/P31/L571) She believes that her life problems, especially financial problem, which happened after the pregnancy termination, are the result of a sin. She felt guilty so she made merit, offered food to the monks, and prayed, including the Panyak Pray. She poured water of dedication to her lost baby, sending it merit and asking for forgiveness. She feels relieved after making merit. *"Karmic retribution in case of abortion killing," "…make merit,…pour dedication water and I told my baby that I'm sorry…Please forgive me," "I need to be stronger."* She wants her youngest son to ordain for the baby to be born again. She also went to see the fortune teller. She believes that her life was better after giving birth to the second son who she believes replace the aborted baby. Previously, she believed her pregnancy termination caused all the problems in her life. These days she however does not believe so. She thinks any women who go through a pregnancy termination have their own reasons. Men should also be responsible. *"If the guy didn't make me pregnant, it would not let any problem happen. The best way is he should have had responsibility as well. But in the society, everyone blames the woman."* (P5(2)/P54/L1006) Women should not be the only one who are accused of the wrongdoing. There should be help and care for the women in the post-termination period.

P6: 31 years old, married, PT= 4 times about 13, 11, 10, 10 years ago, respectively. She has terminated four pregnancies due to financial and relationship problems. She feels very sad that she has terminated many pregnancies, which one of them was so late the baby was already formed. *"It's really sad. It was four months already and it was already formed,"* (P2(1)/P8/L130) It's like she keeps adding up more sin. *"The first guilt is such a big sin. if it has been made many times, it will like continuously making the sin. I feel very guilty and sad for the mistake. When you kill an animal, you do evil but this is a human. You experience hell on earth."* (P6(2)/P2/L27-28) When she first had an

abortion, she thought she heard things, like a baby voice crying. *"I would be the cause of unhealthy baby," "Sometimes I hear a baby crying…May be I was just crazy,"* (P6(1)/P11/L199-201) Right now she does not hear things anymore. She thinks she only commits sin and has never done any merit. If she made merit, offered food to the monks, poured dedication water to those who passed away, and did good deeds; she would be able to erase all her sin. She cannot return to the past and solve all the problems. She has to move forward with her son now. She believes in the law of *Karma* and her life experience has taught her to be strong. If she could turn back time, she would not undertake any abortions. It is unfair to blame only women who have gone through abortions. Every woman has her own reasons. Men and women have different mentality. Women have more responsibility. During her post-abortion, she wanted some kind words and support. If there were some consultants, giving tips on mentally and physically care; it *would be better. There should be a vaginal examination service after an abortion as well. "The counselors will comfort us and make us feel better."* (P6(2)/P8/L130-132)

P7: 43 years old, married, PT=1 time about 24 years ago. She has ended her pregnancy because her husband is not a responsible person. Because of many problems and she did not think that it would be in a complete baby form, just a blood form, she decided to terminate her pregnancy. She did not think that it would be so sinful. She feels guilty because she believes in the law of *Karma*. She accepted that she did wrongdoing *"…accept the truth that we are the cause of this suffering…the fact that I make mistake."* (P7(1)/P6/L100) She solved the problem by ordaining as a Brahmin, joining the meditation retreat, offering food to the monks and chanting. She believes that she has releases herself from the sin. Ordaining as a nun is the highest deed and it helps sending the merit to the baby to reincarnate again. *"Then I went to ordain."* (P7(1)/P15/L274) P7 believes that her baby has already reincarnated and has its own life. She has her life and she feels relieved and at ease. Her life used to be very bad, but now it is better. If someone asked for her advice, she would recommend Buddhism *Dharma*. For her point of view, women alone are not wrong, but both men and women are. There should be a specialized clinic with skilled practitioners. There should be medical consultants, giving advice for post abortion. *"There should have been a special clinic because it needs some medical*

equipment and a specialist doctor and a doctor who gives some advice before and after the abortion." (P7(1)/P12/L206-207)

P8: 43 years old, married, PT=1 time about 24 years ago. P8 ended the pregnancy because she already has enough children and financial problems. She had consulted with her husband about pregnancy termination. During the post-termination, her husband was taking care of her and also comforting her. She feels really sad from what she did. She feels guilty and carries this sin in her heart so she went to the temple, offering food and the essentials to the monks. She also poured dedication water to send the merit to her baby. She released fish and birds in order to ward off bad luck at the temple. She feels more comfort and does not believe much in the law of *Karma* because she always has someone helping and taking good care of her. *"I was thinking only with myself that I always have help. I always have someone helping me. Things have never been really bad. I don't really believe in the law of Karma."* However, she accepted that she did a wrongdoing with her baby. *"I felt guilty because I did badly to him/her(baby)."* (P8(1)/P12/L208) For her point of view with pregnancy termination, men also need to take responsible. *"Anyway, I felt really guilty to him or her so it is not the right thing to put the blame only on the woman. At least the guy must have some responsibilities because it is a part of his wrongdoing as well, right?"* (P8(1)/P6/L100) Women should not be condemned as a mean person by the society. Everybody has their own reasons. There should be help and care during post termination, especially physical care. There should be psychologists giving advice. Obstetrics and gynecology clinics should be set up, giving service in physically care, such as infection prevention and hemorrhage prevention.

P9: 44 years old, married, PT=1 time about 10 years ago. P9 ended her pregnancy because she already has enough children. She talked with her husband and they agreed that they do not want a third child. *"I felt uncomfortable, too. It was like I did wrong, sinful things like that. It was sinful because it hurt someone."* (P9(1)/P2/L29) *"I keep it as a secret because having an abortion is wrong in Buddhism. I don't want people to know. I feel ashamed that I did something terrible."* (P9(1)/P14/L261-262) She went to the temple to make merit, to offer food and essentials to the monk, and to pour dedication

water. She does meditation. Right now, she starts to forget about the past and she is ready to begin again. *"Do not think over it too much. Do it often, go to the temple."* (P9(1)/P8/L133-134) She used to dream of the baby, but not right now. *"I used to dream…that a baby came crying near my house."* (P9(1)/P4/L53) After pregnancy termination, her husband took care of her physical and psychological.

P10: 44 years old, married, PT=1 time about 17 years ago. P10 decided to end her pregnancy because she already has enough children. *"I was very sad. I mean it was psychologically unhealthy. It was like I killed a person."* (P10(1)/P5/L69-70) She believes her life is unprogressive due to wrongdoing. *"I destroyed it. I stopped it from being born into a human. It was my mistake…. I never progress in anything I do. This must be the karma from the abortion."* (P10 (1)/P1/ L201-202) Everyday, she offers food to the monks, pours dedication water to send meritable deed to her baby, wishing her baby will reincarnate and have no revenge. She felt like the baby spirit was following her. She is worried and scared because she believes that the spirit of her baby holds grudge on her. This causes her not achieving anything in her life, neither progressing nor developing in anything in life. She believes that making merit will erase the bad Karma. She suggests, society should not blame women alone. Men should also be responsible. *"In fact, the guy must have shared some responsibilities. It is not right to blame only woman."* (P10(1)/P8/L141) There should be some skilled practitioners, taking care of both mentally and physically parts during the post termination.

P11: 38 years old, married, PT=1 time about 18 years ago. P11 was a university student in her junior year. She was worried that her father would find out about her pregnancy, so she decided to end it. Her mother has taken a very good care of her. Her mother gave away the dead baby to the monk, believing that it will be able to reborn as a monk in the next life. She feels relieved that she has solved the problem, but still feels sad and worried that she had done a sinful thing. *"It's relieving that I can solve the problem."* (P11(1)/P12/L205) *"It's like I have intentionally killed a person. The person who took me there is also sinful. It's like I carry this sin with me until I die."* (P11(1)/P11/L199-200) It would cause bad luck in her life, such as not finishing school or failing in the exam. She feels fear of sin and worried that her father would find out.

She will make merit by offering food and the essentials to the monks in order to send the meritable deed to the baby. She believes in the law of *Karma*. Bad Karma cannot be erased with good Karma, but it might just lighten up. She somehow realized that she had her own reasons in doing things. Everything is a result from her own action, in the present moment. It is not a Karma. She needs to change her belief right now. If she believes that it was a work of Karma, it would be so. She hopes that her family would help solving the problem, not blaming each other but giving support. *"Family needs to give support."* (P11(1)/P27/L502) There is no need to condemn or find out the reasons. She also suggests there should be a female psychiatrist, a female obstetrician, and a psychiatric nurse, taking care of the women after pregnancy termination. This kind of help and service should be announced to the public.

P12: 38 years old, single, PT=1 time about 10 years ago. P12 has terminated her pregnancy due to her education. She felt relieved. *"It was a relief. No more problems and burden with the child that would have been born like this."* (P12(1)/P5/L88) When she was 30 years old, she somehow read about the abortion sin, then she felt really guilty. The result of the abortion has caused her poorly in life and obstacles in achieving anything. *"I feel guilty. Nothing gets progressive. Everything seems to get stuck. I totally believe that it affects everything in your life."* (P12(1)/P5/L69) She solved her bad Karma by making merit, offering foods to the monks, and pouring water of defecation. This comforts her, but she believes that the sin will stuck with her for the rest of her life. She tries to improve her life in a better way. *"Be awaken and do better for tomorrow ... look ahead for the future."* (P12(1)/P14/L241) She has her family support. She wants love and understand from her family. She does not want to be condemned. *"The most thing I would like is the love and understanding from family. Do not blame what that person made any mistakes."* (P12(1)/P17/L308) There should be an organization helping women with pregnancy termination.

CURRICULUM VITAE

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2001	Master of Nursing Science (Family Nursing) Khon Kaen University, Thailand
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Professional Experiences

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