WOMEN'S EXPERIENCES OF MISCARRIAGE AND TERMINATION OF PREGNANCY FOR FETAL ANOMALY IN THAILAND: A PHENOMENOLOGICAL STUDY

By

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ABSTRACT

Background: Pregnancy is a major life event and the loss of pregnancy is an event with potential for adverse psychological outcomes. Although the understanding of grief after perinatal loss has progressed, there has been relatively little work specifically addressing the loss after miscarriage and termination of pregnancy due to fetal anomaly.

Objectives: This study aimed to gain an understanding of experiences of miscarriage and termination of pregnancy for fetal anomaly among a group of Thai women

Study design: An interpretive phenomenology approach was taken using unstructured interviews with 12 women who had undergone termination of pregnancy for fetal anomaly and 11 women who had experienced miscarriage in Chiang Mai province, Thailand. To gain the perspective of care the women received in the hospital, focus groups with 10 doctors and 10 nurse-midwives were conducted.

Results: The data were analysed and interpreted using an Interpretative Phenomenological Analysis. The loss of hope is the essence of the women's experiences of miscarriage and therapeutic termination. Three themes emerged from both groups: 1) facing the loss of hope, 2) gaining emotional balance, and 3) the need for intervention. Although the main findings are similar, significant difference between them is the context of pregnancy loss. While miscarriage is an inevitable event and needs urgent treatment, the diagnosis of fetal anomaly leads the women to have a feeling of ambivalence around the decision to terminate the pregnancy.

Conclusions: This study reinforces the difficulties that women have from the traumatic events of miscarriage and termination of pregnancy for fetal anomaly. The women need more in-depth knowledge and empathetic care from health professionals. Involving family members to support women in the labour unit can reduce the feelings of loneliness and insecurity.

Recommendations: Health care professionals need to be educated to provide emotionally sensitive support for these women.

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GLOSSARY

ABBREVIATIONS

CES-D	The Center for Epidemiologic Studies Depression
D&C	Dilatation and curettage
EPDS	Edinburgh Postnatal Depression Scale
FSD	Fertility-specific distress
HADS	The Hospital Anxiety and Depression Scale
IPL	Involuntary pregnancy loss
PGS	The Perinatal Grief Scale
RCT	Randomised controlled trial
RCOG	Royal College of Obstetricians and Gynaecologists
UEA	University of East Anglia
UK	The United Kingdom
USA	The United States of America
WHO	World Health Organisation

OPERATIONAL DEFINITION

Chromosome abnormality

Genetic defects in the structure of a baby's chromosomes.

Complete miscarriage

When all the pregnancy tissue has been passed and the uterus is empty.

Fetal Abnormality (also called fetal anomaly**)**

A condition detected in the unborn human that is not the normal or average.

Fetal Hydrops

A life-threatening condition in which fluid accumulates in fetal tissues.

Incomplete miscarriage

A diagnosed non-viable pregnancy in which bleeding has begun, but pregnancy tissue remains in the uterus

Induction of labour

A medical intervention that starts labour artificially.

Inevitable miscarriage

A diagnosed non-viable pregnancy in which bleeding has begun and the cervical os is open, but pregnancy tissue remains in the uterus

Missed miscarriage

A non-viable pregnancy identified on ultrasound scan, without associated pain and bleeding (also known as early fetal demise, delayed miscarriage or silent miscarriage).

Nuchal translucency

An ultrasound measurement of the fluid behind the neck of a baby during pregnancy. Used to see if the baby has a greater risk of a genetic abnormality.

Prenatal Diagnosis

Used to diagnose a genetic disease or condition in the developing fetus.

Recurrent miscarriage

The loss of three or more pregnancies before 23^{+6} weeks of gestation.

Termination of pregnancy

Elective abortion, miscarriage management and for pregnancy termination due to fetal anomalies and maternal health conditions.

Threatened miscarriage

Vaginal bleeding in the presence of a viable pregnancy in the first 23^{+6} weeks of pregnancy.

CONFERENCES

During the development of this thesis, some chapters in my thesis were presented at following conferences.

Oral Presentations:

Postgraduate Research Student Conference, UEA 2011. 30 June 2011. University of East Anglia.

Topic: 'Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly'

Poster Presentation:

The Showcase of Postgraduate Research, UEA 2012. 20 June 2012. Forum, Norwich,

England

Topic: 'An interpretive phenomenological study exploring women's experiences of loss through termination of pregnancy for fetal anomaly'

CHAPTER 1

INTRODUCTION

1.1　　Background

For many women, pregnancy is an exciting time when they are planning for the future.
Unfortunately, approximately one quarter of all pregnancies end in pregnancy loss
(Cunningham et al., 2005). In the past, miscarriage, or spontaneous abortion which is
defined as "the spontaneous termination of a pregnancy before the fetus has attained
viability" (WHO Technical Report Series, No. 461 cited in WHO, 2006), was the most
common type of pregnancy loss. Medically, miscarriage is defined by the World Health
Organisation as premature expulsion of an embryo or fetus from the uterus up to 23
weeks of pregnancy and weighing up to 500 grams (WHO, 2001). However, definitions
of miscarriage may vary between countries. In developing countries it is up to 28 weeks
of pregnancy, while in some developed countries it is down to 24 weeks.

In recent decades, advances in the prenatal diagnosis of chromosomal disorders and birth
defects including ultrasonography, amniocentesis, cordocentesis, and chorionic villous
sampling are available. Prenatal diagnosis is offered as a routine medical test for early
detection of fetal anomalies for high risk pregnant women who have an increased chance
of having a baby with a disorder (Royal College of Obstetricians and Gynaecologists
[RCOG], 2001). More recently, new markers and strategies for Down syndrome
screenings, for example nuchal translucency measurement and serum markers, have been
developed. As an accepted goal of prenatal testing is to provide the parents with the
choice of avoiding the birth of an affected child (Abramsky & Chapple, 2003),
termination of the pregnancy has emerged as the other type of pregnancy loss. On the
one hand, prenatal diagnosis has enabled couples to avoid the birth of an unhealthy fetus

and decrease the incidence of newborns with anomalies (Bourke et al., 2005); while, on the other hand, the incidence of termination of pregnancy because of fetal anomalies is increasing year by year (Bourke et al., 2005; Vaknin et al., 2006).

In Thailand, as well as other countries, miscarriage is the main type of pregnancy loss (Warakamin et al., 2004) while the number of women who decide to discontinue the pregnancy due to fetal anomaly is increasing. The medical definition of miscarriage in Thailand follows the WHO (2001) as a pregnancy that ends before 24 weeks and a fetal weight less than 500 grams. Thailand has approximately 64 million inhabitants (Department of Provincial Administration, 2011). Between 2005 and 2007, about 14,000 – 17,000 women were treated for abortion in general hospitals each year. About 74 percent of abortions are due to spontaneous abortion and about 17 percent are due to therapeutic abortion (Taneepanichskul et al., 2009).

At present, to reduce the risk of having a fetus with an abnormality with the following conditions: Down's syndrome, neural tube defects and thalassaemia, technologies for antenatal screening such as ultrasound and amniocentesis are currently receiving concerted attention and support at central and provincial level public hospitals in Thailand. If a fetal anomaly is detected, it is often followed by therapeutic termination. National statistics on the number of therapeutic terminations for fetal malformation are not compiled annually, but hospital records where my research was conducted showed that 109 – 138 women were admitted to the hospital per annum for therapeutic termination for fetal anomaly (Maternal-Fetal Medicine Unit, 2011). This is likely to be related to the expanding use of antenatal ultrasound screening.

Therapeutic termination is performed under the legally defined criteria for the approval of termination of pregnancy called "The Medical Council's Regulation on Criteria for

Performing Therapeutic Termination of Pregnancy in accordance with Section 305 of the Criminal Code of Thailand B.E. 2548" (The Medical Council of Thailand, 2005). Among them is the diagnosis of physical or mental abnormality in the fetus. Approval can be granted by a committee comprising of an obstetrics and gynaecology specialist, a head of the genetics institute, and a director of the obstetrics and gynaecology departments. The therapeutic termination of pregnancy in accordance with Section 305 of the Criminal Code shall be performed only with the consent of the pregnant woman and the physician who performs the therapeutic termination of pregnancy according to this Regulation shall be a medical practitioner under the law (according to the Medical Professional Act).

Although given the understanding of grief, which is a universal emotion in response to a sense of loss after pregnancy loss has progressed, the literature tends to treat pregnancy loss as one entity rather than making distinctions between loss due to miscarriage separately from loss due to termination for fetal anomaly. Within the literature, it is clear that levels of anxiety, distress, and grief are high in women who have experienced miscarriage and termination of pregnancy for fetal anomalies (Callander et al., 2007; Cumming et al., 2007; Kersting et al., 2007; Korenromp et al., 2007; Magee et al., 2003; Neugebauer, 2003; Prommanart et al., 2004; Swanson et al., 2007). However, most studies focus only on the prevalence of the psychological trauma following pregnancy loss and the experiences during the phenomena remain unclear. Very few studies have compared the course of psychological responses after miscarriage with that after therapeutic termination for fetal anomaly. As a result, it is unclear whether experiencing pregnancy loss due to miscarriage or therapeutic termination is comparable.

In addition, there has been relatively little work specifically addressing pregnancy loss in Thailand and the views of loss following termination of pregnancy remain relatively unexplored. There is only one published study in Thailand that found the majority of women after abortion suffered with mild to moderate grief intensity (Prommanart et al., 2004). Nevertheless, this study did not address how women interpret their lives and make meaning of what they experience.

The understanding of loss through miscarriage and termination of pregnancy among Thai women has not been explored fully and therefore it is assumed that the loss in response to miscarriage and termination has similarities with other losses in life. As a result, a grief process based on the Kübler-Ross model (Kübler-Ross & Kessler, 2005) and the Bowlby and Parkes' model (cited by Archer, 1999) is included in the undergraduate nursing programme around grief and loss in response to pregnancy loss. Although these models can describe emotions in response to a sense of loss in general, it is difficult to apply in the situation of miscarriage which is a spontaneous abortion, and termination which is a decision to discontinue the pregnancy. Furthermore, as the Thai socio-cultural context is different from western countries, for example, expressing emotions in public is prohibited; it is difficult to assess and resolve grief by using the view of loss in Western context. Thus, the study of women's experiences of miscarriage and termination of pregnancy due to fetal anomaly in Thailand is required.

The current study is unique as it is set in Thailand and explores both the experiences of women undergoing a miscarriage and the experiences of women undergoing termination for fetal abnormality, and allows for comparisons between both groups of women. Thus, if women's experiences could be understood and they received care and support as they need at the early stage of their loss, this might help them to overcome these difficult

events and have less psychological problems in the future. The results of this study will also be used to develop educational materials to enable health care staff to understand and meet the needs of women suffering pregnancy loss. In addition, it is envisaged that useful information will emerge for the nurse-midwife to develop and implement guidelines that are appropriate to meet the needs of these women.

1.2   Structure of the thesis

This thesis is presented in seven chapters. Chapter 1, an introduction to the thesis, offers a background to my study and my reasons for having an interest in this area. The significance of the issue of miscarriage and termination of pregnancy for fetal anomaly are summarised. A summary of the chapters in this thesis is also provided.

Chapter 2 presents an overview of the literature on women's experiences of miscarriage and termination of pregnancy for fetal anomaly and identifies a gap in existing knowledge on this subject. This is followed by a discussion of the topic under investigation. The gaps in the literature support the purpose and aims of this study.

In chapter 3, the research questions and the objectives of the research are stated. I then explore the basics of hermeneutic phenomenology, my chosen philosophical underpinning to the research method of this project, and examine its philosophical concerns and some of the history of its evolution. In this chapter, the methods of data collection, the study setting, the participants, and ethical issues are also discussed. The six steps of interpretive phenomenology analysis guided by Smith *et al* (2009) for data analysis and interpretation are described. Tables which help to explain the analysis are also included. Care is taken to address the issue of reliability and credibility in phenomenological research and the organization of my data in this project.

Chapter 4 describes the process of analysis of the women's experiences of miscarriage. Three themes, Facing the loss of hope, Gaining emotional balance, and Need for interventions, emerged from the interpretation are presented.

Chapter 5 describes the process of analysis of the transcripts of the women who undergo termination of pregnancy for fetal anomaly. The search for meaning from the transcribed interviews and my attempts to make sense of the findings result in the development of three themes: Facing the loss of hope, Gaining emotional balance, and Need for interventions.

In Chapter 6, I discuss and critique the findings presented in chapters 4 and 5 in order to seek a deeper understanding of women's experiences of miscarriage and women's experiences of termination of pregnancy for fetal anomalies in Thailand.

Chapter 7 illustrates the concluding thoughts of this body of work. The strengths and limitations of the study are provided. The implications of the findings are also discussed. Recommendations and suggestions are made with the intention of developing educational materials and informing health professional interventions for women who experience miscarriage and therapeutic termination for fetal anomaly.

CHAPTER 2

LITERATURE REVIEW

2.1   Introduction

This chapter summarises existing research literature concerning women's experiences of miscarriage and women's experiences of termination of pregnancy for fetal anomaly. The literature included in this review covers both quantitative and qualitative studies related to the issue of miscarriage and termination of pregnancy for fetal anomaly. It is intended to give an overview of the current knowledge of these issues. Finally, gaps in the knowledge and the need for further research are identified.

An integrative literature review guided by Cooper (1998) was performed. This approach was chosen because it provided a comprehensive understanding of knowledge relevant to the topic. It was useful in gathering together a volume of empirical studies, summarising research, and drawing overall conclusions from many separate investigations that address related issues (Cooper, 1998). All relevant studies, both quantitative and qualitative studies, were included and this enabled a comprehensive overview of published literature relating to women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly. Cooper's (1998) five steps were carried out in this literature review, including problem formulation, data collection, data evaluation, analysis and interpretation, and presentation.

The following questions were formulated to search for research papers related to my research topic:

- What are the experiences of women who experience a miscarriage?

- What are the experiences of women who undergo termination of pregnancy for fetal anomaly?

An electronic search was conducted through the University Metalib included; Academic Search Elite (EbscoH), CINAHL, Medline (Ovid), PsycINFO (OCLC), Web of Science, Wiley interscience Journals databases, and Google Scholar. The search was limited to articles published between 1999 and 2009 to capture the most recent studies of women's experience of miscarriage. Then a further search to identify studies of women's experiences of termination of pregnancy for fetal anomaly was undertaken. A further search was conducted in 2012 for new literature. Thus, the findings can be representative of the most recent studies on the topic.

2.2 The review of women's experiences of miscarriage

2.2.1 Search method

The electronic search through the University Metalib was conducted using the following keywords: "miscarriage," "spontaneous abortion," "missed miscarriage," "abortion," "pregnancy loss," "traumatic loss," "grief," and "women's experiences".

2.2.2 Inclusion and exclusion criteria

The literatures included in the review were published studies which focused upon women's experiences of miscarriage. Both qualitative and quantitative research methods were included. The only exclusion criterion was non-English language papers.

2.2.3 Search outcome

Of the 78 papers selected as original research from the initial search results, some papers only examined women's experiences of management options; some focused on another

type of pregnancy loss consisting of ectopic pregnancy, stillbirth, and perinatal loss;

some explored women's experiences of elective abortion, or induced abortion; some

investigated or explored only the impact of prior pregnancy loss on subsequent

pregnancies; and some abstracts were not available as full text. After removing these

from the list, 19 papers (11 qualitative papers, 6 quantitative papers, and 2 secondary

data analysis) which focused on women's experiences of miscarriage were identified for

in-depth review. Full details of the search strategy employed in the review are given in

Figure 2.1.

Figure 2.1: The process of selecting papers which focused upon women's experiences of

miscarriage

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2.2.4   Quality appraisal

The appraisal tools suggested by Beck (Polit & Beck, 2006), were used as a critiquing framework to critically appraise both the quantitative and qualitative studies. These tools provided a set of questions to critically read and assess the strengths and weaknesses of the research process. After reviewing all 19 full papers which focused on women's experiences of miscarriage, no studies were eliminated based on quality.

In the quantitative studies, one study was prospective with a follow up at 6 and 13 months after miscarriage; one study used a comparative cohort method; and four were cross-sectional descriptive studies. When considering outcomes of one study using secondary analysis design, I included these in the inclusion of quantitative studies relating to miscarriage. Three quantitative studies were carried out in the United Kingdom, three in the United States, and one in Thailand. Only a few studies reported the use of a large sample size and could be assumed as representative of a target population.

In qualitative studies, four studies used interpretative phenomenology; three studies employed descriptive phenomenology; one study used grounded theory; one study used secondary data analysis; and three studies used non specific qualitative methods. Three studies were carried out in the United Kingdom, four in Australia, two in Sweden, one in the United States, one in Mexico, and one in Israel.

The study characteristics of quantitative and qualitative studies are described in Table 2.1 and 2.2 respectively.

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Table 2.1: The quality of the quantitative studies relating to women's experiences of miscarriage

Study and country	Design	Sample size	Main Measure (s) used	Comment
Callander et al. (2007) UK	Cross-sectional, descriptive study	62 women aged 22–44 years who had experienced recurrent miscarriage	The Hospital Anxiety and Depression Scale (HADS), and Thought listing tasks based on an adapted verbal fluency paradigm	The target population was limited by the fact that the response rate was only 35.4%. The researchers provided rich details about the study method and the validity and reliability of the measures they used.
Cumming et al. (2007) UK	Prospective study with follow up at 6 and 13 months after miscarriage	273 women and 133 men at baseline, 6, and 13 months after miscarriage	The Hospital Anxiety and Depression Scale	The researchers provided rich details about the study method. Thus, the findings from this study were strengthened by prospective design with a large sample size and its rigorous method.
Magee et al. (2003) UK	Cross-sectional, descriptive study	61 women who had experienced the loss of at least three consecutive pregnancies	The Hospital Anxiety and Depression Scale Positive and Negative Affect Scale Roles and Goals Questionnaire Future Thinking Task	No evidence of power calculations. Using standardised self-report questionnaire Providing rich details about the study method
Neugebauer (2003) USA	Comparative cohort	A cohort of 114 women at 6–8 weeks after miscarriage A cohort of 318 community women not recently pregnant	The Center for Epidemiologic Studies Depression (CES-D)	The significant difference in sociodemographic and reproductive history characteristics between the two groups may have biased the final results
Prommanart et al. (2004) Thailand	Cross-sectional, descriptive study	132 women who attended the abortion clinic	A short version of the Perinatal Grief Scale	The translated PGS was validated by a psychiatrist, a psychologist, and an obstetrician and reliability was tested, with coefficient alpha = 0.89.

Study and country	Design	Sample size	Main Measure (s) used	Comment
Shreffler et al. (2011) USA	Cross-sectional, descriptive study	1,284women who have experienced a pregnancy loss included 1,152 women who experienced miscarriage(s) only and 132 women who have had at least one stillbirth	Fertility-specific distress (FSD)	As the distress resulting from pregnancy loss was measured at the time of the interview, the trajectory of distress before, during, and following the pregnancy loss was unclear.
Swanson et al. (2007) USA	Secondary analysis of data from a subsample of women who participated in Swanson's (1999b) the Miscarriage Caring Project	Handwritten descriptions of 85 women's feelings about miscarriage at 1, 6, 16, and 52 weeks	Description of feelings Changes in feelings and responses over time Comparison of contexts of responses	This was a secondary analysis of data from a non-randomly selected sample that could not be assumed as representative to a target population. However, the researchers clarified limitations of the study that would assure readers of the quality of the study.

Table 2.2: The quality of the qualitative studies relating to women's experiences of miscarriage

Study and country	Design	Participants	Method (s) used	Comment
Abboud & Liamputtong (2005) Australia	Phenomenological approach	6 women aged 22–45 years of age who had experienced a miscarriage, together with their partners	In-depth interviews	Participants were at different time after miscarriage ranging from six months to four years, which also affected the investigated experience. The researchers did not provide any information of rigour in their study.
Adolfsson et al. (2004) Sweden	Interpretive phenomenology	13 Swedish women who were treated for miscarriages in an emergency ward in southwest Sweden	Interviews were conducted within 12 weeks by mean after the diagnosis of miscarriage	The researchers provided rich details about the study method and the strengths of the study design. However, they did not discuss the trustworthiness and the weakness of the study.
Adolfsson (2010) Sweden	Heidegger's interpretive phenomenology	13 Swedish women who were treated for miscarriages in southwest Sweden	Interviews conducted with a general interview-guide	The researcher provided rich details about data collection and data analysis. The strengths of the study design were presented while the weakness of the design was not discussed. The trustworthiness of the study was not described.
Erviti et al. (2004) Mexico	Interpretive phenomenology	34 low-income women who had been admitted to the emergency room of a public hospital for abortion-related complications.	In-depth interviews were carried out during the second day of hospitalization, before the women were discharged	The researcher provided rich details about data collection and data analysis. However, the trustworthiness and the weakness of the study were inadequately described.

Study and country	Design	Participants	Method (s) used	Comment
Frost et al. (2007) UK	Not specified	79 women who had experiences of early miscarriage: 63 women had participated in a large quantitative medical study which was a Randomised Controlled Trial (RCT) and 16 women who had not participated in the RCT.	Semi-structured interviews	The researchers explained how key findings were checked for accuracy by inviting the participants to comment and respond to the findings. However, only a small number of women chose to attend. The researchers did not explain how they dealt with extraordinary details which the participants accounted for in the key findings. Other methods to ensure the reliability of the study were not provided.
Gerber-Epstein et al. (2009) Israel	Not specified	19 women who had lost their first pregnancy	Individual interviews were conducted between 1 and 4 years after miscarriage	Women in this study had already become mothers or were in advanced pregnancy, their meaning towards the miscarriage may have been influenced. Participants were at different time after miscarriage ranging from six months to four years, which also affected the investigated experience. The researchers provided reasonably rich details of the method, rigour, ethical issues, findings, and limitations of the study.
Harvey et al. (2001) Australia	Descriptive phenomenological approach	3 women who had experienced a miscarriage within the last 12 months	Open ended, unstructured individual interviews	The small sample size might limit interpretation of findings. The researchers provided the methods they used to strength the credibility of the findings but it was not adequately described.

Study and country	Design	Participants	Method (s) used	Comment
Maker & Orden (2003) UK	Interpretative phenomenology	13 women who had been diagnosed with a miscarriage within the first 14 weeks of their pregnancy	Semi-structured interviews were conducted up to five weeks after the miscarriage	The researchers provided reasonable details of the method but they did not provide any information about rigour, and the strengths and weakness of the study. Although the interviews at five weeks after miscarriage could not be representative of the women's adaptation in the long term, the women indicated a shift in their emotional responses to the miscarriage and an ability to integrate the miscarriage within their broader life experience.
Rowlands & Lee (2010) Australia	Not specified	9 women who had experienced miscarriages within 2 years	Semi-structured interviews	The small sample size might limit interpretation of findings. However, the researchers provided the methods they used to enhance the rigour of the findings (e.g. a clear account of the process of data collection and analysis and respondent validation)
Simmons et al. (2006) UK	Secondary data analysis of qualitative findings from the NWHS	172 narrative responses relating to miscarriage	Open ended questionnaires	As the NWHS was not designed to collect qualitative data on miscarriage, information may be incomplete and unspecified. However, to ensure the quality of the research, the researchers provided rich details about the study method and also clarified a number of limitations in their study.

Study and country	Design	Participants	Method (s) used	Comment
St John et al. (2006) Australia	A descriptive, exploratory qualitative study	3 women who had a prenatal loss	Unstructured interviews	The researchers provided reasonable details of the method and ethical issues. However, they did not provide any information about rigour.
Van & Meleis (2003) USA	Grounded theory	20 Women who identified themselves as English-speaking adult African Americans with a history of involuntary pregnancy loss within the past 3 years	Semi-structured interviews	The researchers provided reasonable details of the method and ethical issues. They also provide three criteria for assessing and promoting rigour: credibility, fittingness, and auditability.

2.2.5   Data abstraction and synthesis

The data abstraction and synthesis process consisted of re-reading, extracting, comparing, categorising and relating the data to each other. Initially, I re-read the papers several times and discussed with my supervisors to gain an overall understanding. Subsequently, information on women's experiences after miscarriage was extracted. These were then categorised using the main outcomes reported in the quantitative studies, consisting of the level of anxiety and depression, level of maternal grief and related factors, level of depression in bereaved and non-bereaved women, psychological factors related to the levels of anxiety and distress, and changes in women's feelings after miscarriage. Of the qualitative papers, the results were divided into three categories using thematic analysis, namely the nature of loss, the process of adaptation, and the coping strategies after miscarriage. This analysis was also discussed several times with the supervisors.

2.2.6   Results

1)   Outcomes reported in the quantitative studies

The summary of the main outcomes of the quantitative studies relating to women's experiences of miscarriage is shown in Table 2.3.

Table 2.3: The main outcomes of the quantitative studies relating to women's experiences of miscarriage

Outcome	Study	Results
Level of anxiety and depression	Callander et al. (2007) UK	Of the 62 women who had experienced recurrent miscarriage, 31 women (50%) scored within the range for clinical anxiety and 4 women (6.5%) scored within the range for clinical depression.
	Cumming et al. (2007) UK	The prevalence of cases for the 400 women was 28.3% for anxiety and 10% for depression. The number of cases with anxiety and depression were significantly higher at baseline than at 13 months after miscarriage.
	Magee et al. (2003) UK	Of the 61 women who had experienced recurrent miscarriage, 31 women (51%) scored within the clinical range for anxiety and 6 women (10%) for depression.
Level of maternal grief and related factors	Prommanart et al. (2004) Thailand	Of the 132 women, 7 women (5.3%) had severe grief intensity, 50 women (37.9%) had moderate grief intensity, and 75 women (56.8%) had mild grief intensity. The factors associated with PGS scores were low income, had had ultrasonography, gestational age of > 16 weeks and methods of treatment.
Comparison psychiatric outcomes in bereaved and non-bereaved women	Neugebauer (2003) USA	The depressive symptom levels among a cohort of 114 women at 6-8 weeks after miscarriage were statistically significant elevated over a cohort of 318 community women unexposed to pregnancy loss (adjusted difference in means between cohorts, 4.9, 95% confidence interval [CI] 2.3–7.4).
Related factors associated with the levels of psychological outcomes following recurrent miscarriage	Callander et al. (2007) UK	There was a positive association between upward counterfactual thoughts and anxiety. Future plans were not related to lower distress verse relationship between search for meaning and distress.
	Magee et al. (2003) UK	Women who were over-invested in the parent role compared to other roles showed highest distress; women whose thoughts about the future were characterised by the presence of negative child-related thoughts

Outcome	Study	Results
		and an absence of positive thoughts about other, non-child-related experiences showed highest levels of distress.
Women's feelings about miscarriage at 1, 6, 16, and 52 weeks	Swanson et al. (2007) USA	The feelings about miscarriage were described by 3 responses: healing, actively grieving, and overwhelmed.

Women who were actively grieving or overwhelmed at 1 week experienced significantly less distress from 6 weeks on.

Women's responses to miscarriage at 6 weeks were not significantly different from their responses at 1 year. |
| Variations in the effect of distress from pregnancy loss among women who have ever experienced a stillbirth or miscarriage. | Shreffler et al. (2011) USA | Pregnancy-relevant commitment and attachment measures were associated with greater Fertility-specific distress (FSD). Women who experienced losses of planned pregnancies reporter greater FSD than women who lost unplanned pregnancies. Women who knew the cause of their pregnancy loss, women with self-identified fertility problems, women who currently desired a baby and women who placed a higher value on motherhood were more distressed than women not in these categories. |

The following discusses the outcomes reported in the quantitative studies.

Level of anxiety and depression following miscarriage

The three UK studies examined the relationship between the level of anxiety and depression among women who had experienced miscarriage. These studies employed a similar standardised self-report psychiatric rating scale to the Hospital Anxiety and Depression Scale, but used different study designs. The levels of anxiety and depression were variable in the three studies. Two cross-sectional studies (Callander et al., 2007; Magee et al., 2003) focused on women who had experienced recurrent miscarriage, that is, the loss of at least three consecutive pregnancies, whilst one prospective study (Cumming et al., 2007) focused on women who had experienced one or less miscarriage at 6 and 13 months after miscarriage.

Of the two cross-sectional studies focusing on recurrent miscarriage, the findings both showed a relatively high prevalence of clinical anxiety. Half of 62 women who had experienced recurrent miscarriage scored within the range for clinical anxiety and 6.5-10% scored within the range for clinical depression between 6.45 and 10 months, on average, after miscarriage (Callander et al., 2007; Magee et al., 2003). However, conclusions from these studies should be viewed with caution due to the small sample size.

When considering better quality studies, that is, ones which were a prospective design with a large sample size and a rigorous method (Cumming et al., 2007), it found a lower rate of cases for anxiety (28.3%) but a similar rate for depression (10%). This study also indicated that women experienced elevated anxiety and depression at 6 months after miscarriage and the level of anxiety and depression declines over a period of 13 months.

The levels of anxiety and depression were significantly higher at 6 months than at 13 months.

It should be noted that these three studies were conducted from a non-randomly selected sample which might influence the generalisation of the findings. However, it might be accepted because it seemed to be unrealistic, or in some cases unethical, to conduct random sampling in a miscarriage study.

Level of maternal grief and related factors

The only study which was conducted in Thailand (Prommanart et al., 2004) reported the level of maternal grief at two weeks after miscarriage by using a short version of the Perinatal Grief Scale (PGS), all women (N=132) who miscarried also experienced feelings of grief. More than half of them, 75 women (56.8%), experienced mild grief intensity, 50 women (37.9%) moderate grief intensity, and 7 women (5.3%) severe grief intensity. The study also indicated that women on a low income, those who had a previous ultrasound scan and a pregnancy over 16 weeks all had high PGS scores as well as those who underwent methods of treatment which were significantly related with increased PGS scores. Although this study could demonstrate factors related to maternal grief, it failed to provide insights about why they were related. Moreover, the main limitation of this study was the other confounding factors which may have influenced maternal grief, such as an existing belief system and age, therefore methods to control confounding variables were not accounted for.

Level of depression in bereaved and non-bereaved women

The only study conducted in the United States (Neugebauer, 2003) compared the level of depression in women at 6-8 weeks after miscarriage and women who were not recently

pregnant by using the Center for Epidemiologic Studies Depression (CES-D) scale. The study showed that miscarriage seems to increase the risk of depressive symptoms. The depressive symptom levels in women at 6-8 weeks after loss due to miscarriage were statistically higher than those in a comparable sample unexposed to pregnancy loss. However, significant differences in sociodemographic and reproductive history characteristics between the two groups may have biased the final results. These differences displayed a failure to exclude confounding variables which were associated with the outcomes. Thus, the confounders might make interpretation of the results unreliable.

Psychological factors related to the levels of anxiety and distress after miscarriage

There were two studies conducted in the United Kingdom and one study in the United States which investigated the psychological factors associated with the levels of anxiety and distress following miscarriage. Callander et al. (2007) found a positive association between upward counterfactual thoughts and anxiety. Considering the levels of distress, Callander et al. (2007) pointed out that there was an inverse relationship between the search for meaning, and the distress felt by the patient; they also found future plans were not related to lower distress. The other study (Magee et al., 2003) found that women who had more negative child-related thoughts about the future and fewer positive-related thoughts about other, non-child-related experiences were at highest risk of distress. While the remaining study (Shreffler et al., 2011) reported that pregnancy-relevant commitment and attachment were associated with greater fertility-specific distress. They explained in their results that the meanings the women attributed to pregnancy were crucial in shaping the psychological response to pregnancy loss.

However, it was not possible to make direct comparisons between these studies because of the different psychological measures used.

Changes in women's feelings over the first year after miscarriage

The only United States study (Swanson et al., 2007) was a secondary analysis of data, which reported women's feelings about miscarriage and changes in feelings over the first year after miscarriage. It used handwritten descriptions of women's feelings about miscarriage at 1, 6, 16, and 52 weeks. The feelings about miscarriage were categorised into 3 responses namely: healing, actively grieving, and being overwhelmed. The findings found that 14.5% (N=12) had a healing response at 1 week, and 47% (N=39) were in the healing range by 6 weeks. The women who were actively grieving (N=44) or overwhelmed (N=21) at 1 week experienced significantly less distress from 6 weeks on. However, women's experiences of miscarriage at 6 weeks were not significantly different from their responses at 1 year. This study suggested that 6 weeks post miscarriage would be an appropriate time to offer women a visit and to ask women about their feelings and their strategies to deal with their miscarriage. Therefore interventions at this time could improve outcomes at one year. However, the main limitation of this study was that it was a secondary analysis of data from a non-randomly selected sample that was limited in the diversity of participants. An additional limitation of this study is that the influence of women's pre-loss mental or physical health on responses to miscarriage is unknown.

2)   Outcomes reported in the qualitative studies

A summary of the main outcomes of the qualitative studies researching women's experiences of miscarriage is shown in Table 2.4. The 10 studies investigating the women's experience of miscarriage employed different study designs and differences in time

aspects between each study. The methodology used may have had some impact on the findings reported for each study. Therefore, in attempting to draw comparisons, it must be remembered that the comparison is not like for like.

Table 2.4: The main outcomes of qualitative studies relating to women's experiences of miscarriage

Study	Outcomes	Results
Abboud & Liamputtong (2005)	Coping with pregnancy loss	The women utilised a number of coping strategies to help them manage their grief and mourn the loss of their baby including resting, thinking of the future and another pregnancy, working, and taking care of other children they had. A good support network and positive contacts with health care professionals also impacted on how well the women and their partners were able to cope with their loss.
Adolfsson et al. (2004)	Swedish women's experiences of miscarriage	The Major theme (essence) was emptiness and guilt. Six sub themes included: 1) Feeling emotionally split - anticipation and anxiety 2) Bodily sensation – sensations in a woman's body give certain signals, and when the child is expelled they experience other signs 3) Loss – the loss of identities and rights as mothers 4) Grief – a reaction to loss 5) Abandonment – abandonment as professional avoidance and abandonment as verbalizing or "masking" 6) Guilt – the women hold themselves responsible for the miscarriage
Adolfsson (2010)	Swedish women's experiences of miscarriage	The women's feelings and impressions were influenced by past experiences of miscarriage, pregnancy, and births. Present conditions in the women's lives contributed to the experience including their relationships, working situation, and living conditions. Each woman's future prospects and hopes have been structurally altered with regard to their aspirations for their terminated pregnancy.
Erviti et al. (2004)	Strategies used by low-income Mexican women to deal with miscarriage and "spontaneous" abortion	Both marriage and motherhood provoked feelings of "captivity" and social isolation. Four strategies to avoid stigmatisation were explained as moral survival strategies consisting of : 1) "Accepting"; 2) "Ignorance" or ambiguity about the pregnancy - to plead ignorance of their pregnancy; 3) "Acceptance" of the pregnancy - maintaining an ambivalent attitude concerning the desire to be pregnant; 4) Accidents or unintentional actions – presenting the abortion as the result of an "accident"

Study	Outcomes	Results
Frost et al. (2007)	The special nature of bereavement in the case of first trimester miscarriage	Sequestration and scientisation: the experience of miscarriage 1) Sequestration and silence: the privacy of suffering 2) Imperfect scientisation and ambiguities around the event – a loss of a (potential) life in which it is not clear when the moment of death has actually occurred: a) an incomplete or failed attempt to conceive: b) a baby that was lost: c) part of their family that was lost. 3) Miscarriage as the loss of possibilities – the women confront the loss holistically, in terms of their own lives and identities. 4) Why me? Incomplete femininity and imperfect scientisation – in cultures where death has been 'scientised', any death which does not seem to have any reason behind it is particularly difficult to make sense of

Gerber-Epstein et al. (2009)	Israeli women's experience of miscarriage in first pregnancy	Five themes were revealed
		1) The greater the joy, the more painful the crash –were explained as: (a) receiving the news that the embryo is dead; (b) waiting for the vacuum aspiration; and (c) the end of the vacuum aspiration
		2) The nature and intensity of the loss
		  a) The intensity of the loss – the loss of the pregnancy, collapse of dreams and fantasies, feeling a deep pain
		  b) The nature of the loss – even years after the miscarriage, women still brood about what they lost
		3) Sources of support – the partner, the birth family, and women who had had a similar experience
		4) Life after the miscarriage needs to be coped with day after day
		5) Recommendations to professionals
		  a) Choosing a doctor who suits the individual needs of each woman at this significant and sensitive stage in her life
		  b) Turning to professional counsellors
		  c) Being with the women in their pain

Harvey et al. (2001)	Australian women's experience of the phenomena of early miscarriage within the previous 12 months	Three major themes of loss emerged: 1) The loss of a baby 2) The loss of the role of motherhood 3) The loss of the hopes and dreams the women possessed for their baby

Study	Outcomes	Results
Maker & Orden (2003)	The women's experience of early miscarriage occurring in the first trimester in UK	The themes were categorised into three stages which were described as dynamic process: 1) The turmoil of miscarriage 2) Adjustment to miscarriage –boost their own sense of self: social comparisons, sharing and finding meaning 3) Resolution
Rowlands & Lee (2010)	The impact of other people on shaping the respondents' miscarriage experiences	Engagement (other people's reactions to the miscarriage), acknowledgement and support from families, health care providers and the community were positive aspects for women after miscarriage. Unfortunately, the medical management of miscarriage was often described as poor. A lack of information received, in combination with insensitive comments and lack of empathy while being treated in hospital, were very negative aspects of women's miscarriage experiences.
Simmons et al. (2006)	Personal accounts of miscarriage by adult women living in the UK	Four key themes emerged: 1) Searching for meaning of the miscarriage to help reduce feelings of guilt and responsibility for the loss and promote acceptance 2) Justification of motherhood which depended on the respondent's reproductive history 3) Medicalisation and the lived experience of miscarriage which related to the respondent's previous experiences 4) Support which included improved professional support and follow-up
St John et al. (2006)	The experiences of women who have suffered a prenatal loss prior to a full term pregnancy	Women's experiences were conceptualised as the theme of "dealing with the experience of grief, loss, anger, self-blame in a world of silence' captivity and isolation". Two sub-categories 'being on the outside looking in' and 'being changed or transformed by loss' were identified.

Van & Meleis (2003)	The coping strategies used by African American women following their involuntary pregnancy loss (IPL)	The strategies for coping with several aspects of the grief experience following IPL:
		1) Coping with personal reactions and responses:
		  a) Talking
		  b) Have not dealt with it
		  c) Prayer
		  d) Going inside myself
		2) Coping with reactions of others
		3) Coping with memories of the baby
		4) Coping with subsequent pregnancies

The three main outcomes have been summarised.

The nature of loss

The five studies reporting the theme of loss on women's experiences after miscarriage were conducted in different countries and in different periods of time after miscarriage. However, four studies demonstrated the miscarriage as a holistic loss. Adolfsson et al. (2004) interviewed 13 women within 12 weeks after miscarriage and Harvey et al. (2001) interviewed 3 women within 12 months after miscarriage and found not only the loss of a baby, but also the loss of identity and rights as mothers. Adolfsson (2010) presented the findings based on the same participants of the previous study (Adolfsson et al., 2004). The 13 interviews were interpreted with respect to Heidegger's "Being and Time" and demonstrated that past experiences of miscarriage, pregnancy, and births influenced the women's feelings and impressions of their present conditions. Each woman's future prospects and hopes had been structurally altered with regard to their aspirations for their terminated pregnancy. For these three studies, the researchers provided rich details about the methodology they used and the process of data collection and data analysis. However, the trustworthiness and the weakness of the studies were not adequately described. As a result, the credibility of their findings is difficult to evaluate.

Similarly, Frost et al. (2007) also demonstrated the loss of possibilities in terms of women's lives and identities. Although the researchers explained how to gain the accuracy of key findings by inviting the participants to comment and respond to the key findings, only a small number of women chose to do this. Moreover, the researchers did not explain how they dealt with the details which the participants accounted for in their key findings. Thus the reliability of the findings was unclear.

While the last study (Gerber-Epstein et al., 2009) demonstrated the painful feeling of loss which tended to remain and came up frequently in the different stories years after miscarriage. Nevertheless, as the women in this study had already become mothers or were in advanced pregnancy, their feelings towards the miscarriage might be influenced. In addition, the participants were interviewed at different times after miscarriage ranging from six months to four years, which may have affected their views or perceptions of the investigated experience.

The process of adaptation

There was only one study conducted in the United Kingdom which described the dynamic process after miscarriage (Maker & Orden, 2003). The interviews were conducted up to five weeks after miscarriage and three stages were conceptualised in terms of the stages of turmoil, adjustment and resolution. It could be noted that although the interviews at five weeks after miscarriage could not be representative of the women's adaptation in the long term, the findings indicated a shift in the women's emotional responses to the miscarriage and an ability to integrate the miscarriage within their broader life experience. Nevertheless, the main limitation of the study was that the researchers did not provide any information of rigour in their study.

The coping strategies

Of the four studies reporting strategies to deal with miscarriage, two examined coping strategies among a small group of women in Australia (Abboud & Liamputtong, 2005; Rowlands & Lee, 2010), one focused on strategies to avoid stigmatisation among low income Mexican women (Erviti et al., 2004), and the other explained the coping strategies used by African American women after loss (Van & Meleis, 2003).

Abboud and Liamputtong (2005) conducted a qualitative phenomenological analysis and found that a small group of ethnic women living in Australia utilized a number of coping strategies to help them manage their grief and mourn the loss of their baby. These strategies included resting, thinking of the future and another pregnancy, working, and taking care of other children they had. The findings also indicated that a good support network and positive contacts with health care professionals impacted on how well the women and their partners were able to cope with their loss. However, the participants were interviewed at different times after miscarriage ranging from six months to four years, which also affected the investigated experience. An additional limitation of the study is that the researchers did not provide any information of rigour in their study.

The other study in Australia (Rowlands & Lee, 2010) identified engagement, acknowledgement and support from families, health care providers and the community were positive aspects for women after miscarriage. While a lack of information received, in combination with insensitive comments and lack of empathy while being treated in hospital, were very negative aspects of women's miscarriage experiences. Although the small sample size might limit interpretation of findings, the researchers provided rich details about the process of semi-structured interviews, steps of data analysis, and the trustworthiness of the study (e.g. respondent validation).

The study conducted in Mexico by Erviti et al. (2004) described four strategies to avoid stigmatisation which were explained as moral survival strategies, consisting of: accepting social norms, ignorance, acceptance of the pregnancy, and accidents or unintentional actions. However, the participants were representative of the women who had been admitted to the emergency room of a public hospital. It is possible that the experience of being treated within an emergency room situation makes their situation different to

women experiencing other treatment at time of miscarriage. Also there is a necessity to understand cultural norms and beliefs in order to understand responses to any type of loss. The stigma associated with pregnancy loss in Mexico may make the findings in this study less transferable to other settings.

The last study presented four strategies for coping with several aspects of grief experience following pregnancy loss, which included: coping with personal reactions and responses after loss, coping with the reactions of others, coping with memories of the baby, and coping with subsequent pregnancies (Van & Meleis, 2003). Although the issue of a small number of participants in qualitative research has received considerable attention, the researchers were able to address the issue of quality in their research. The researchers provided reasonable details of the methodological and ethical issues. They also provided three criteria for assessing and promoting rigor in the qualitative study, credibility, fittingness, and auditability, as the framework for their study.

Personal accounts of miscarriage

A study in the United Kingdom analysed the experience of miscarriage which was written by adult women living in the UK (Simmons et al.*,* 2006). It found that searching for a cause of miscarriage and the respondent's reproductive history affected the patient's meaning of miscarriage and ability to cope with their loss. In addition, women expressed concern about inappropriate medicalisation and a perceived lack of emotional support from professionals involved with miscarriage care. Although these findings were analysed from 172 narrative responses, one should be aware of the limitation of using secondary data. As the UK National Women's Health Study (NWHS) was not designed to collect qualitative data on experience of miscarriage, information may be incomplete

and unspecified. Analysis was only performed with the data limited to what already existed.

2.2.7   Conclusions

The loss of a baby due to miscarriage was explored by using different study designs and different standard measures. However, it is still under-researched and imperfectly understood. Although this review was able to present a comprehensive overview on women's experiences of loss through miscarriage, some abstracts were not available for full texts and unpublished papers, also non English language papers were not included. Therefore, the review may have lost some points of view on the topic. Again, drawing a comparison of findings across studies was difficult because of a wide variation of study designs, in the measures used, and in the timing of assessments.

Out of seven quantitative studies, typical outcomes included anxiety and depression, grief, and psychological factors. It is clear that the levels of anxiety, distress, and grief are high in women who have experienced miscarriage and miscarriage has an emotional impact on the woman. As some studies were conducted at a single site, this may make results less generalisable. However, there may be some aspects of the experience that might be transferable across settings and across cultures.

Although the available quantitative studies have explored the psychological consequences of miscarriage, they only focus on the prevalence of the psychological trauma following miscarriage and fail to investigate specific factors directly relating to the psychological outcomes. It might also be useful to consider the wider impact of miscarriage on couples or families.

From several cross-sectional qualitative studies, it appears that miscarriage is a personal, private, and intimate experience both physically and emotionally. A sense of loss was found to be the most common response occurring in women who have experienced miscarriage. These studies assist in developing an in-depth understanding towards the experience of miscarriage. However, although recent qualitative studies focus only on miscarriage, these explore different aspects of the experience and are based on different designs. As a result, it seems to be difficult to compare the findings with other studies. More qualitative research based on phenomenology and grounded theory designs are still needed to gain a deeper understanding of the variety of aspects of miscarriage. Moreover, as a number of qualitative studies do not clarify the rigour of their studies, it may be difficult to judge the quality of their findings. Thus, it is the role of the researchers to be able to provide full descriptions of research methods, the process of data collection and analysis, and the rigour of their studies.

2.3 The review of women's experiences of termination of pregnancy for fetal anomaly

2.3.1 Search Methods

The keywords used in an electronic search were "termination of pregnancy," "fetal anomaly," "therapeutic termination," and "women's experiences". The studies included in the review were those which focused on women's experiences of termination of pregnancy for fetal anomaly. Both qualitative and quantitative research studies were included in the review. The only exclusion criterion was non-English language papers.

2.3.2 *Search outcome*

Of the 37 papers selected as original research from the initial search results, some papers explored women's experiences on elective abortion or induced abortion without medical reasons; some inspected only the prevalence of termination of pregnancy for fetal anomaly; some focused on management options in pregnancy termination; and some abstracts were not available as full texts. After removing these from the list, 11 papers (8 quantitative papers and 3 qualitative papers) which focused on women's experiences of termination of pregnancy for fetal anomaly were identified for in-depth review. Full details of the search strategy employed in the review are given in Figure 2.2.

Figure 2.2: The process to select studies which focused on women's experiences of termination of pregnancy for fetal anomaly
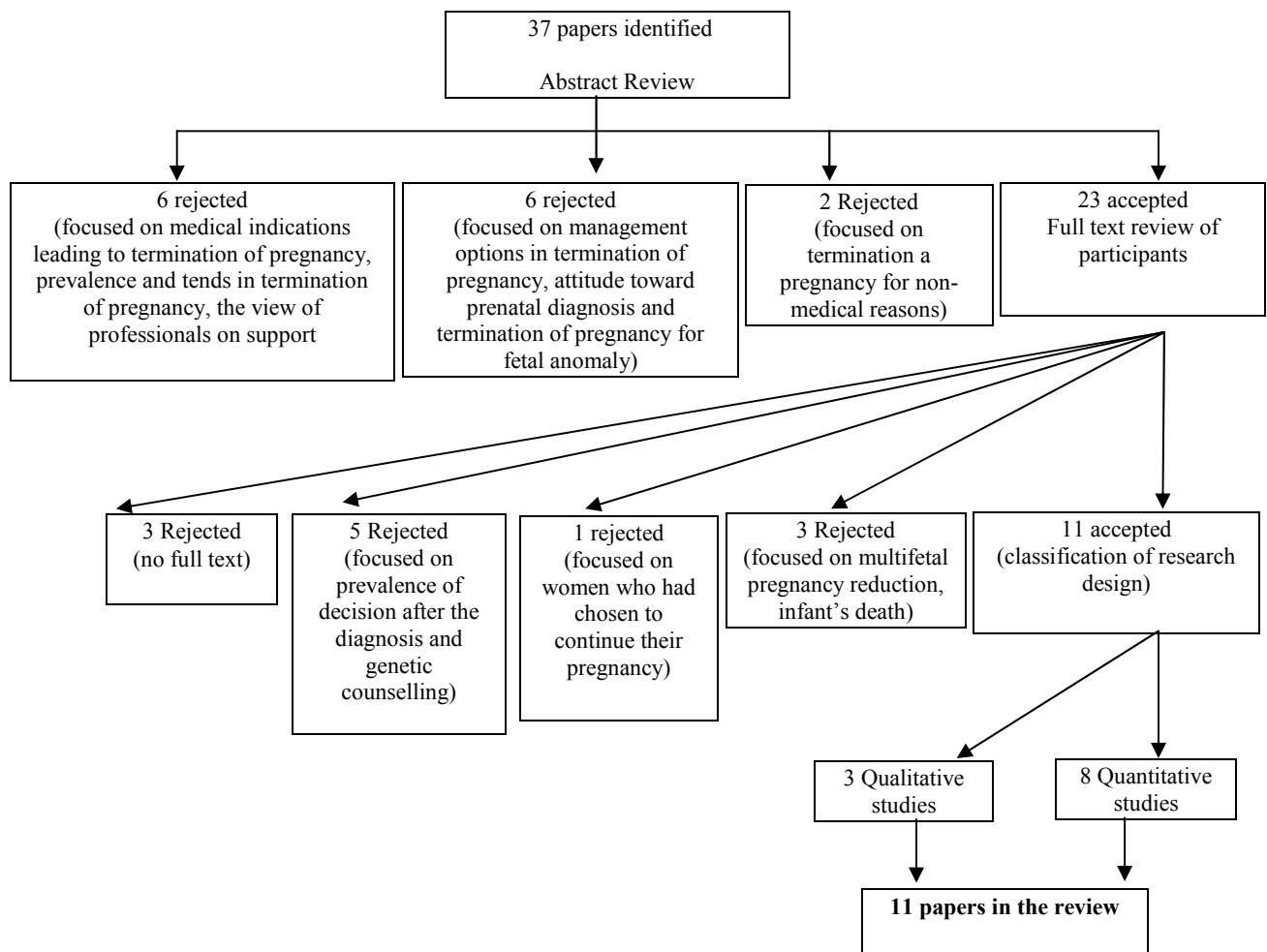
2.3.3 Quality appraisal

The studies were subjected to a critical appraisal using the critiquing framework by Beck (Polit & Beck, 2006). After reviewing the 11 papers which focused on women's experiences of termination of pregnancy for fetal anomaly, no studies were eliminated based on quality. The study characteristics of quantitative and qualitative studies are described in Table 2.5 and 2.6 respectively.

Table 2.5: The quality of quantitative studies relating to women's experiences of termination of pregnancy for fetal anomaly

Study and country	Design	Sample size	Main Measure (s) used	Comment
Burgoine et al. (2005) USA	Prospective cohort study (follow-up to 1 year after the procedure)	49 women choosing 2nd trimester abortion caused by fetal anomalies by either medical induction of labour (27 women) or dilatation and evacuation (22 women)	The Edinburgh postnatal depression scale was used to evaluate depression The Perinatal Grief Scale was used to assess bereavement	The strength of this study is using standardised instruments. The primary limitations of this study are randomisation and high dropout rate; of 49 initial subjects, just 29 completed a 12-month follow-up and only 14 completed all follow-ups.
Davies et al. (2005) UK	Cohort study	30 women aged 20-40 years in a north London teaching hospital, 14 of whom had had a first-trimester termination and 16 a second-trimester termination for fetal anomaly.	Semi-structured qualitative interviews and four questionnaires: the General Health Questionnaire (GHQ), the Beck Depression Inventory (BDI), the Perinatal Grief Scale (PGS), and the Impact of Event Scale (IES) at 6 weeks, 6 months and 12 months after termination	The data from semi-structured qualitative interviews were not presented. Small sample size may not be reflective of true prevalence rates. This may also have prevented exploration of the effect of other types of risk factor such as parity or fetal anomaly.
Geerinck-Vercammen & Kanhai (2003) Netherlands	Prospective study	89 couples who terminated their pregnancy in the second and third trimester	Semi-structured interviews were conducted before termination of pregnancy, after six weeks and six months after termination.	The measures were inadequately defined, and the details of the reliability and validity of the interviews were not provided. Another weakness was that the interviews were carried out by the interviewer who was one of the psychosocial caregivers of the parents involved. This may have affected their responses of the investigated experience.

Study and country	Design	Sample size	Main Measure (s) used	Comment
Kersting et al. (2007) Germany	Longitudinal study to obtain information on the course of grief following a traumatic loss at 14 days, 6 months and 14 months after the event	62 women who had undergone termination of pregnancy between the 15th and 32nd gestational week and 65 women after spontaneous delivery of full-term healthy child	Psychiatric diagnoses were confirmed using the German Version of the Structured Clinical Interview for DSM-IV The degree of complicated grief was assessed using a modified German version of the Complicated Grief Module Grief after loss was measured using a modified German version of the Perinatal Grief Scale Posttraumatic stress reactions were assessed using the Impact of Event Scale Revised The severity of depressive symptoms were measured using the Beck Depression Inventory Self reported anxiety was assessed with the Spielberger State Trait Anxiety Inventory	The strength of this study is using standardised self and clinician rated assessment techniques. The limitation is the final response rate of respondents in the group of women after TOP is quite low (58%). The low response rate may influence the representativeness of the sample.
Kersting et al. (2009) Germany	Prospective longitudinal study at 14 days, 6 months, and 14 months after the event.	62 women after termination of late pregnancy in the 2nd or 3rd-trimester, 43 women after preterm birth, and 65 women after the delivery of a healthy child serving as controls were investigated	Psychiatric diagnoses were confirmed using the German Version of the Structured Clinical Interview for DSM-IV Posttraumatic stress reactions were assessed using IES-R Self reported anxiety was assessed with STAI	The final response rates of women after termination (58% at 3rd-trimester) and those women after preterm birth (65% at 3rd-trimester), both being lower than the response rate of the control group (82%).

Study and country	Design	Sample size	Main Measure (s) used	Comment
Korenromp et al. (2005) Netherlands	Cross-sectional study	196 women, 2 to 7 years after TOP for fetal anomaly before 24 weeks of gestation	Dutch versions of validated self-completed questionnaires: 1) Maladaptive symptoms of grief were measured by the Inventory of Traumatic Grief (ITG) 2) Symptoms of posttraumatic stress (PTS) were measured by the revised Impact of Event Scale (IES-r) 3) Psychological well-being was measured with the use of three subscales of the Symptom Checklist-90 (SCL-90): depression, anxiety, and somatic complaints 4) Questions on perceived external pressure in the process of decision making, perceived support, seeking of professional help, and questions about doubt or regret.	The strengths of this study are using standardised questionnaires and a response rate of 79%. However, the assessment took place between 2 and 7 years after the event which may affect emotional problems caused by the termination of pregnancy as the possibility for other distressing life events may occur in the mean time.
Korenromp et al. (2007) Netherlands	Prospective cohort study	217 women and 169 men completed questionnaires at 4 months after termination	Psychological adjustment was measured by the Inventory of Complicated Grief (ICG), the Impact of Event Scale (IES), the Edinburgh Postnatal Depression Scale (EPDS), and the Symptom Checklist-90 (SCL-90).	The strength of this study is using standardised questionnaires, a large sample size and prospective study design.

Study and country	Design	Sample size	Main Measure (s) used	Comment
Korenromp et al. (2009) Netherlands	Longitudinal study	147 women 4, 8, and 16 months after termination of pregnancy for fetal anomaly	Maladaptive symptoms of grief were measured by the Inventory of Complicated Grief (ICG. Symptoms of posttraumatic stress (PTS) were measured by the Impact of Event Scale (IES). The Symptom Checklist (SCL)-90 was used to assess the level of generalized psychological malfunctioning. Depression was measured by the Edinburgh Postnatal Depression Scale (EPDS). The Generalized Self-efficacy Scale (GSE) assessed self-confidence as a personality characteristic	A limitation of this study is the lack of detailed information on the non-response group.

Table 2.6: The quality of qualitative studies relating to women's experiences of termination of pregnancy for fetal anomaly

Study and country	Design	Sample size	Method (s) used	Comment
Gammeltoft et al. (2008) Viet Nam	Anthropological research	17 women who had a late-term abortion due to a fetal malformation	Observations and conversations with 17 women and 14 doctors A focus group discussion with doctors	The authors provided only limited details of data analysis and interpretation. Procedures for establishing trustworthiness were not presented.
Hunt et al. (2009) UK	Secondary analysis of narrative qualitative interview data	Transcripts from 48 interviews with people living in the UK who have taken the decision to end a pregnancy following a diagnosis of fetal abnormality	The analysis highlighted a number of dilemmas and choices that parents faced in the hours and days after experiencing a termination for fetal abnormality.	Secondary analysis of qualitative data made its difficult to assess whether the focus of interest for the secondary analysis was fully explored with every participant.
Ferreira da Costa et al. (2005) Brazil	Qualitative design	10 women who had a pregnancy termination for fetal abnormality	Semi-structured interviews were carried out about 40 days after the procedure.	The researcher provided details about data collection and data analysis. However, the trustworthiness and the weakness of the study were not described.

2.3.4   Data abstraction and synthesis

After re-reading the papers several times, the information on women's experiences of termination of pregnancy for fetal anomaly was extracted. This information was then categorised using the main outcomes reported in the quantitative studies, that is, they consisted of a decision to terminate pregnancy following prenatal diagnosis of fetal anomaly and the psychological outcome after termination. Of the qualitative papers, the results were divided into three categories using thematic analysis, namely, the emotional responses of termination of pregnancy for fetal anomalies, the process of adaptation following fetal anomaly diagnosis, and coping with termination of pregnancy for fetal abnormality.

2.3.5   Results

1)   Outcomes reported in the included quantitative studies

A summary of the main outcomes of the quantitative studies into women's experiences of termination of pregnancy for fetal anomaly is shown in Table 2.7. However, these 8 studies reported only comparative information, rather than information that allowed the interpretation of women's experiences of termination of pregnancy.

Table 2.7: The main outcomes of quantitative studies relating to women's experiences of termination of pregnancy for fetal anomaly

Outcome	Study	Results
Psychological reactions after termination of pregnancy for fetal anomalies	Geerinck-Vercammen and Kanhai (2003) Netherlands	Feelings such as doubt, guilt, failure, shame, anger, anxiety and relief were experienced during the period of termination of pregnancy and the following weeks but practically disappeared after six months.
	Korenromp et al. (2005) Netherlands	5 women (2.6%) of participants had pathological scores for grief and 33 participants (17.3%) had pathological posttraumatic stress scores. The result also indicated that there was no decrease in symptomatology between 2 and 7 years after the event.
	Korenromp et al. (2007) Netherlands	Both women and men showed high levels of posttraumatic stress (PTS) symptoms (44 and 22%, respectively) and symptoms of depression (28 and 16%, respectively) at 4 months after the event.
	Korenromp et al. (2009) Netherlands	Four months after termination, 67 women (46%) showed pathological levels of posttraumatic stress symptoms, decreasing to 20.5% after 16 months. As to depression, these figures were 28% and 13%, respectively.
	Burgoine et al. (2005) USA	There was a high rate of depression diagnosed by the EDPS at enrolment among both groups of women, 13 women (59.1%) for women who terminated a desired pregnancy by D&C and 14 women (51.9%) for those who chose induction of labour.
	Kersting et al. (2007) Germany	Of the 36 women after termination of pregnancy at 14 months, 16.7% were diagnosed with psychiatric disorders.
Comparison psychiatric outcomes in bereaved and non-bereaved women	Kersting et al. (2007) Germany	14 months after termination of pregnancy, 16.7% of bereaved women were diagnosed with psychiatric disorder, compared to none in the control group of women. Women who underwent termination of pregnancy showed significantly higher symptoms of posttraumatic stress, depression, and anxiety than women after spontaneous delivery

Outcome	Study	Results
Compare psychological morbidity following first- and second-trimester termination for fetal anomaly	Davies et al. (2005) UK	There were high levels of psychological distress in both groups at each time point. Psychological morbidity following termination of pregnancy for fetal anomaly is prevalent and persistent.
Comparison grief resolution among women who terminated a desired pregnancy by D&C and those who chose induction of labour	Burgoine et al. (2005) USA	However, there was no significant difference in grief resolution among women who terminated a desired pregnancy by either medical or surgical abortion
Factors influencing adverse psychological outcomes following termination of pregnancy for fetal anomalies	Korenromp et al. (2007) Netherlands	Determinants of adverse psychological outcome were a high level of doubt in the decision period, inadequate partner support, low self efficacy, lower parental age, being religious, and advanced gestational age.
	Korenromp et al. (2009) Netherlands	Outcome at 4 months was the most important predictor of persistent impaired psychological outcome. Other predictors were low self-efficacy, high level of doubt during decision making, lack of partner support, being religious, and advanced gestational age.
	Kersting et al. (2007) Germany	Initial high fear of having an unhealthy child and an initial high perception of social support positively influenced grief 14 months later. Self-reported grief, stronger religious faith, and better-perceived social support as assessed 14 days after the loss predicted lower level of grief 14 months later. Maternal age, marital status, educational level, stressful life events, gestational age, having living children, and having taken part at the funeral did not correlate significantly with any of the psychopathological instruments at any time point.

The following section describes the outcomes formulated from the quantitative studies.

Psychological outcome following termination of pregnancy for fetal anomalies

A number of studies revealed that termination of pregnancy for fetal malformation could be considered as a traumatic life event with high psychological impact. One longitudinal study in the Netherlands (Geerinck-Vercammen & Kanhai, 2003) assessed the emotional state using semi-structured interviews with 89 couples before termination of pregnancy, six weeks after termination and six months after termination. This study found feelings such as doubt, guilt, failure, shame, anger, anxiety and relief were experienced during the period of termination of pregnancy for fetal anomaly and the following weeks but disappeared after six months. The researchers identified that seeing the dead baby, saying farewell, and the medical and psychosocial support received from professional caregivers gave them a good feeling afterwards. The strength of this study was the use of semi-structured interviews, which allowed participants to generate their own response rather than restricting them to the list of possible emotional responses. However, conclusions from this study should be viewed with caution as the measures were inadequately defined, and the details of the reliability and validity of the interviews were not provided. An additional limitation was that the interviews were carried out by the person performing the counselling. This may have affected the responses of the patients.

A prospective cohort study of 49 women in the USA choosing second-trimester abortion caused by fetal anomalies was conducted to compare grief resolution after dilation and evacuation or induction of labour (Burgoine et al., 2005). The result found that there was no significant difference in grief resolution among women who terminated a desired pregnancy by either medical or surgical abortion. This means that the method of termination of pregnancy was not found to be significant to the psychological outcome.

Although standardized instruments were used to measure the psychological outcome, the primary limitations of this study were randomisation and high dropout rate; of the 49 initial subjects, just 29 completed a 12-month follow-up and only 14 completed all follow-ups. This may lead to an underestimation of negative effects on the outcome.

Korenromp et al. (2009) studied psychological outcomes in 147 women at 4, 8, and 16 months after termination of pregnancy for fetal anomaly in the Netherlands. The results revealed that 17% of women indicated that they had had severe feelings of doubt and 12% had perceived pressure during the period of decision making. In relation to the psychological outcome, at 4 months after termination, 46% of women showed pathological levels of posttraumatic stress symptoms, decreasing to 20.5% after 16 months.

A cohort study of 30 women in a north London teaching hospital (Davies et al., 2005) found high levels of psychological distress in women undergoing termination of pregnancy in the first and second trimesters at 6 weeks, 6 months and 12 months after termination. Women who chose termination of pregnancy after a diagnosis in the second trimester were significantly more distressed six weeks after the termination than women who received a diagnosis in the first trimester of pregnancy. However, there were no significant differences between groups in other measures of psychological morbidity. This study concluded that whether it was a first or second trimester termination for fetal abnormality, psychological morbidity is "prevalent and persistent".

On the contrary, a cross-sectional study performed with 217 women at 4 months after a termination of pregnancy due to fetal anomaly found that advanced gestational age at termination of pregnancy was associated with higher levels of grief and posttraumatic stress symptoms (Korenromp et al., 2007). The results of this study were remarkably

similar to those of other published study with a similar methodology, in which there was an assessment on psychological outcomes with 196 women at the period between 2 and 7 years after termination of pregnancy (Korenromp et al., 2005). However, it should be noted that these two published studies presented the findings in different sections based on the same study. In addition, the assessment which took place between 2 and 7 years after the event could have affected emotional problems related to termination of pregnancy because the possibility for other distressing life events could have occurred during that time.

In assessing the impact of termination of pregnancy for fetal anomaly, the inclusion of comparison groups is beneficial. One study compared psychiatric outcomes of women after termination due to fetal anomaly, compared with women after the delivery of a healthy child in Germany at 14 months. The study reported that women who underwent termination of pregnancy showed significantly higher symptoms of posttraumatic stress, depression, and anxiety than women after spontaneous delivery (Kersting et al., 2007). When comparing the psychological status of women having severe complications during pregnancy to women who underwent termination for fetal anomaly, Kersting et al. (2009) found that both events could lead to severe psychiatric morbidity with a lasting psychological impact. However, posttraumatic stress and clinician rated depressive symptoms were highest in women after termination. Unfortunately, these two studies report only comparative information, rather than information that allows the interpretation of absolute levels of psychological morbidity. A further limitation is the final response rate of the group of women who underwent termination of pregnancy is quite low (58%). A low response rate may influence the representativeness of the sample.

In assessing factors which influenced adverse psychological outcomes following termination of pregnancy for fetal anomalies, Korenromp et al. (2007) and Korenromp et al. (2009) reported that adverse psychological outcomes were a high level of doubt in the decision period, inadequate partner support, low self efficacy, lower parental age, being religious, and advanced gestational age. The other study identified self-reported grief, stronger religious faith, and better-perceived social support as predictors of lower level of grief (Kersting et al., 2007).

2)   Outcomes reported in the qualitative studies

A summary of the main outcomes of qualitative studies in women's experiences of termination of pregnancy for fetal anomaly is shown in Table 2.8. However, the three studies investigating the women's experience of termination of pregnancy for fetal anomaly employed different study designs and differences in time aspects between each study which made comparison across studies difficult.

Table 2.8: The main outcomes of qualitative studies relating to women's experiences of termination of pregnancy for fetal anomaly

Study	Outcomes	Results
Gammeltoft et al. (2008)	Vietnamese women's emotional strands of termination of pregnancy for fetal anomalies	Three different emotional strands were interpreted 1) Sorrow and pain- what they lost was not only a child-to-be that they had already begun to feel attached to, but also the social recognition that they would have received as the successful mothers of a healthy and "perfect" child. 2) Guilt and fear-their belief about ensoulment of their child-to-be caused them to have the feelings of pity for their child and fear for not allowing their child to live. 3) Uncertainty-they were struggled with the pain of uncertainty regarding the causes of this reproductive mishap and uncertain outcome of their next pregnancy.
Hunt et al. (2009)	Dilemmas and choices occurring after experiencing a termination for fetal abnormality in UK	Three dilemmas and choices that parents faced 1) Whether to see and hold the baby-participants had mixed feelings about whether they should have seen their baby, though the author suspects they might have regretted it if they had not. 2) Whether to have a funeral or cremation-most respondents had not thought of this issue and they were unable to make a decision when they were first approached. 3) Whether to have photographs, hand or footprints of the baby- some respondents were positive about having the photographs and hand/footprints, while others had been upset as it was a "tangible record" of their experience of loss.
Ferreira da Costa, et al. (2005)	A process of adaptation following fetal anomaly diagnosis in Brazilian women	The participants moved through a seven-stage process including: 1) The diagnosis of malformation-the women faced a terrible shock on learning of the diagnosis. They responded with tears, fear, despair, anguish, suffering, guilt, a sense of uselessness, and refusal to accept the situation. 2) The decision to terminate the

Study	Outcomes	Results
		pregnancy- the reason for this decision is to relieve both the suffering of the fetus and their own. 3) Requesting legal authorisation- obtaining legal authorisation to terminate the pregnancy was very difficult both emotionally and bureaucratically. 4) Going through the termination- the women experienced sadness, despair and guilt, and all these feelings caused them intense suffering. 5) After the termination- on the one hand the killing of the fetus was the most difficult part of the termination for them, on the other hand, afterwards, they were satisfied with the decision taken and believed that it was the correct one, despite the anguish it caused. 6) Plans for another pregnancy- although the women were afraid of going through the same thing again, they affirmed that they would like to become pregnant again. 7) Repercussions for the marital relationship- this event strengthened the ties of affection and did not change their sexual relationships.

The following three outcomes were formulated from the qualitative studies.

The emotional responses of termination of pregnancy for fetal anomalies

The emotional responses after termination of pregnancy for fetal anomalies were interpreted from three studies. An anthropological research that investigated 17 Vietnamese women who opted for termination of pregnancy for fetal anomalies found a complexity of different emotional strands, including: pain, sorrow, guilt, fear, and intense uncertainty (Gammeltoft et al., 2008). The women related sorrow and guilt to their loss that was not only the loss of a child-to-be, but also the loss of a social identity as a mother. Guilt and fear were related to their belief about the soul of their child-to-be. Finally, they struggled with the pain of uncertainty regarding the causes of this reproductive trauma and uncertainty about the outcome of their next pregnancy. The researchers employed observations, interviews, and a focus group discussion for data collection. However, they did not clarify how the different data sets were analysed to

establish the findings because only limited details of data analysis and interpretation were described. Procedures for establishing trustworthiness were not presented.

Another study in the UK demonstrated three dilemmas and choices that parents faced after experiencing a termination for fetal abnormality, including whether to see and hold the baby, whether to have a funeral or cremation, and whether to have photographs, hand or footprints of the baby (Hunt et al., 2009). The participants had mixed feelings and found it difficult to make a decision about these issues. In this study, as the secondary analysis was conducted on qualitative data, it is difficult to assess whether the focus of interest for the secondary analysis was fully explored with every participant.

A process of adaptation following fetal anomaly diagnosis

Ferreira da Costa et al. (2005) pointed out that the loss of a baby due to pregnancy termination for fetal anomaly was a very sad experience for Brazilian women. This study presented a seven-stage process that the women moved through, including the diagnosis of malformation, the decision to terminate the pregnancy, requesting legal authorisation, going through termination, after the termination, planning for another pregnancy, and repercussions for the marital relationship. The women experienced not only mixed feelings of sadness, despair and guilt, uselessness, and refusal to accept the situation, but also the difficulty of going through each stage. Again, the researchers did not provide adequate details of rigour in their study.

2.3.6   Conclusion

In general, the quantitative studies reporting women's experiences of termination of pregnancy for fetal anomaly were well designed and used standardised assessment measures. It is clear that termination of pregnancy for fetal anomaly is associated with

long-lasting psychological morbidity for a considerable number of women. Although a criticism of these studies is small sample size which might limit the generalisation of the results to other populations, these have provided insight into the psychological consequences of termination of pregnancy for fetal anomaly. However, a limitation of the available quantitative studies is that these fail to investigate the whole picture of psychological responses before, during, and after termination of pregnancy.

Of the three qualitative studies, all provided rich expression and description of the experience in the words of the participants. However, the findings interpreted from different qualitative approaches are unable to clearly understand women's experience of termination of pregnancy. Thus further qualitative research involving replication of these studies is required.

2.4   Gaps of knowledge

Of the quantitative studies on miscarriage and termination of pregnancy for fetal anomaly, it is clear that the levels of anxiety, distress, and grief are high in women who have experienced miscarriage or termination of pregnancy and these events have an emotional impact on the woman. Although this is a useful approach to map the prevalence of psychological problems after miscarriage and termination of pregnancy for fetal anomaly, it provides only broad insights and misses the complexity of the miscarriage experience.

From the qualitative studies, it appears that miscarriage and pregnancy termination are a personal, private, and intimate experience both physically and emotionally. A sense of loss is found to be the most common response occurring to women who have experienced these events. However, the studies employed different study designs and differences in time aspects between each study. Therefore, in attempting to draw

comparisons, it must be remembered that the comparison is not like for like. Qualitative studies probing women's thoughts and feelings pertaining to personal, relationship, and contextual factors that entered into their emotions, thoughts, and experiences are needed to do justice to the inherent complexity of this area of study. However, a major criticism of the qualitative studies is that although the samples as well as the process of data collection and analysis are relatively well described, the researchers fail to describe full details of strategies for ensuring rigour in the study. As the methods used in qualitative research may unavoidably influence the objects of inquiry, a clear explanation of the process of data collection and analysis is important. Therefore, it is a responsibility of a researcher to provide sufficient data regarding the procedures for establishing trustworthiness is needed in order to allow readers to judge whether the interpretation offered is adequately supported by the data.

Furthermore, the majority of recently available studies have been carried out in Western countries which present the findings in different points of view depending on the socio-cultural context of each study. Only a few studies have been conducted in the socio-cultural context of the Far East, clearly this context is different from the context of Western countries. In particular, there was only one published study on women's experiences of miscarriage conducted in Thailand and there is no available study on women's experiences of termination of pregnancy for fetal anomaly. Thus, to gain a deep insight into women's experiences after a miscarriage or after a termination of pregnancy due to fetal anomaly in Thai context, studies in this region are required.

CHAPTER 3

METHODOLOGY

3.1   Introduction

This study aims to gain an in-depth understanding of women's experiences of miscarriage and termination of pregnancy due to fetal anomaly. It is research into not only the meaning of the experience but also how women interpret their lives and make meaning of what they experience. The meaning of this phenomenon cannot be understood without women themselves telling their own stories in their own words. To achieve a deep understanding of this issue, research approaches and methods which enable me to gather in-depth and rich data are required. In this chapter, four main parts are explained.

The first part includes the statement of the research question, the research questions and the objectives of this study.

The second part describes the research methodology and the interpretive constructionist paradigm which has been used as the philosophy underpinning this research. I then indicate why this paradigm is appropriate and how interpretive phenomenology emerges from this approach. Furthermore, the use of hermeneutic phenomenology as the methodology for this study is justified.

In the third part, I explain the study design, which includes: how I achieved data collection through a careful choice of participants and conducted unstructured interviews. I then examine research ethics that are central to conducting research, by emphasising the obligations of the researcher to protect the participants from harm as a result of the

research. Moreover, the logic and techniques of interpretative phenomenological analysis are described in order to illustrate how I identified themes and combined them to answer the research problem. Finally, thoroughness concerning the rigour of research is presented in terms of credibility, transferability, dependability, confirmability, and authenticity (Guba & Lincoln, 1994).

In the fourth part, reflections on the research process, I demonstrate the challenges I have found in data collection and how I managed these problems.

3.2   Statement of the research question

This study attempts to fill the gaps of knowledge described earlier by exploring women's experiences of miscarriage and termination of pregnancy for fetal anomaly in Thailand. The comparison of both groups will be drawn and women's perceived priority needs after miscarriage and termination of pregnancy for fetal anomalies will be identified. The results of this study will be used to produce educational materials to enable health care staff to meet the needs of women suffering pregnancy loss, as well as providing useful data for the nurse-midwife to develop and implement guidelines that are appropriate to meet the needs of these women.

The aim of this study was to explore the similarities and differences of experiences of miscarriage and termination of pregnancy for fetal anomaly among a group of Thai women. The following research questions were formulated:

1.   What are the women's experiences of miscarriage in Thailand?

2.   What are the women's experiences of termination of pregnancy for fetal anomaly in Thailand?

The objectives of this study were:

1. To explore Thai women's experiences of miscarriage.

2. To explore Thai women's experiences of termination of pregnancy due to fetal anomalies.

3. To draw comparisons of the women's experiences of miscarriage with those of termination of pregnancy for fetal anomalies.

4. To identify women's perceived priority needs and concerns after miscarriage and termination of pregnancy for fetal anomalies.

3.3   Research methodology

From doing a thorough review of the existing literature, it appeared high levels of anxiety, distress, and grief could be predicted by quantitative studies in women who had experienced miscarriage or termination of pregnancy. However, the impact of loss on women's lives could not be evaluated by mathematical tests. This meant that the reality could be viewed not only as things which were accessed from scientific deduction, but also as societally embedded knowledge which was constructed jointly in interaction by the researcher and the researched (Grbich, 2007).

According to the interpretive constructivism, Guba and Lincoln (1994) stated "realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures), and dependent for their form and content on the individual persons or groups holding the constructions" (p.110). The research based on this paradigm focused on exploration of the way people interpreted and made sense of their experiences in the worlds in which they lived (Grbich, 2007). On the other hand, what is important in the interpretive constructionist philosophy is how people

view an event that happened to them and the meaning that they attribute to it. In this research, I looked for the shared meanings in the group of Thai women who experienced miscarriage and in the group of those who underwent therapeutic termination due to fetal anomalies. To achieve this aim, interpretive constructionist philosophy allowed me to synthesise the understanding of the reality which was constructed from different women experiencing a particular event.

Although the nature of the research question directed me towards qualitative methods and lent itself to a phenomenology, it was essential for me as the researcher to choose the type of phenomenological approaches which enabled me to understand the experience of loss in the two groups of Thai.

I reviewed the use of phenomenology in nursing research, and found a number of articles which demonstrated the phenomenological approach had become utilised as a method of investigating experiences in nursing research studies (Lopez & Willis, 2004; Mackey, 2005; Pereira, 2012; Thomas, 2005). The phenomenological approach was considered as a good fit for researching nursing questions and seeking understanding about phenomena of vital importance to the practice of nursing (Lopez & Willis, 2004; Munhall, 1994).

However, problems were found in the use of phenomenology approach in some nursing research studies. Dowling (2004), Giorgi (2000), and Mackey (2005) discussed the lack of the researchers' philosophical understanding of phenomenology which led to confusion around the foundations on which the method was built and how the study produced knowledge. Lopez and Willis (2004) agreed that implementing a method without an examination of its philosophical basis could result in research that was ambiguous in its purpose, structure, and findings. Thomas (2005) and Mackey (2005) claimed that although many published reports of phenomenological nursing research

indicated the use of Husserlian, Heideggerian, and other phenomenology, they had failed to clearly explore the philosophical underpinnings which determined the role of the researcher in the research process. Another example was Draucker's (1999) review of Heideggerian hermeneutic research in nursing which found reference to the philosophical basis of this approach varied greatly.

In order to solve the problems surrounding the use of phenomenology in nursing research, Lopez and Willis (2004) and Pereira (2012) suggested that as assumptions drove methodological decisions and the research findings generated would depend on which philosophical approach was used, the researcher should be aware of the values and claims associated with each approach before making a commitment to a choice of method.

It was essential for me as the researcher to clarify my understanding of the assumption of phenomenology. The fundamental principle of phenomenology accepts that human experience is a valuable source of knowledge, and its methodological approaches allow the complexity and depth of human experience to be uncovered (Mackey, 2005). However, with consideration of the philosophical bases, assumptions, focus of research, and research outcomes, there are several differences between Husserlian phenomenology and hermeneutic phenomenology.

Firstly, phenomenology, founded by Edmund Husserl and situated within the positivist and post positivist paradigm, is descriptive in nature, seeking to explore and describe phenomena as they present themselves in the lived world in order to find meaning of the phenomena for itself (Laverty, 2003). Whilst interpretive phenomenology or hermeneutic phenomenology, which was developed by Heidegger and based on the paradigm of constructivism/interpretivism, focuses on interpretation of a phenomenon.

Heidegger's approach emphasises the rich description and the interpretive basis of all understanding (Mackey, 2005). In hermeneutic phenomenology, Adams and Van Manen (2008) stated that phenomenology became hermeneutical when its method was taken to be interpretive rather than purely descriptive. Thus, hermeneutic phenomenology aims to investigate how people interpret their lives and make meaning of what they experience (Cohen et al., 2000). Heidegger argued that all description is always already interpretation and every form of human understanding is interpretive (Adams & Van Manen, 2008). This means that interpretation allows that which is already understood to be revealed.

Secondly, phenomenology is the study of lived experience of the life world without resorting to categorization or conceptualization (van Manen, 1997). The main focus for phenomenology is the study of phenomena as they appear through consciousness (Kvale, 1996). Like phenomenology, hermeneutic phenomenology is concerned with the life world or human experience as it is lived. However, Heidegger's hermeneutic phenomenology focuses on 'Dasein', that is translated as 'the mode of being human' or 'the situated meaning of a human in the world' (Laverty, 2003). It provides a way of approaching research which focuses on the person and the context of their existence. Therefore, there is no escape from the historical foundation of researcher's understanding because it serves as an ontological base for the researcher's being-in-the-world (Crist & Tanner, 2003). Hermeneutics could be considered as the interpretive process which the research goes through in order to gain knowledge and understanding and therefore give meaning to the phenomena (Laverty, 2003). Heidegger uses the metaphor of the hermeneutic circle to represent the dynamic movement between the parts and the whole of texts to seek understanding. Therefore, the meaning of the parts depends on the

whole, and the meaning of the whole depends on the meaning of the parts (Annells, 1996).

Thirdly, as phenomenology emphasises subjectivity and the discovery of the essences of experience through consciousness, the process of phenomenological reduction or bracketing is needed in order to successfully achieve contact with essences (Laverty, 2003). This is a process of suspending one's judgment or bracketing particular beliefs about the phenomena in which Husserl proposed that one needed to bracket out the outer world as well as individual biases in order to see it clearly (Laverty, 2003). In contrast, the techniques of bracketing and phenomenological reduction have no place within hermeneutics (Annells, 1996). Heidegger stressed the importance of 'being in the world' and, hence, trying to eliminate one's own concepts in interpretation is impossible (Koch, 1996). Based on this Heideggerian view, the researcher's personal beliefs and standpoint are not seen as biases to be eliminated but rather as being necessary for making sense of the experiences of other individuals (Fade, 2004). The process of interpretation is built on fore-structure which is referred as pre-understanding or background. Thus, the researcher's ability to interpret the data is reliant on previous knowledge and understanding (McConnell-Henry et al., 2009; Polt, 1999).

Consequently, for this study, the interpretive phenomenology or hermeneutic phenomenology which is a strategy of inquiry based on the paradigm of constructivism/interpretivism was used to guide specific methods of collecting and analysing empirical data for several reasons.

Initially, as this research aimed to understand, rather than to explain women's experiences of loss through miscarriage and termination, and to utilise the knowledge rooted in experience, interpretive approaches based on the work of Heidegger allowed

me to richly and deeply probe the phenomenon. It was most congruent with the research purpose of interpreting and understanding the women's experiences of loss.

Additionally, as my experiences in maternal-child nursing and teaching prompted the research question, these personal manifestations related to Heideggerian philosophy that 'we are always already in the world' (van Manen, 1997). I therefore cannot stand outside the pre-understandings of my experience. The Hermeneutic approach enabled me to hold particular positions and gain understanding of the women's experiences of miscarriage and termination of pregnancy due to fetal anomaly.

Utilisation of an interpretative approach requires the researcher to accept and value the descriptions given by the participants as their reality, their understanding of the phenomenon (Koch, 1996). Thus, the process of conducting research requires the researcher to engage in both descriptive and interpretive activities (Mackey, 2005).

Munhall (2012, p.113) pointed out that "to accomplish a respectable status in research, it seems one must use a method and use it correctly for the research to be valid". From reviewing the nursing literature on the use of hermeneutic phenomenology, Mackey, (2005) suggested that it should be concerned not only laying the philosophical foundations, but also the methodological foundations on which the method was built. As Giorgi (2000) discussed although the use of philosophy of hermeneutics has been increasingly used in nursing research, the application of the work of this philosophy to interpretive nursing research had proved problematic because it failed to recognise, or act upon, obligations inherent in their work. Therefore, in order to strengthen the quality of hermeneutic research in nursing, the conceptual elements and the role of the researcher in the research process which underpins hermeneutic phenomenological method should be

explored in order to guide the researcher's approach to data collection and data analysis (Koch, 1996; Mackey, 2005; Munhall, 2012).

According to Heidegger's philosophy, Benner (1994, p. 71) provides the assumptions and basic philosophical issues of hermeneutic phenomenology. These assumptions are that:

1.   Human beings are social, dialogical beings.

2.   Understanding is always before us in the shared background practices; it is in the human community of societies and cultures, in the language, in our skills and activities, and in our intersubjective and common meanings.

3.   We are always already in a hermeneutic circle of understanding.

4.   Interpretation presupposes a shared understanding and therefore has a three-fold forestructure of understanding.

5.   Interpretation involves the interpreter and the interpreted in a dialogical relationship.

From these assumptions, Benner (1994) noted four basic aspects that were essential issues for hermeneutic phenomenology as a methodology. These included the forestructure of understanding, interpretation, the hermeneutic circle, and modes of involvement (Benner, 1994, p.71).

The forestructure of understanding was explicated by Heidegger as the forestructure of understanding upon which all interpretation was grounded. Heidegger acknowledged our background that made an interpretation possible. Because of our background, we have a point of view from which we make an interpretation and have some expectations of what we might anticipate in an interpretation (Benner, 1994).

Interpretation was a method of inquiry which was linked to the forestructure. Benner (1994) suggested two senses of the forestructure needed to be brought forward more explicitly. First, as part of the credibility of the project, the researcher should lay out preconceptions, biases, past experiences that might affect how the interpretation took shape. Second, the researcher might bring forth the forestructure of understanding for the study participants. This might be part of the narrative that the researcher elicited in the study in order to make sense of the participants' situation.

The hermeneutic circle was described as the interpretive process which was necessarily circular, moving back and forth between part and whole, and between the initial forestructure and what was being revealed in the data of the inquiry (Benner, 1994). This demanded a deep and enduring commitment (and existential presence) on the part of the researcher to stay true to the text and to honour the lived experience of the research participants. Through systematic analysis of the whole, the researcher would gain new perspective and depth of understanding. The interpretive process would follow this part-whole strategy until the researcher was satisfied with the depth of understanding.

In mode of involvement it was pointed out that the researcher has a world and exists in historical time just as the subject does. In order to have an "objectively valid" interpretation, one would have to understand from a position outside of history, which is impossible, given the phenomenological view (Benner, 1994, p.57).

As mentioned, these conceptual elements which underpin the hermeneutic phenomenological method were used as guides for my approach to data collection and data analysis in order to strengthen the quality of this research.

This section has discussed the philosophical underpinning of this research study, which is grounded in hermeneutic phenomenology. The focus of the next section is to describe

how I used the philosophy and the conceptual elements of hermeneutics to undertake my study.

3.4   The study design

The aim of this study was to compare the experience of loss of women who had experienced miscarriage with those who had experienced termination of pregnancy for fetal anomaly. This section will describe the process of data collection, ethical considerations, data analysis, and the rigour of the research.

3.4.1   Data collection

The process of data collection through careful choice of participants and unstructured interviews is demonstrated.

Setting

The study was conducted in Chiang Mai province, the northern part of Thailand. This province was selected for recruitment of participants for three reasons:

1) An adequate number of participants could be successfully recruited in this area because this setting is the second largest province of Thailand in which large groups of women of childbearing age reside or work;

2) I had worked as a lecturer in Chiang Mai University and had professional contacts in public health care organisations who served the target population and were willing to help recruit participants for the study; and

3) The benefits of this research would be expedited by examining the area in which I had worked and lived. As the aim of this study was to understand the experience

of loss through miscarriage and termination of pregnancy among a group of Thai women, the results of this study would be useful in producing educational materials for nursing programmes in order to reduce adverse psychological outcomes and promote adaptation for these groups of women.

This study presented challenges in the recruitment of potential participants, as the conventional means of recruitment such as, posting my invitation in public, sending my invitation by post, or inviting via the internet were not feasible as only some potential participants could access these methods. The specific place where I could meet my potential participants was a clinical setting where they were admitted for treatment and/or interventions for miscarriage and therapeutic termination. Thus, two public hospitals were approached to take part in this study. The first was Maharaj Nakorn Chiang Mai hospital which was a Chiang Mai university hospital and under the management of Chiang Mai University, Ministry of Education. The second hospital was Nakornping hospital which was a Chiang Mai general hospital and under the management of Ministry of Public Health. As they were the largest tertiary hospital and the largest secondary referral hospital in Chiang Mai province, respectively, they represented a wide variety of experiences and demographic characteristics: age, social status, and municipality (urban, semiurban, or rural).

Participants

The aim in participant selection in hermeneutic phenomenological research is to select participants who have the lived experience that is the focus of the study, and who are willing to talk about their experience, and who are diverse enough from one another to enhance possibilities of rich and unique stories of the particular experience (van Manen, 1997). As this research aimed to understand women's experiences of loss through

miscarriage and termination, choosing participants who had experiences of these events was needed.

Purposive sampling was used to recruit women who had experienced a miscarriage and women who had experienced a therapeutic termination for fetal anomaly. The purpose of selecting participants for a phenomenological study was not to meet statistical requirements or predict the phenomena but to demonstrate variation in the description of the experience (Miles & Huberman, 1994). This meant that participants were selected purposively because they could offer the study insight into a particular experience. Inclusion criteria were established to ensure that the participants were selected based on their particular knowledge of the phenomenon.

The inclusion criteria of the miscarriage group were:

- Women were treated for miscarriage in a gynaecological ward and could speak Thai, so they could offer the study insight into the experiences of miscarriage. Although 'miscarriage' was used as a general diagnosis, there were several different types of miscarriage recommended by the RCOG (2006), namely inevitable miscarriage, incomplete miscarriage, complete miscarriage, missed miscarriage, anembryonic pregnancy (early fetal demise), delayed miscarriage (blighted ovum), miscarriage with infection (sepsis), and recurrent miscarriage. Therefore the women who were diagnosed with any type of miscarriage would be included in this study.

- Women were 18 year old or older. This criterion aimed to avoid the ethical issue because the legal age of consent in Thai law is 18 years old. Moreover, as talking about sensitive topics might possibly make informants feel uncomfortable and induce emotional trauma, maturity of individuals was an important consideration.

Women with a past history of other types of pregnancy loss including induced abortion and therapeutic termination for fetal anomaly were excluded because this experience might change the individual's perception of loss through miscarriage.

The inclusion criteria of the therapeutic termination group were:

- Women were admitted in an obstetric ward for therapeutic termination for fetal anomaly before 24 weeks of gestation, so they could offer the study insight into the experiences of loss following therapeutic termination for fetal anomaly. As the aim of the study was to compare the experience of loss between the two groups of women, it was important that the gestational age at which the loss occurred was not different between the groups.

- Women were 18 year old or more and could speak Thai. Women with previous therapeutic termination for fetal anomaly were also included.

Women with past history of other types of pregnancy loss including miscarriage and induced abortion were excluded because this experience might change the individual's perception of loss through miscarriage.

All participants were required to be willing to be involved in the study by giving their written informed consent. To attain an understanding of the phenomenon, 11 women who had experienced miscarriage and 12 who had undergone termination of pregnancy for fetal anomaly were recruited. The demographic characteristics of the participants are presented in Chapter 4 and Chapter 5.

In order to gain an understanding of the context of the care that women received in hospitals, focus group interviews were undertaken with health professionals. For the focus group interviews, the participants were recruited from nurse-midwives and doctors

who gave care to women who had experienced miscarriage/therapeutic termination for fetal anomaly in the participating hospitals. Five nurse-midwives and five doctors who were willing to take part in this study were included from each hospital. Separate focus groups of the nurse-midwives or doctors were conducted in each participating hospital in order to avoid the issue of hierarchy and power between doctors and nurse-midwives in the Thai health care system that might impact on the data.

Recruitment

Recruitment refers to the processes conducted by the researcher in order to identify and attract individuals that meet appropriate selection criteria to participate in research (Miller, McKeever, & Coyte, 2003). I started to recruit and collect the data between October 2010 and December 2010 after approval had been received from the Ethics Committee of the Faculty of Health, University of East Anglia and from the committee for ethics of the hospitals where the study was carried out (Appendix A). Each process of recruitment I undertook is explained.

Recruitment of participants for interviews

Step 1: Identifying and recruiting the participants

The director of Maharaj Nakorn Chiang Mai hospital and Nakornping hospital allowed me to invite patients to participate in this study. In order to identify and recruit the participants from these hospitals, it was first necessary to gain the support from the nurses in the gynaecology ward and the obstetric ward. I asked for co-operation from the nurses to help recruit participants for the study. I firstly gave introductory information about the research and then asked for their co-operation to inform the women in their ward that the researcher would ask them to participate in this study. I also informed the

nurses that they could opt out at any time and they could use their discretion about the approach. The nurses agreed to help me recruit participants for the study for 3 reasons. Firstly, as I had worked as a lecturer in Department of Obstetrical and gynaecological nursing, Chiang Mai University and had regular professional contact with the nurses in these organisations for 13 years, the close relationship led them to be willing to help me. Secondly, informing the women did not disturb their working time. Finally, the nurses needed to improve and achieve the standard of care for these groups of women. The nurses who were the key people in providing health services in hospitals were expected to improve the quality of services and achieve the hospital accreditation standards. Although they needed to establish guidelines and standards of care for these women, the limitations of time and knowledge were the main obstacle for conducting research. When I conducted the study on these women, they tended to be willing to help me. Moreover, as one of the study objectives was to identify women's perceived needs and concerns, this benefit encouraged them to help me succeed in data collection.

Step 2: Approaching the potential participants

Once the name of and details of the women were obtained through the nurses, I made the first contact with the women by a face-to-face visit in the hospital prior to their discharge and screened each person to determine whether they met the inclusion criteria for participation. Normally, these women were admitted to the hospital for a period of 3 days for treatment and recovery.

On first contact with the women, I had asked the nurse before approaching them to ensure that they were in good physical and psychological condition and approaching them did not impose an additional emotional trauma. I approached each woman in a natural style of conversation in order to establish a relationship of equality and trust. I

started the conversation by introducing myself and then asking the women about their conditions and readiness before informing them about the study. Then I explained what my project was about. I gave them the information sheet (in Thai) (Appendix B1) and explained the aim of the study, the method to be used, the risks and benefits of participation in the study. I also ensured that they understood that there was no advantage or disadvantage whether they decided to participate in the study or not. I then gave them my telephone number so they could call if they had any questions before their consent or refusal to participate was ascertained. Finally, the women were informed that they were given time to consider their willingness or unwillingness to participate in the study and I would make contact in two weeks. They were asked how they wanted to be contacted about the research. All women were willing to be contacted by phone and gave me their telephone number.

However, after I informed the women about the time to consider their willingness or unwillingness to participate in the study, 4 cases of therapeutic termination women and 4 cases of miscarriage women had indicated their willingness to participate in the study and gave permission for me to interview them before discharge. There were two reasons that they needed me to interview them at the hospital before discharge. Firstly, some women were referred from hospitals in their provinces where they lived to the hospital in Chiang Mai province for proper management. Thus, when they went back to their home town, it was not convenient for them to make an appointment with me in Chiang Mai province and it was also difficult for me to make an appointment with them or look for their houses in other provinces which were unfamiliar to me. Secondly, some women needed their private space. When they returned to their work, they could not make an appointment with me in the working day and it was inconvenient to make an appointment with me at their home. As the aim of my project was to understand women's experiences

of loss through miscarriage and termination and these women were experienced and knowledgeable in this event, and were willing to participate in the study, after discussion with the field supervisor professor Kannika Kantaruksa we decided there was no reason to exclude them.

The other women were contacted by telephone two weeks after their discharge to ask for their willingness or unwillingness to participate in the study.

Step 3: Asking for participation in the study

At two weeks after discharge, the women were contacted by telephone to ask for their willingness or unwillingness to participate in the study. The two week period was considered as the recovery period after treatment. Thus this period was set to ensure that the women were ready both physically and mentally for participation in the study. In addition, the two week period was set to allow the women time to experience both the physical and emotional aspects of having a miscarriage and/or termination of pregnancy for fetal anomaly.

All women I approached were willing to take part in this study. I then asked them to return the consent forms with their signatures on the day of interview (Appendix B3). Consequently, each participant was asked to arrange a mutually convenient date and time for the interview to take place. Some women requested to be interviewed at the hospital on the day they were discharged, some women were willing to be interviewed at their homes, and some women requested interview at the hospital on the day they came for a follow up appointment (4 weeks after discharge). Interviews were scheduled at a time and place that was convenient to help them relax and feel comfortable, and willing to talk about their experiences.

There might be two reasons that the women chose to participate in the study. Firstly, Thai people usually respect and depend on their health care providers. When health care providers ask for their co-operation, they tend not to decline a medical authority figure. Although I informed them about my current status as a student, they still perceived and accepted me as a health care provider figure. Secondly, a face to face approach gave me a chance to clearly explain about the project and the women also clearly understood about it. Moreover, the face to face approach also benefited in establishing and developing a relationship between me and the women. It is hoped this relationship allowed them to trust me so they felt willing to talk about their experiences.

Recruitment of participants for focus groups

Step 1: Accessing and recruiting the participants

In order to access focus group participants who were health professionals, it was necessary to gain the support from the head obstetricians and the head nurses of the gynaecology ward and the obstetric ward in targeted hospitals. I asked for their co-operation to inform the doctors and nurse-midwives in their wards that the researcher would be asking them to participate in this study. The head obstetricians and the head nurses suggested that I should approach the group of nurses and doctors during their regular staff meetings.

Step 2: Approaching the potential participants

Once the dates of staff meetings were obtained through the head obstetricians and the head nurses, I made an approach with each group of doctors and nurses. I introduced myself and explained what my project was about. I gave them the information sheet (in Thai) (Appendix B2) and explained the aim of the study, the method to be used, the risks

and benefits of participation in the study. I also ensured that they understood that there was no advantage or disadvantage whether their decided to participate in the study or not. I then gave them my telephone number so they could call if they had any questions before their consent or refusal to participate was ascertained. Finally, the professionals were informed that they were being given time to consider their willingness or unwillingness to participate in the study and I would make contact in two weeks. They were asked how they wanted to be contacted about the research. Some professionals were willing to be contacted by phone and gave me their telephone number, some were willing to be contacted by electronic mail, and some wanted to contact me by phone.

Step 3: Asking for participation in the study

Two weeks after they were first approached, the potential participants were contacted by telephone to ask for their willingness or unwillingness to participate in the study. Some sent me an electronic mail or contacted me by phone to inform me if they were willing to participate in the study. For participants who intended to participate in the study, I then asked then to return the consent forms with their signatures on the day of focus group (Appendix B4) and asked to arrange a convenient date and time for the focus group to take place. Most participants requested a focus group at the hospital on the day they had staff meetings. Focus groups were scheduled at a time and place that was convenient for them so they would be relaxed, and comfortable to participate and share their information in a group setting.

Interviews

Benner (1994) explained that in hermeneutics, the primary source of knowledge that was studied and interpreted in order to discover the hidden or obscured meaning could come from interviews, participant observation, diaries, and samples of human behaviour.

Interviewing was considered the main research method which has been closely associated with hermeneutic inquiry as a means to obtain the lived experience material from the viewpoint of the person who has that experience (Walker, 2011).

This was confirmed by reviewing the use of an interview in hermeneutic phenomenological studies. The results found that the interview served very specific purposes of the hermeneutic phenomenology because it was used as a means to explore and gather the narratives of lived experiences and it allowed participants to share their stories in their own words (Ajjawi & Higgs, 2007; Fleming et al., 2003; Lindseth & Norberg, 2004).

As this research aimed to understand women's experiences of loss through miscarriage and termination, and to utilise the knowledge rooted in experience, interviews were the best means to generate depth of understanding. Each step of the interviews I undertook is explained below.

Step 1: Identifying preunderstandings

As mentioned in Heidegger's philosophy that interpretation was a method of inquiry which linked to the forestructure, it was accepted that the researchers could bring their preconceptions to the interview (McCance & Mcilfatrick, 2008). However, Benner (1994) suggested the forestructure needed to be brought forward more explicitly. This meant that laying out the researcher's preconceptions, biases, and past experiences that might affect how the interpretation took shape was needed to aid the blending or fusion of the meanings articulated by the participants and the researcher during the interpretive process (Koch, 1996; Lopez & Willis, 2004).

To demonstrate a commitment to the Heideggerian concept, before conducting the research interviews, my supervisors encouraged me to reveal my prior knowledge and experience of loss through miscarriage and termination of pregnancy for fetal anomaly. I then wrote memos to myself in my research diary to explain my point of view at the start of the research. The point was that to clarify how my background influenced my point of view of the loss experiences, and how my concerns had shaped the way in which I conducted and interpreted the interviews.

Step 2: Determining the type and style of interview

The main aims of the interview were to encourage the participant to share as much depth and relevant breadth as possible and to elicit information in the participant's own words. There are various ways of conducting research interviews, including structured, semi-structured, and unstructured interviews (Minichiello et al., 1999). Van Manen (1997) argued that deciding on the most appropriate type of interview should be determined by 'the fundamental question that prompted the need for the interview in the first place'. In addition, choosing the type of interview was also linked to the depth of response sought and the degree to which the researcher has control over the content and process of the interview (Walker, 2011).

Benner (1994) explained that the role of storytelling was central to interpretive phenomenology so the interviewer had to learn to listen to the story with as little interruption as possible. As the purpose of this study was to explore the meaning of loss through miscarriage and termination of pregnancy for fetal anomaly from the perspectives of women who had experienced this situation, an unstructured interview was chosen in this research to minimise the degree of the researcher's control over the transaction of the interview. Imposing too much structure on the interview would inhibit

the participant's responses so the researcher might be likely to come away with only an incomplete understanding of the phenomenon of interest (Nunkoosing, 2005).

In the unstructured interview, the participants were invited to offer a rich, detailed, first-person account of their experiences, whilst the researcher responded to and then asked further questions in response to what the researcher heard from the participants rather than relying on predetermined questions (Rubin & Rubin, 2005). Set questions were not used, as the purpose of the research was to explore the participants' perceptions of what was important in relation to the phenomenon rather than to look at what the researcher deemed important (Smith et al., 2009). Through unstructured interviews, I could understand experiences and reconstruct events of what happened to the women, and how they lived with and adapted to these events.

Step 3: Eliciting the lived experience

On the day of interview, I explained about the study again to ensure that the participants clearly understood it. According to the responsive interviewing based on Rubin and Rubin (2005), there are no fixed rules in interviews. The most important thing in interviews was making the participants feel comfortable to tell me their experiences in the way they wanted and in the topic that was important for them. Thus, I could develop different styles in each interview to match the participants' personality. Usually, I preferred a gradual approach. I spent more time before the interview in building up a relationship with chat on non-related or related matters before beginning to ask questions. Some small talk helped to establish rapport with the participants and created a relaxed atmosphere so as to facilitate the progress of the conversation. Following this, I started with a broad question, for example, "Can you tell me what happened to your pregnancy", and gave the participants the opportunity to answer from their own

experiences. To achieve the depth, detail, and richness sought in interviews, I had to listen carefully to what they told me, and ask additional questions about their answers until I really understood them. This responsive approach (Rubin & Rubin, 2005) ensures that the researcher is responding to and then asking further questions about what the researcher hears from the participants rather than relying on predetermined questions. Different probes were prompted by the nature of the responses until the experience was fully described, such as, "As you mentioned about the sin, could you please explain more?" or "You do this ritual for what?" Clarifications were asked for and the participants were prompted for information during the interview as necessary until they had no more to tell. The interviews were between one and a half hours and two and a half hours to cover the sensitive nature of the content.

According to the responsive interview (Rubin & Rubin, 2005), the researcher is a human who has emotions, a temper, and opinions, not an automaton, so the researcher inevitably affects what is learned. The first thing I learnt from interviewing was being relaxed created an environment for a thoughtful, rich interview.

Step 4: Capturing the data

All interviews were voice recorded with permission of the participant. This enabled me to capture the description and to engage with the interview rather than concentrating on note taking. Thus taking notes was conducted as little as possible during interviews.

However, field notes of each interview were made after each interview to describe non-verbal information that might not be audible in the recorded interview, for example, physical expressions, and gestures. The non-verbal information was inserted into the transcript immediately after transcription in order to help interpret the data. There was not only additional information, but also self-reflection after each interview. As the

interviewer and interviewee interact and influence each other, the interviewer has to be self-aware, examining their own biases and expectations that might influence the interviewee (Rubin & Rubin, 2005). I found that self-reflection could help improve the quality of interviews. It helped me gain insight into how questions could be framed. Is the wording too biased? The self reflection allowed me to improve my interview technique after each interview. In addition, debriefing with my fieldwork supervisor, Associate Professor Dr. Kannika Kantaruksa, after conducting each of the two pilot interviews was also valuable. She reflected upon my strengths and weaknesses, and suggested alternative approaches that could be used in future interviews.

Step 5: Terminating the interview

I concluded each interview by asking participants if they had any further issues that they would like to share on the topic or questions that they would like to ask about the research or the subject matter. I then encouraged the women to speak about the effect of the interviews on their feelings. This was because emotionally charged issues might be raised during the interview and might arouse feelings that were too hard to deal with. The women who requested support were given the contact telephone number of a counselling centre in the hospital. All women said to me that the interviews helped them to express, release and realise their feelings. Although there was no woman who requested support, I still gave them the contact telephone number of a counselling centre. I offered this supportive option to them in order to ensure that they could find a source of emotional support if they had any emotional suffering after finishing the interviews. Finally, the interviews were concluded by thanking the participants for their time and sharing their experiences.

Focus groups

In addition to the women's interviews, to gain understanding of the context of care interviews with professionals concerned with managing miscarriage and termination of pregnancy (nurse-midwives and doctors) in the participating hospitals took place in focus groups. From reviewing the literature on the use of focus groups in social science research, it could be concluded that focus groups were designed to allow research participants to exchange, discuss, agree or disagree about opinions, attitudes, and experiences (Shaha et al., 2011; Smithson, 2000). Shaha et al. (2011) also summarised the benefits of this method including that it was less intimidating and time intensive than one-on-one interviewing; it provided more depth than questionnaires; it acknowledged participants as experts; it yielded insight into participants' language and concepts; it allowed group interactions; it permitted researchers to learn more about the degree of consensus on a topic; and it encouraged attempts to identify, describe, analyse and resolve key issues. Thus, the method of interviewing via a focus group was selected to explore the views of health professionals on miscarriage and therapeutic termination care.

Four focus groups were conducted with two groups of doctors ($n =10$) and two groups of nurse-midwives ($n =10$) in December 2010. Some authors advised that groups should consist of four to eight (Barbour & Kitzinger, 1999), or four to five (Twinn, 1998) in order to manage the groups easier, especially if the topics were highly emotional and there was much discussion (McLafferty, 2004). Separate focus group of nurse-midwives and doctors was carried out by me as the facilitator in a private room and lasted for 60 minutes. In Thailand there is a hierarchical relationship between doctors and nurses

therefore it was important to have separate groups to enable the nurses in particular to feel free to voice their opinions.

Each participant was issued with a consent form to read, which was signed when they presented for the focus group discussion (Appendix B4). Refreshments were provided in the form of tea and coffee as McDaniel and Bach (1996) described the use of refreshments as a measure to relax the atmosphere. The focus group was conducted by me as a moderator. I began the focus group by asking two open questions: "Tell me what is has been like to take care of…" and "What are your feelings about this experience?" I then tried to invite all participants to share their opinions while sticking to the group discussion topic. The focus group discussion was audio-recorded. At the end of the discussion, I summarised the main issues raised by the group and asked the group to comment on data accuracy. At the end of the focus group discussion the participants were reminded of the need to maintain confidentiality.

3.4.2   Ethical considerations

As the experience of loss was a sensitive topic, the interview had the potential to be a further traumatic experience for participants. To protect the participants from potential harm as a result of the research, the following procedures were conducted.

1. This study received approval from the Ethics Committee of the Faculty of Health, University of East Anglia and agreement from the hospitals where the study was carried out.

2. Both the information sheet and consent form were translated into the Thai language to ensure that it was accessible to all participants. I explained the purpose and

the method of this study for the participants and asked for their permission to collect

data. A consent form was used to ensure that the subjects had volunteered. All the

participants were informed that they were free to withdraw from the study at any stage of

the process, even after they started to answer the questions, and this did not affect their

status in any way. This helped to confirm to the participants that their rights were

respected and protected at all times. Moreover, after the first approach was made,

participants were given 2 weeks to consider whether they wanted to participate or not.

3. The participants were informed that confidentiality was maintained at all times

through the use of a code number for any subsequent publications or presentations. A

code number was assigned to each participant and used in all written records of the study

to protect the anonymity of participants. Only I had access to the list which associated

code numbers with informants' real names. Computers used were password protected.

The interview recordings were only available to me and will be erased on successful

completion of the thesis and viva. . The transcripts will be stored securely for 5 years

according to the requirement of the ethics committee.

4. Talking about sensitive topics might possibly make the informants feel

uncomfortable and induce emotional trauma. Thus, before the interview, I informed the

participants that if they felt uncomfortable or found the discussion hard to deal with, they

could do any of the following: they could take a break and continue later, they could

choose to stop the interview, and if they needed emotional support, the contact telephone

number of the counselling centre in the hospital would be given. During the interview, I

continually observed their feelings and informed them again what they could do. At the

end of the interview, the participants were given the opportunity to speak about the effect

of the interview on their feelings to ensure that they were not left distressed after talking

about sensitive topics. All women were given the contact telephone number of the counselling centre in the hospital.

3.4.3 Data analysis

Preparing texts for analysis

The recordings of each interview were transcribed verbatim as soon as possible after they were collected and then the transcription of each interview was verified with the audiotapes. As the original transcriptions were in Thai, I translated into English. To ensure the accuracy of the interpreting of the meaning of language, some samples of the transcriptions were checked by a lecturer in Department of English, Faculty of Humanities, Chiang Mai University, Thailand. Examples of the process of translation of data were provided in Appendix C.

As a hermeneutic phenomenological study generates a significant amount of qualitative data, a good data management system is essential for quick review and the process of analysis (Cohen et al., 2000). To manage the documents of this study, I saved them as Word files and stored them in separate folders, one for miscarriage and one for termination of pregnancy.

Conducting the Interpretive Phenomenological Analysis

In this hermeneutic study, it focused on understanding the experience of Thai women after miscarriage and termination of pregnancy for fetal anomalies. The Interpretative Phenomenological Analysis described by Smith et al. (2009) was chosen to analyse the research interviews. The main reason I chose this process of analysis was because Smith's method reflected the philosophical assumption of hermeneutic phenomenology. Firstly, Smith's method aims to understand what it is like from the point of view of the

participants without attempting to bracket the researcher's pre-understanding and assumptions. Secondly, it emphasises a dynamic process with an active role for the researcher in the process which reflects the concept of the hermeneutic circle explained by Heidegger. In addition, it offers structured guidance which is easy to understand and follow.

The interview data were analysed manually. I started the process of analysis with the first case in detail, then moved to the second case by doing the same, and then moved to the third case, and so on. The following steps were taken as the process of analysis for each case:

Step 1: Reading and re-reading

The transcriptions and field notes were read and reread many times so that I could be fully immersed in the data in order to ensure that the participant became the focus of analysis. I did this because sometimes the process of beginning analysis was accompanied by a feeling of being overwhelmed by ideas and possible connections. This procedure allowed my focus to remain with the data.

Step 2: Initial noting

I started writing notes on the transcript as I began reading, and further exploratory notes or comments were added with subsequent readings. My aim was to produce a comprehensive and detailed set of notes and comments on the data. This step related to the process of writing and rewriting (Van Manen, 1990) which stated that these activities are crucial to interpretive phenomenology in order to systematically extract the meaning unit, categories and themes that reflected the informants' lived experiences, and weave all these themes into a coherent whole and then report them. The meaning of the experience will be fully illuminated through a lot of writing, rewriting, and pondering.

Step 3: Developing emergent themes

Emergent themes were written in the next right hand column of the page. I then re-checked the agreement of the emergent themes with the notes and original transcripts to ensure that the emergent themes truly represented the meaning of the data.

Step 4: Searching for connections across emergent themes

The aim of this step was looking for patterns and connections between emergent themes and developing a super-ordinate theme. I typed all emergent themes in chronological order into a list and then moved themes around to search for the connection. The themes which represented similar understandings were placed together and a super-ordinate theme was constructed to represent deeper understanding.

Step 5: Moving to the next case

I repeated the first four steps of the analysis process to the next participant's transcript by attempting to make interpretation of each case based on its own story.

Step 6: Looking for patterns across cases

Looking for patterns across cases was necessary in order to understand both the part and the whole experience of loss. The questions suggested by Smith et al. (2009) were used to help the process of analysis, including, What connections are there across cases?; How does a theme in one case help illuminate a different case?; Which themes are the most potent? The final result of this process was displayed in the form of a table of themes for the group, showing how themes were nested within super-ordinate themes and illustrating the theme for each participant.

During each step of the data analysis, I had regular discussions with my supervisors who were knowledgeable in phenomenology, and who gave invaluable feedback on the interpretations of the collected study data. Finally, to draw comparison of loss experience of Thai women following miscarriage with those following termination of pregnancy for fetal anomalies, the data from these two groups were analysed in separate groups and then themes produced by data analysis compared for similarities and differences between them.

Examples of the interpretive process from the words of the women who experienced termination of pregnancy for fetal anomaly

In research reports, the narratives of the participants, the presuppositions of the researcher, and the processes by which these viewpoints are merged should be described in enough detail for the reader to evaluate the quality of the analysis and the interpretive findings (Koch, 1996, p. 178). This section discusses in detail the interpretive process, which presents a step-by-step approach taken in the analytic process in order to explore the phenomenon of loss among Thai women following termination of pregnancy for fetal anomaly.

As the Interpretative Phenomenological Analysis process described by Smith et al. (2009) was used to guide the data analysis, the following steps were taken as the process of analysis for each case:

Step 1: Reading and re-reading

I transcribed each interview and translated the Thai transcriptions into English myself, this procedure gave me a chance to read and re-read each transcript many times which was considered the first step of the data analysis. Reading and re-reading the transcripts allowed me to immerse and re-immerse myself in the participant's world. To remind myself of what I understood about each case, the memos including the summary and main points of what I grasped from the story were noted at the end of each transcript. More main points were added and some points were changed with subsequent readings.

The memo helped me to save the knowledge that my first impressions captured, and meant I could always come back to these memos later. As pointed out by Smith et al. (2009), sometimes the process of beginning analysis is accompanied by a feeling of

being overwhelmed by ideas and possible connections. Thus these memos could help me to reduce the level of this overwhelming feeling by recording them somewhere and allow my focus to remain with the data in the next step of the interpretive process.

Step 2: Initial noting

The aim of this step was to produce a comprehensive and detailed set of notes and comments on the data in order to examine the semantic content and language used on a very exploratory level (Smith et al., 2009). To achieve this aim, firstly I maintained an open mind and noted anything of interest within the transcript. Secondly, I tried to stay close to the things which mattered to the participant and the meaning of those things for the participant in order to understand how and why the participant had these concerns. This involved looking at the language that the participant used, thinking about the context of her concerns, and identifying more abstract concepts which helped me to make sense of the patterns of meaning in her description.

As Heideggerian phenomenology is based on the perspective that the understanding of individuals cannot occur in isolation of their culture, social context, or historical period in which they live, wholeness and context are important in interpretation (Crotty, 1998; Draucker, 1999). This is because the participants have put their message into the words of their stories. Thus, if the researcher and the participants have approximately the same social background and belong to the same culture, it may be easier to understand each other (Benner, 1994). As a Thai woman who grew up in Thai culture, I was familiar with the language and beliefs of this particular population. Therefore, my background was useful in gaining a better understanding of the phenomena. This can be illustrated by an example:

*I may be unable to **Tam jai** with it, if suppose I see his face, I see his face in the same condition as these babies* (the babies who are admitted to the neonatal intensive care unit)*, I have to be unable to **Tam jai** with it.* (TT04, p.2)

*I still feel sad, but I must **Tam jai** because my life must continue.* (TT03, p.2)

Both sentences contain the word *Tam Jai.* But in the first sentence the word means something like 'to calm her mind down', or 'to put up with the fact' whereas in the second sentence it means that she has to accept and get over it. Hence the same word has a different meaning in two different contexts.

Moreover, because of my own personal experiences as a midwife who took care of these women for 14 years and as a mother who could have a profound understanding about the intense and true love of the mother to the baby, it was inevitable that these experiences became very important in my interpretation of the data. However, although the process of the Interpretative Phenomenological Analysis allows me as the analyst to use myself and my own thoughts, feelings, and experiences as a touchstone (Smith et al*., 2009*), it is important to remember that the analysis is primarily about the participant, not myself. Thus, to limit the projection of my own world onto the text, attending to the participant's words had to be always kept at the front of my mind. In addition, checking the initial notes with the transcript was required to make sure that it made sense of what the participant was saying, not imported from outside. Let me illustrate this step in Table 3.1 from analysing the transcript of TT02:

Table 3.1: Initial noting

Transcription	Initial notes
I didn't prepare my mind before coming to the hospital, I had never thought that my baby would have disease because the doctor told me that my baby was healthy and had completely organs (from ultrasound result). (p.5) *I couldn't do anything at all, just listen to the doctor. If I kept my baby, I feared that he would get torture, he would be born with torture, and he had to require blood transfusions, ...I was worried all over what I had to decide about my baby, if I let my baby born, it seemed like I took him the torture, I thought over and over again what I had to do...*(p.7) *...at that time, I was confused, I can't make decision what I had to do, I didn't say anything with the doctor, I let my grandmother talk to the doctor.* (p.8) *I called to my parent, and then they came to Chiang Mai at the same day I knew the result. We talked together whether we would keep him, if he was born he had to have torture afterward, I didn't want him to have the torture. My mother told me that it depended on my decision, if I didn't want him to have torture, let him go. For a while if I wanted to have a baby, I can have a new one.* (p.9) *I couldn't sleep through the night, I feared that I would get in any trouble, I didn't want to eat anything at all, I didn't want to do anything, I felt really worn-out, ..., I thought over and over again about this, I asked myself how sure I was that I wanted to take him off, but if I let him be born, ..., I didn't want him to be like this, I wanted him to be born healthy, so I had decided to terminate my pregnancy. (p.11)* *The next day, I admitted to delivery room. I didn't want to talk to anyone, I felt not well, I can't even explain what I was feeling, deep within my mind, I didn't want to do this with my baby...(p.12)* *...I give him a life, he might want to be born and stay with me, it seems like whether I am harming him or not, but if he is born, he must have suffering, I don't want to see him has suffering at that time, so I decide to terminate my pregnancy. (p.13)* *During admitting to delivery ward, I were alone, my family members couldn't come in, I wanted to meet my father and mother but the doctor didn't allow them to come in....I wanted to talk with father and mother in order to make me feel relieved that I might not get in any trouble. (p.14)* *I must make myself to go to sleep but I can't sleep, I thought a lot, I feared that will I get in any trouble, will my baby come out, is there any problem, what is going on, will I have suffering?...I thought a lot because I had never had this experience before. (p.16)* *I feared that if I looked at my baby, I would not be able to Tam Jai,... I feared that it would be impressed in my eyes for a long time, he was a person, he had full organs, on one side of my mind I had Tam Jai that if I let him be born, he might have suffering more than this, but I didn't want to look at him in the healthy condition at this time, I didn't want to do harm to him, but he would have torture if he was born. (p.15-16)*	- Perceiving the good ultrasound results brought her hope and encouraged her to continue her hope for her pregnancy. As a result, fetal abnormality was considered as an unexpected event. - Her brain had been shut down suddenly when facing with the unexpected results. - She was drowning in her thought and overwhelmed with ambivalence, worry, and confusion. As the fetal abnormality was the unexpected event, it was very hard to make decision hastily, especially when her brain had been shut down. - Discussion with family members was not just seeking the solution of the problem but also sharing feeling and emotional supporting to each other. The sympathy and participation of family members at this time was truly supportive because she didn't confront and go through this anguished event alone. - She was overwhelmed by stress to the anguished fact. She described physical responses to stress including shutting down and having very little energy. - The conflict in making decision to pregnancy termination. She was struggling with moral issue and emotional conflict to terminate the baby. - She tried to calm her mind and encourage herself to accept that making the decision to terminate the pregnancy was the best solution. - She is struggling with moral issue and emotional conflict to terminate the baby. Even she herself could not completely get over the emotional conflict. As moral issue, she perceives that termination of the pregnancy may be harming human life. This induced the feeling of self-inflicted guilt in making decision to pregnancy termination. - She felt alone in facing with unfamiliar environments and unknown situations alone during admitting in the hospital. She needs support from her family members to help her feel relieved and secure. She was in fear, stress, and anxiety because of facing unfamiliar environments and unknown situations alone. - Looking at the baby might induce unforgettable memory, refusing to look at the baby was a means to escape from the awkward situation that made her to have difficulty to overcome her sadness.

Step 3: Developing emergent themes

According to Smith et al. (2009), the emergent themes reflected not only the participant's original words and thoughts but also the analyst's interpretation. In looking for emergent themes, my aim was to simultaneously attempt to reduce the volume of detail both in the transcript and the initial notes and maintain my understanding about the complexity of connection between exploratory notes. See Table 3.2 which presents the emergent themes for the piece of transcript in Table 3.1.

Table 3.2: Developing emergent themes

Transcription	Initial noting	Emergent themes
I didn't prepare my mind before coming to the hospital, I had never thought that my baby would have disease because the doctor told me that my baby was healthy and had completely organs (from ultrasound result). (p.5)	- Perceiving the good ultrasound results brought her hope and encouraged her to continue her hope for her pregnancy. As a result, fetal abnormality was considered as an unexpected event.	Facing the loss of hope
I couldn't do anything at all, just listen to the doctor. If I kept my baby, I feared that he would get torture, he would be born with torture, and he had to require blood transfusions, ...I was worried all over what I had to decide about my baby, if I let my baby born, it seemed like I took him the torture, I thought over and over again what I had to do...(p.7) *...at that time, I was confused, I can't make decision what I had to do, I didn't say anything with the doctor, I let my grandmother talk to the doctor. (p.8)*	- Her brain had been shut down suddenly when facing with the unexpected results. - She was drowning in her thought and overwhelmed with ambivalence, worry, and confusion. As the fetal abnormality was the unexpected event, it was very hard to make decision hastily, especially when her brain had been shut down.	Physical and Emotional reactions
I called to my parent, and then they came to Chiang Mai at the same day I knew the result. We talked together whether we would keep him, if he was born he had to have torture afterward, I didn't want him to have the torture. My mother told me that it depended on my decision, if I didn't want him to have torture, let him go. For a while if I wanted to have a baby, I can have a new one. (p.9)	- Discussion with family members was not just seeking the solution of the problem but also sharing feeling and emotional supporting to each other. The sympathy and participation of family members at this time was truly supportive because she didn't confront and go through this anguished event alone.	Seeking family involvement and support
I couldn't sleep through the night, I feared that I would get in any trouble, I didn't want to eat anything at all, I didn't want to do anything, I felt really worn-out, ..., I thought over and over again about this, I asked myself how sure I was that I wanted to take him off, but if I let him be born, ..., I didn't want him to be like this, I wanted him to be born healthy, so I had decided to terminate my pregnancy. (p.11)	- She was overwhelmed by stress to the anguished fact. She described physical responses to stress including shutting down and having very little energy. - The conflict in making decision to pregnancy termination. She was struggling with moral issue and emotional conflict to terminate the baby. - She tried to calm her mind and encourage herself to accept that making the decision to terminate the pregnancy was the best solution.	Physical reactions Emotional reactions Gaining self confident
The next day, I admitted to delivery room. I didn't want to talk to anyone, I felt not well, I can't even explain what I was feeling, deep within my mind, I didn't want to do this with my baby...(p.12) *...I give him a life, he might want to be born and stay with me, it seems like whether I am harming him or not, but if he is born, he must have suffering, I don't want to see him has suffering at that time, so I decide to terminate my pregnancy. (p.13)*	- She is struggling with moral issue and emotional conflict to terminate the baby. Even she herself could not completely get over the emotional conflict. As moral issue, she perceives that termination of the pregnancy may be harming human life. This induced the feeling of self-inflicted guilt in making decision to pregnancy termination.	Emotional reactions

Transcription	Initial noting	Emergent themes
During admitting to delivery ward, I were alone, my family members couldn't come in, I wanted to meet my father and mother but the doctor didn't allow them to come in….I wanted to talk with father and mother in order to make me feel relieved that I might not get in any trouble. (p.14) *I must make myself to go to sleep but I can't sleep, I thought a lot, I feared that will I get in any trouble, will my baby come out, is there any problem, what is going on, will I have suffering?...I thought a lot because I had never had this experience before. (p.16)*	- She felt alone in facing with unfamiliar environments and unknown situations alone during admitting in the hospital. She needs support from her family members to help her feel relieved and secure. She was in fear, stress, and anxiety because of facing unfamiliar environments and unknown situations alone.	Seeking emotional security Emotional disturbance during labour
I feared that if I looked at my baby, I would not be able to Tam Jai,… I feared that it would be impressed in my eyes for a long time, he was a person, he had full organs, on one side of my mind I had Tam Jai that if I let him be born, he might have suffering more than this, but I didn't want to look at him in the healthy condition at this time, I didn't want to do harm to him, but he would have torture if he was born. (p.15-16)	- Looking at the baby might induce unforgettable memory, refusing to look at the baby was a means to escape from the awkward situation that made her to have difficulty to overcome her sadness.	Escaping from unforgettable memory

Step 4: Searching for connections across emergent themes

The aim of this step was to search for patterns and connections between emergent themes and to develop a super-ordinate theme which was a sense of what emerged at a higher level as a result of putting the themes together. This involved clustering themes together. Firstly, I had established a set of themes within the transcript and then the themes were ordered chronologically. The next step, I tried to draw together the emergent themes and produce a structure which allowed me to point to all of the most interesting and important aspects of my participant's account. I typed all the themes in chronological order into a list and then moved themes around to form clusters of related themes. Themes which represented similar understandings were placed together. The next stage involved a more analytical ordering, as I tried to make sense of the connections between themes. Some of the themes were clustered together, and some emerged as a super-ordinate theme. The clusters were given a name and represented the super-ordinate themes. Once each transcript had been analysed by the interpretative process, a final table of super-ordinate themes was constructed. See Table 3.3 which presents super-ordinate themes from TT02.

Table 3.3: Searching for connections across emergent themes

Emergent themes	Super-ordinate themes
Facing the loss of hope	Facing the loss of hope and existing in an emotional unrest
Physical reaction	
Emotional reactions	
Being in emotional unrest	
Struggling with uncertainty of subsequent pregnancy	
Seeking family involvement	Overcoming self-inflicted guilt
Seeking family support	
Gaining self confidence	
Escaping from unforgettable memory	
Practicing the traditional rite based on the Buddhist belief	
Seeking emotional security	The need for intervention
Seeking emotional tranquillity	
Seeking information	
Seeking emotional support	
Seeking coordinated health care team	

Step 5: Moving to the next case

This step involved moving to the next participant's transcript and repeating the process. This then continued for each subsequent case. During the process, I was inevitably influenced by what I had already found from the previous cases. However, it was important to treat the next case in its own terms, to do justice to its own individuality. This means, as far as was possible, bracketing the ideas which emerged from the analysis of the first case while working on the second to allow new themes to emerge with each case. To ensure the themes emerged from its own participant's transcript, they were checked in the transcript to make sure that the themes made sense in relation to what the participant actually said. See Table 3.4 which presented an abridged example taken from TT07.

Table 3.4: Emergent themes and super-ordinate themes from the next case

Key words	Emergent themes	Super-ordinate themes
Not yet able to forget, the sadness still remains (p.2)	Remaining feeling of sadness	Facing the loss of hope and remaining in sadness
Unexpected result, hope being gone (p.4)	Facing the loss of hope	
Could not sleep throughout the night, I felt sad and cried again and again (p.5)	Physical reaction	
Sadness, wonder why this event happened; why my baby had to have an anomaly (p.5), *overwhelmed with sorrow and anxiety* (p.6)	Mixed emotional response	
The loss of baby is the most terrible event that happened in my life (p.36)	Emotional traumatic situation	
Fear of getting pregnant again (p.36)	Struggling with the uncertainty of a subsequent pregnancy	
We cried together when knowing the final result and made an agreement to terminate the pregnancy (p.13)	Seeking family involvement	Overcoming self-inflicted guilt and sadness
My husband stayed with me and tried to soothe me, this made me feel relieved (p.13)	Seeking family support	
I have to Tam Jai, it is over, from this time forth I have to improve myself to be cheerful and try to accept that it is over. (p.37)	Seeking emotional calmness	
I had to Tam jai because the ultrasound was done two times and the final result was done by expert, my baby had a low chance of survival (p.18) *I felt relieved when I heard that there were many women had to face with the event that was worse than me* (p.25)	Realising the truth of loss	
I was unable to endure anymore if I saw my baby, I didn't want to have his image fixed in my mind (p. 30)	Escaping from unbearable situation	
Although I had no chance to take care of my baby, one thing that I could do, I had to do and I had already done for my baby was make merit to him, I wanted my baby to go peacefully, and I didn't have to worry about my baby at all. (p.3)	Fulfilling the obligations of being a mother	
This might be my baby's karma, I should pray and made a wish for my baby to be born healthy and please don't come back again with abnormality like this. (p.20)	Believing in Karma and practicing the traditional rite based on The Buddhist belief	
Fear of being alone (p. 22)	Seeking emotional security	The need for intervention
I felt comforted that everyone in the labour ward took care of me closely and tried to soothe me (p.36)	Seeking emotional support	
Information was the most important thing I needed to make me relieve from worry (p.37)	Seeking information	

Step 6: Looking for patterns across cases

As suggested by Smith et al. (2009), I laid each table of emergent themes and super-ordinate themes from each case on a large surface. Then I tried to look across them by asking the following questions: What connections are there across cases? How does a theme in one case help illuminate a different case? Which themes are the most potent? I found that this method could help the analysis to move to a higher analytic level because it led to a reconfiguring and relabeling of themes. Table 3.5 demonstrates how the first theme, facing the loss of hope, developed from two sub-themes of the awareness of the loss of hope and psychological and physical consequences. Table 3.6 illustrates how the second theme, gaining emotional balance, developed from four sub-themes of gaining self awareness, believing in karma based on the Buddhist belief, escaping from unbearable memories, and fulfilling the obligations of being a good mother. Table 3.7 displays how the third theme, the need for intervention, developed from four sub-themes of seeking emotional security, seeking information, seeking emotional support, and seeking coordinated health care.

Table 3.5: Facing the loss of hope

Words of participants	Initial noting	Emergent themes	Sub-themes
I wished to have a daughter,…, I always prayed for my baby to have 32 complete organs,…, I prayed for my baby to be healthy, I didn't want him to have anomalies like this, I wanted to take the role of mother in looking after him. Suddenly, all my wishes slipped away and never came back, I felt deep sorrow and I didn't know how to change this event. (TT01, p.8)	Fetal abnormality was an unexpected event and all wishes had slipped away	Facing an unexpected and uncontrollable event	The awareness of the loss of hope
Although it might be a dim hope, I still prayed and expected that the result was a mistake. Finally, my hope did not come true. My baby was too severe to treat. (TT06, p.3)	Hope faded away	Facing the loss of hope	
I suddenly felt Meut Bpaet Daan (to be dark with eight sides; it means be utterly mystified, to be completely in the dark, or see no way out), I could think nothing, I had no idea at all how I should start, where I should start (TT04, p.7)	Everything is shut down	Physical reaction	Psychological and physical consequences
If I kept him, I feared that he would get torture, he would be born with torture, and he had to require blood transfusions. I was thinking what I had to do about my baby. I was worried all over what I had to decide about my baby, …, I was confused, I can't make decision what I had to do… (TT02, p.8) *I gave him a life, he might want to be born and stay with me, it seems like whether I am harming him or not, but if he is born, he must have suffering, I don't want to see him has suffering at that time, so I decide to terminate my pregnancy. (TT02, p.13)*	Overwhelming with ambivalence, worry, and confusion.	Emotional reactions	
The doctor did the ultrasound and said that my baby had an anomaly,…,at that time, only I heard the doctor who did the ultrasound say this, I then felt dispirited; at that time, I began to lose my will power, I felt despair (TT04, p.5)	Feeling dispirited; loss of will power, feeling of despair	Emotional reactions	
I felt overwhelmed with sadness, I also wondered why this event happened with me; why her baby had to had an anomaly, I also worried what would happen with me and what I had to do next (TT07, p.5)	Overwhelmed with despondency, questions, and worry	Mixed emotional responses	
I still have fear of getting pregnant again, I am not sure whether or not this event will happen with me again (TT09, p.33	Fear and uncertainty	Mixed emotional responses	

Table 3.6: Gaining emotional balance

Words of participants	Initial noting	Emergent themes	Sub-themes
On that day, when I went back to my workplace, I tried to search the internet for what a chromosome was, why abnormalities happened, what the symptoms were. After reading the information on the internet, a number of symptoms were similar to the ultrasound results that the doctor told me,...(TT03, p.7)	Searching for the truth of condition to gain the recognition of the condition and get rid of suspiciousness in the diagnosis	Gaining self confident	Gaining self awareness
I then called to my husband, he said that it should depend on the doctors' discretion, what he was most concerned about was me because I had migraine as my illness, if the baby developed the reaction to me, he didn't want me to be in trouble, he told me that it might be better if we terminated this pregnancy and tried to get pregnant again, and we would consult the doctor again about our next pregnancy. Then I and my husband agreed to terminate of my pregnancy. (TT04, p.13)	Seeking family involvement and support		
Firstly, I thought that there was only me that had to meet this event, I thought that there was no one else like me, there was no one getting worse than me, I felt totally hopeless,..., but after I had heard from the doctors and nurses that in fact, some cases of fetal anomaly were more severe than me, ..., After I heard this information, I felt that there were still other people that had the same problem as me, it was alright, I was not the only one in a hundred or one in a million, there was still other people that has the same condition as me, so I had to get over it. When I thought like this, it helped me be able to accept more and get better. (TT12, p.16)	Learning from the other's experience of loss	Gaining self motivation	
The one thing I tried to do was I encouraged myself that if my baby had no fingers or had no arms, I could take care of him, I could support him, but the brain was the most important part of the body, if the brain was not functioning, how could he live? (TT04, p.12)	Keeping a positive self attitude		
As for my decision to terminate my pregnancy, I believe that my baby might understand me why I have to do, I don't hurt him and nobody hurt him, this is the result of his deeds in the past life, both he and I also have Karma (the accumulated merit or demerit of past incarnation reflected in happiness or suffering in this life) and the bad thing that happens to us is a result of past Karma. (TT01, p.9)	Religious faith is a source to help her feel comfortable and relive from disillusionment	Believing in Karma as an emotional anchor	Believing in karma based on the Buddhist belief

Words of participants	Initial noting	Emergent themes	Sub-themes
At the time my baby was born, I was not sure whether I should see him or not; but I felt that my baby's image at my first sight still was fixed in my mind; I didn't want to have his image fixed in my mind, so I decided not to see my baby,…, But if I saw him and touched him, I might be unable to endure anymore, it might be very difficult to get over this event, and I might take an extremely long time to get over it. His image might be forever fixed in my mind; but I didn't see him, I was still OK. (TT06, p.16)	Refusing to look at the baby was a means to escape from the awkward situation	Escaping from awkward situation	Escaping from unbearable memories
When my baby came out, the doctor asked me at that time that I wanted to see the baby or not, but I didn't want to see my baby because…um… I feared, I feared that if I saw my baby, I might be unable to tolerate, if I saw my baby, I might cry a lot, I didn't want to see my baby, I feared that his image would be fixed in my mind and made me think a lot later. (TT10, p.22)	Looking at the baby might make her have difficulty to overcome her sadness		
After going back home, I made merit at the temple and consigned merit to my baby, I think that it might help my baby to go peacefully without any torture. (TT05, p.20)	This deed would be a strategy to improve their baby's karma in the present life to be better in the next life	Fulfilling the maternal role as being a good mother	Fulfilling the obligations of being a good mother
Although I had no chance to take care of my baby, one thing that I could do, and for me, I had to do and I had already done for my baby was make merit to him, I wanted my baby to go peacefully, and I didn't had to worry about my baby at all. (TT07, p.3)	Fulfill the maternal role for their baby in order to being accepted as a good mother for the baby		

Table 3.7: The need for intervention

Words of participants	Initial noting	Emergent themes	Sub-themes
I want to know what the doctor will perform on me, how to do the procedure, if it will take a long time, how it will affect me, if I will have pain, how long I have to stand, how long I have to stay in delivery room… *…the doctor also told me that it is the same as giving birth, normal birth or something like that, but I don't know what normal birth is like because this is my first baby,…*(TT02, p.30)	The more informed she was about the procedure before having it, the less severe her emotional reaction would tend to be	The information is needed	Seeking information
…and I also want the doctor to stay with me because I don't know what will happen to me, I am afraid that I can't stand, I am afraid that if I give birth and there is no doctor stay with me, I am afraid that I will get in any trouble, I want the doctor to stay with me, while the doctor stayed with me, I felt good, because of worry, I need the doctor to be near me,… (TT02, p.31)	She was seeking security and emotional support in coping with emotional disturbance during labour.	Seeking emotional support	Seeking emotional support
Everyone took very good care of me, but there was one thing during giving birth, the doctor who was the birth attendant would raise my baby up in order to let me see, until the nurse must tell him that I didn't want to see, this point is what I don't like, I can't accept it because he raised my baby up, he wanted me to see my baby but I didn't want to see, it was a good thing that the nurse told him that I didn't want to see, it seemed like he wanted me to see but I didn't want to see. (TT02, p.37)	The care did not meet her needs because of the lack of communication between health care providers	Good coordination between health care as emotional support	
At that time (during admission to the delivery ward) I was alone, my family members couldn't come in, I wanted to meet my father and mother but the doctor didn't allow them to come in. I must Tam Jai to be alone. I wanted to talk with father and mother in order to make me feel relieved that I might not get in any trouble. (TT02, p.14)	Staying with family member helped her relieve from feeling alone and insecure	Seeking emotional security	Seeking security
There is one thing that's in little doubt, it is about shift change report, some doctors didn't know any information about me, they asked me again and again, and then for a while another one asked me again with the same question, it made me wonder why they didn't give the report at shift change about the patient's detail, I was not impressed by this point. In fact, they should have all my details in their hands, they should know all details thoroughly and accurately, I wondered how they can give me a good care if they didn't know about my details and the reason for admission…(TT03, p.30)	Lack of communication between health care providers made her feel unconfident with the care she received	Seeking security from coordinated health care team	

The final result of this process was in the form of a table of themes for the group. The following table summarises these themes as presented in the next section.

Table 3.8: Sub-themes and super-ordinate themes for the group

Sub-themes	Super-ordinate themes
The awareness of the loss of hope	
Physiological and psychological consequences	Facing the loss of hope
Gaining self awareness	
Believing in karma based on the Buddhist belief	Gaining emotional balance
Escaping from unbearable memories	
Fulfilling the obligations of being a good mother	
Seeking information	
Seeking emotional support	The need for intervention
Seeking emotional security	

3.4.4 Rigour

Any qualitative research study must be able to withstand scrutiny to ensure rigour in the research and to avoid sloppiness or excessive subjectivity (Conroy, 2003). Particularly, as the goal of interpretive phenomenology is to gain understanding of the interpretations of the meaning of experience, expressions of rigour were necessary to ensure high quality research methodology and findings (de Witt & Ploge, 2006). I selected a framework of rigour developed by Guba and Lincoln (1994) for use in qualitative research, to ensure the trustworthiness of this study. The criteria in this framework are: credibility, transferability, dependability, confirmability, and authenticity (Guba & Lincoln, 1994).

Credibility

To enhance credibility, choosing participants who were experienced and knowledgeable in the research problem was critical to ensure the results were convincing (Rubin & Rubin, 2005).

The credibility of this qualitative inquiry was especially dependent on the credibility of the researcher because the researcher was the instrument of data collection and the centre

of the analysis process. As pointed out by Marshall and Rossman (1999), to obtain volumes of data, the interviewer should have superb listening skills and be skilful at personal interaction, question framing, and gentle probing for elaboration. In order to increase the credibility of this study, I practiced interviewing skills by conducting two pilot interviews with two participants; one had experienced a miscarriage and the other one had experienced a therapeutic termination. After each of the pilot interviews, strengths, weaknesses, and alternative approaches that could be used in future interviews were discussed with Associate Professor Dr. Kannika Kantaruksa who was my fieldwork supervisor. This training increased my competence and provided an opportunity for learning interview techniques to be successful in obtaining rich phenomenological data. I had to be cautious not to impose my views on the interviewee. If the interview questions stayed close to what the participants knew and were willing to talk about, the resulting report would be fresh and credible.

The establishment and development of rapport between myself and the participants led them to have willingness and trust to reveal their real feelings and experiences. As I did not have clinical responsibility for the particular informants, they were able to describe experiences openly and honestly without fear that their care would be affected.

To become familiar with data in intimate ways, all transcriptions were not only read and reread many times, but also translated into English by myself. By intensively reviewing the women's description of their lived experiences, I then increased my understanding of all phenomena and the findings were concluded in relation to the data collected.

I discussed the research process and findings with impartial supervisors who had expertise in phenomenology. This could also increase credibility by checking categories developed out of data and by looking for disconfirming or negative cases.

To achieve congruence of data, triangulation of data from in-depth individual interviews with the two groups of women, focus group interviews with nurse-midwives, and focus group interviews with doctors was undertaken. This not only helped me to understand the women's description of their experience, but it also allowed for comparisons of findings that emerged from different sources of data. The findings might have greater credibility with the readers if similar findings emerge at different sites (Shenton, 2004).

Respondent validity is considered as a means to gain the accuracy of key findings by inviting the participants to give comments on the key findings (Krefting, 1991). However, this was not undertaken in this study because I was concerned about the applicability and limitations. As there was a long gap between data collection and data analysis, some women might have become mothers or in advanced pregnancy and consequently, their feelings and views towards their experiences of miscarriage or termination of pregnancy might have altered. In addition, I must also consider the ethical aspect of this strategy because it could be harmful to the well-being of the women. Respondent validation might have caused this group of women to revisit an experience that was negative at a time when they were feeling positive about becoming a mother.

Transferability

Guba and Lincoln (1994) suggested that the original context must be described adequately so that a judgement of transferability can be made by readers. Thus, it was my responsibility to explicate a thick enough description of design, sampling, data collection, analysis, and finding, so that readers can decide for themselves the applicability of the research findings to their own contexts (Lincoln & Guba, 1985; Koch, 1996; Seale, 1999).

Dependability and confirmability

Besides in-depth interviews with women, I conducted focus group interviews with professionals in order to gain understanding of contextual information about hospital care. This helped me to be able to understand the women's description of their experience. In addition, Guba and Lincoln (1994) recommend a means to establish confirmability by explaining the decisions taken about the methodological and analytic choices. Marshall and Rossman (1999) also pointed out that displaying a description of each design decision and the rationale behind it allowed readers to inspect and judge whether it was adequate and makes sense. Thus, to achieve confirmability, the ways in which my interpretations had been arrived at and my decision trail were presented throughout the study.

Authenticity

Authenticity was demonstrated through fairness in representing and reporting findings. Ensuring that the voices of both the participants and the researcher are evident in the text also enhances authenticity (Lincoln & Guba, 2000). This was achieved by the use of rich description and, where possible, the use of participants' words to allow them to speak for themselves. In addition, by constantly cross-checking my interpretation with the original transcripts, I sought to maintain closeness (or faithfulness) to the participants' constructs, grounding interpretations in the data. This strategy to maintain authenticity was suggested by Lincoln and Guba (2000).

3.5   Reflections on the research process

The challenges I found in data collection and how I managed with these problems are demonstrated in this section.

The challenges of recruiting the participants

The challenge in this process was how I could access and approach potential participants into my study. As previously mentioned, I asked for co-operation from the nurses to help me recruit participants. However, I missed a few women who had experienced miscarriage in the early period of data collection because of a misunderstanding about the diagnosis of miscarriage or spontaneous abortion. The nurses understood that I needed only the women who were diagnosed as miscarriage or spontaneous abortion, so they missed recruiting women who were diagnosed as any type of miscarriage, for example, inevitable abortion, incomplete abortion, and missed abortion. It was necessary for me to meet with the nurses again to clearly inform them about the criteria and definition of miscarriage or spontaneous abortion in order to ensure that all potential participants were included.

The problem I faced in approaching the women was my dual role as a nursing instructor and a researcher. Although my current status is a PhD student, the nurses in the clinical setting still perceived and respected me as a nursing instructor. This was because I had regular professional contact with them for more than ten years, so they knew me and still called me *Archan*, which means instructor. The dual role had effects on my introduction to the women. Firstly, I presented myself to the women as a PhD student. However, when they heard the nurses call me *Archan*, this made them wonder what my real status was. As I could not change my dual role, I needed to introduce myself accurately by explaining my status and where I worked. However, in order to ensure that the women

were truly willing to participate in the study, not because they were pressured from my professional image, I needed to clearly explain that I had no influence on the health care services of health care providers. Thus, there was no advantage or disadvantage whether they decided to participate in the study or not.

The Challenges of interviews

According to the responsive interview (Rubin & Rubin, 2005), the researcher is a human who has emotions, a temper, and opinions, not an automaton, so the researcher inevitably affects what is learned. The first thing I learnt from interviewing was being relaxed created an environment for a thoughtful, rich interview. If I was fatigued, I had problems with concentration and paying close attention to what the women said and then missed important points on which to follow up. This problem occurred with me when I scheduled to interview two cases in a day, one in the morning and another one in the afternoon. After the first interview, I felt exhausted because during an interview, my level of concentration had to be high; I had to listen carefully, decide what to follow up and how, and then ask for explanation. Before interviewing another case, I took time to calm down by taking a meal and relaxing myself to prepare to interview the next woman. However, the exhaustion from listening to these emotive stories challenged my powers of concentration and I had trouble in paying close attention to the conversation and I missed following up some points. So I faced this problem and decided to limit myself to one interview a day in order to make me fresh and ready to achieve an environment for a thoughtful and rich interview. Secondly, personal involvement was a great strength of the interview. The researcher's empathy could encourage the participant to talk. However, too much involvement in the interview also created a problem because my own emotions and biases influenced what I asked and how the participant responded. For

example, I ignored following up in places that warranted additional questioning because I thought that I understood already. To avoid this problem, self-reflection was a very useful strategy to help me sensitise myself to these biases and learn to compensate for my own slant. Thirdly, discussion with supervisors was very helpful to provide debriefing, encourage me to be aware of the influences of my own emotions and biases on interviews, and support me to cope with my emotions.

The next problem I faced was taking notes during the interview which interrupted the conversation; this was particularly evident in the first interview. Anytime I took notes, the participant stopped talking and paid attention to what I was writing. Sometimes the participant tried to continue talking about some points that I was taking note because she perceived that I was interested in those points, and not follow the story that they wanted to tell me. As I needed the participant to tell me in the way they wanted, in the topic that was important for them, not for me. Thus note taking was left to a minimum.

The challenges of focus groups

Unlike the individual interview, the focus group capitalised on group interaction and group norms. A problem occurred during the first focus group interview as there appeared to be more interactions between me and the participants rather than between participants. What I learnt was that in order to achieve the goal of focus group interviewing, I needed to be sensitive and to be aware of the aims of the focus group. I needed to encourage all group members to participate in the discussion by creating a friendly and warm environment, and inviting all participants to share their opinions whilst adhering to the topic of the discussion. I found that this manner allowed group interactions, permitted me to learn more about the level of agreement on the topic, and

encouraged group members to identify, describe, and resolve key issues on the care of women who had experienced a miscarriage or therapeutic termination for fetal anomaly.

The next thing I learnt from conducting focus groups with nurse-midwives was that I, as the facilitator, had to carefully plan and conduct the interviews to minimize participants' discomfort but still gain useful data. As I was known to the participants and was familiar with the nursing role, I was able to gain their confidence and was accepted by the participants. However, this also caused a conflict of interest because I was now there as a researcher so I had to gain the trust of the group by reviewing the purpose of the group discussion, allowing time for the discussion without any unnecessary interruption, ensuring respect in the instances where there was disagreement, and ensuring information was shared voluntarily and remained confidential.

Due to the hierarchy in the healthcare system in Thailand, I conducted separate groups for nurse-midwives and doctors in order to encourage each group to speak freely. However, all the doctors involved in the focus group still perceived me as a nursing instructor and what challenged me in this situation was a potential power imbalance and distinction. The ability to speak freely might also have been constrained because disclosure might reveal compromises in the quality of care. Therefore, it was necessary for me to define the purposes of the study, and why focus group discussions with doctors were also necessary. I also reminded the participants of the need to maintain confidentiality of all information shared in the group before, during, and after the focus group discussion.

The challenges of data analysis

In hermeneutic phenomenology, the process of interpretation is built on fore-structure which is referred to as pre-understanding or background. The researcher's ability to

interpret the data is reliant on previous knowledge and understanding (McConnell-Henry et al., 2009; Polt, 1999). However, I also found that my pre-understanding was a struggle to approach the text with an open mind because it tended to direct my eye in a particular direction. To manage this problem, self-reflection was a very useful strategy to help me sensitise myself to these biases. For instance, when I completed the process of analysis with each transcript, I then reflected by writing in my research diary about my vulnerability in interpreting and using this to improve my interpretation for next transcripts. Secondly, multiple interpretations in each transcript of each interview seemed to be a strategy to help me confront the depth and uniqueness of the text and to bring about a deeper understanding. Thirdly, discussion with my supervisors was very helpful to encourage me to be aware of the influences of my own perceptions on my interpretation and allow me greater insight into the richness of the text.

Summary

In this chapter, I describe interpretive phenomenology as the methodology chosen for this research. I explain how I achieved data collection and data analysis through careful choice of participants and conducted unstructured interviews. Ethical issues in each step of conducting this research project were discussed. The issue of rigour was also discussed in this chapter. The next chapter, Chapter Four, will provide my understanding of the women's experiences of miscarriage. Chapter Five will provide my understanding of women's experiences of termination of pregnancy due to fetal anomaly.

CHAPTER 4

THE WOMEN'S EXPERIENCES OF MISCARRIAGE

4.1   Introduction

As described in the methodology chapter, there are two groups of participants, women who have experienced a miscarriage and women who experienced a miscarriage. The data from these two groups are analysed separately and the themes produced for each group are compared for similarities and differences. In order to gain insight into the experiences of loss in each group, the findings from the first group are presented in this chapter and the findings from the second group are provided in the next chapter.

The first section of this chapter provides a summary of the demographic details of the participants who underwent a miscarriage. The snapshots of two participants' experiences related to the phenomena are also presented in this section in order to provide some examples of participants that contextualise them within the focus of the study. The second section explains the final section presents the themes that emerged from the participants' stories and expands my understanding of the phenomenon.

4.2   Introducing participants: Overview

The participants were eleven Thai women, aged between 20 and 39 years. Each person was assigned a reference number to ensure anonymity and preserve confidentiality. Table 4.1 provides a summary of the demographic details of participants.

Table 4.1: Demographic characteristics of participants

Age	
20-30	6
31-40	5
Religion	
Buddhist	11
Marital Status	
Married	8
Living together	3
Length of Marriage/ Time Living Together	
1-5 ys	5
6-10 ys	5
11-15 ys	1
Education Level	
Primary	2
Secondary	5
Tertiary	4
Occupation	
Home Duties	3
Self-employed	1
Employee	3
Government Officials	2
Casual/Part-time job	2
Number of Children	
0	6
1	4
2	1
Number of Previous Miscarriages	
0	5
1	3
2	2
4	1
Family Members in the household	
Nuclear family (Spouse and Children)	7
Extended family (Spouse, Children and other Relatives)	4
Family Income (in Baht)	
5,001-10,000	3
10,001-20,000	3
20,001-30,000	2
30,001-40,000	3

In order to gain insight into the experiences of loss among the participants to contextualise them within the focus of the study, two brief stories from two participants are provided.

M02's Story

M02 is a twenty-seven-year-old woman. She has been married for 3 years, her husband is employed. This is her first pregnancy after trying to have a baby for 1 year. The interview was undertaken in M02's house two weeks and three days after discharge from the hospital. I was made to feel very welcome by M02 and her husband. M02's husband agreed with her decision to be involved in the study. The interview took place in the living room. I started the conversation with general topics about her physical condition after her miscarriage and her demographic characteristics in order to establish rapport with M02 and to create a relaxed atmosphere before interviewing. Then I asked M02 to tell me what happened to her pregnancy.

She described her family as a nuclear family but her house was located in the same area as her parents' house. So she had a close relationship with her parents and close relatives. She described herself as healthy and had no problem getting pregnant within the first year after coming off the contraceptive pill. M02 and her husband were very happy with her pregnancy. She started antenatal care as early as possible and tried to do her best to nourish her baby. Two days before the third appointment date, she had a little bleeding with some small clots but had not experienced any cramping. At the appointment date, vaginal examination and ultrasound were performed after a doctor was informed about these symptoms. She was given a diagnosis of incomplete miscarriage and the doctor recommended having curettage immediately.

M02 described feeling shocked, frightened, and doubtful. She thought that her baby might be too small and very hard to see. She prayed to the Triple Gem to protect her baby. But her wish did not come true. She was admitted to the hospital and the dilatation and curettage procedure was performed immediately in order to prevent her from haemorrhage. After recovering from the treatment, she was stunned and had many questions that were unable to be answered.

She was discharged the next day. When she came back home, everyone at home tried to soothe and encourage M02 and her husband not to give up on attempting to have a baby. However, she stated that the first week after miscarriage passed very badly because the feelings of sadness and regret still remained in her mind. Her husband was the most important supporter at this time.

M02 had not given up on her intention to have a baby. She and her husband still had so much hope and believed that they still have a chance to have a baby. However, what concerned her most was the uncertainty of getting pregnant again. She still felt worried about the causes of her miscarriage and afraid to face the same situation again. So what she said she needed from health care providers was information about the causes and prevention of miscarriage.

M07's story

M07 is a twenty-nine-year-old woman, married to a government officer for 4 years. She had 2 miscarriages in the last 2 years both of which occurred in the first trimester. This was her third pregnancy. She became pregnant 6 months after her last miscarriage. The interview was undertaken in M07's house three weeks after discharge from the hospital. At the beginning of the interview, M07 appeared nervous but when the interview progressed, she appeared to relax and become more comfortable to talk about her story.

Her family is a nuclear family but she still kept in close contact with her parents who lived in another district. M07 started her story with her feelings after the two miscarriages. She explained to me not only feeling disappointed at losing a baby but also feeling disappointed with the loss of self.

Although she was very excited at becoming pregnant, she was worried every moment that miscarriage might happen to her again. She did not want to face another miscarriage but she needed to prepare her mind for it. Otherwise she might be overwhelmed by sadness and be unable to endure it. Finally, she had to face feeling disappointed again when she started gushing bright red blood at seven weeks into her pregnancy.

She was given a diagnosis of complete miscarriage and there was no need to have any procedure. Although her body was not hurt from the treatment, her mind was overwhelmed with disappointment and sadness. She stated that she felt tired trying to have a baby and felt like giving up trying.

M07 acknowledged her husband as her most important supporter. He raised her up from feeling depressed and disappointed and had never let her deal with this problem alone. Although she was not admitted to the hospital for treatment, during the process of diagnosis she was a patient who was in the process of the hospital. She felt unsatisfied with the bustling atmosphere in the hospital. During her hospital stay she said she felt a sense of depression and disappointment, but also frustration caused by the busy atmosphere. She reported that she really needed to escape to stay quietly by herself. What she needed most from health care staff was time to ease her mind and a private area to be alone or with her husband.

The stories of the participants' experiences allowed me to become emerged in the whole view of each participant which represented the 'parts' of the phenomenon. In the interpretive process, the 'whole' picture that described the women's experiences of loss following miscarriage was formed. This interpretive process is presented in brief in the next section.

4.3 Understanding the women's experience of miscarriage

As a step-by-step approach of the analytic process guided by Smith et al. (2009) was presented thoroughly in chapter 3, this section presents three super-ordinate themes which emerged from the interpretive process, including facing the loss of hope, gaining emotional balance, and the need for interventions. The interpretive process of these themes from the words of the participants, initial notes, emergent themes, sub-themes, and super-ordinate themes are presented in Appendix D.

The following table summarises these themes which is presented in the next section.

Table 4.2: Sub-themes and super-ordinate themes for the miscarriage group

Sub-themes	Super-ordinate themes
The awareness of the loss of hope	Facing the loss of hope
Physiological and psychological reactions	
Gaining self motivation	Gaining emotional balance
Believing in karma based on the Buddhist belief	
Seeking knowledge	The need for intervention
Seeking emotional support	

Although in table 4.2, the three super-ordinate themes, **facing the loss of hope, gaining emotional balance**, and **the need for intervention**, are separated as individual components, they are all components of the loss experience following miscarriage. In the interpretive process, I acknowledge that the three themes have a strong connection to each other and that one influences the other. Figure 4.1 demonstrates the relationship

between these three themes.
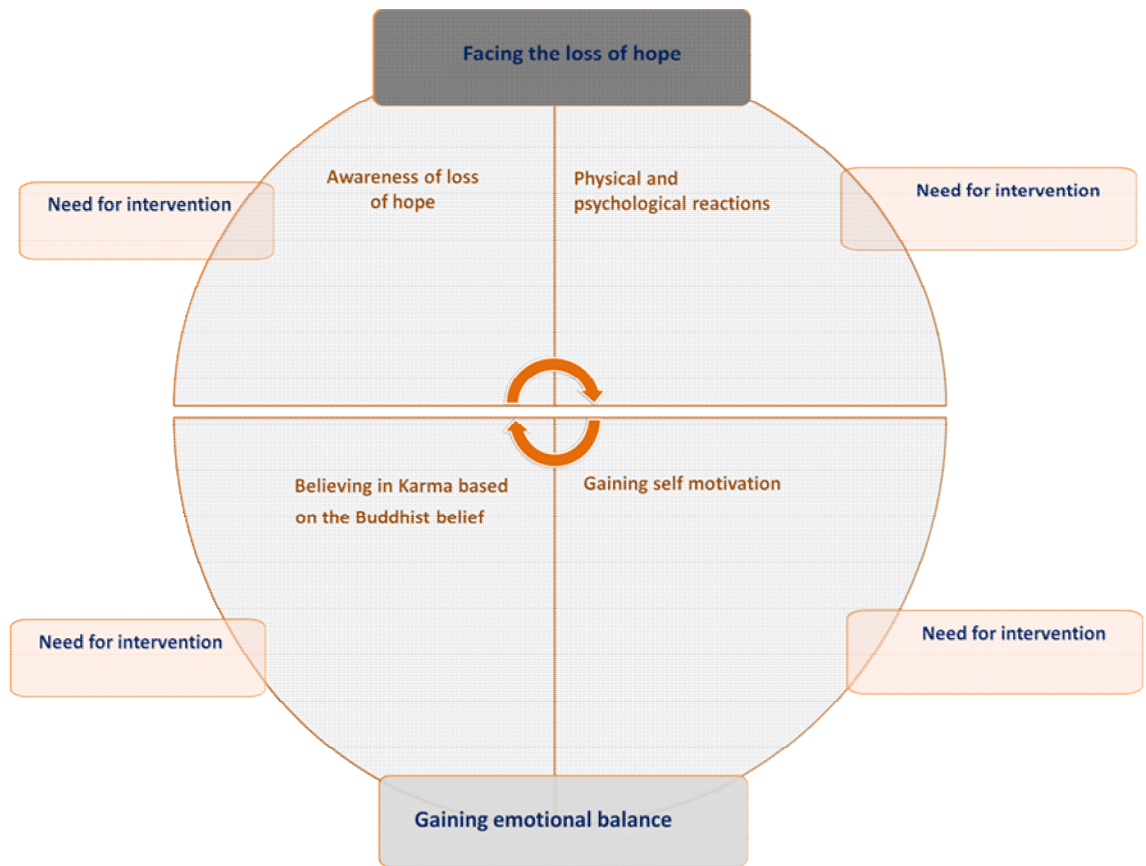
Figure 4.1: The experience of miscarriage

In figure 4.1, the three themes are represented as a process in which each theme is related to another. Suffering psychological and physical imbalance and gaining emotional balance are viewed as spiralling circles which are the dynamic movement to seek a sense of balance. Whilst facing the loss of hope and suffering with emotional unrest, the participants attempted to regain their emotions to be in balance. The need for intervention is entwined throughout the loss experience because it is explained as an important factor to support the participants to overcome the loss of hope and gain emotional balance.

In order to present the phenomenon of the loss experience following miscarriage in an easy way to understand, the findings from the stories of eleven participants are presented in a pattern that moves from the themes to the sub-themes and the initial statements. The three themes are presented and examined as individual components in order to provide clarity for the reader. However, they are all components of one experience so they are interrelated and one theme always calls forth another.

4.3.1 Facing the loss of hope

In the process of interpreting the transcript, it became obvious that the first experience of all the participants was facing the loss of hope. The theme, facing the loss of hope, was used to demonstrate the perception that they found themselves in an unexpected situation which was absolutely different from their expectation. This theme relates to the meaning of having a baby. Although having a baby has several meanings among the participants depending on their own context, getting pregnant gives them the hope to achieve the meanings they expected. When their pregnancies ended, they had to confront the loss of all the hope and dreams of what might have been.

M02 summed up her expectation of becoming a mother as a view of having a complete family.

> *I was very excited that I was going to be a mother. My family was going to be complete. My happiness was very short, only 2 months and then it had gone in an instant.* (M02, p.5)

M08, in reflecting on her experience of facing the loss of hope to have one more child also related:

> *I was happiest that I could get pregnant because I was advanced in years. I wanted to have one more child after having a six year old son. But something unexpected happened when I had some bleeding and my hope was broken when a doctor said that I was having a miscarriage.* (M08, p.4)

A further example of facing the loss of hope is found in M05's story. She related that:

> *We tried to have a baby for so long and all happiness and dream we had since getting pregnant was taken away from us in a short period of time.* (M05, p.5)

The stories of these participants described how they felt uprooted from all their hopes and drawn into an unexpected painful situation. The consequence of facing the loss of hope was that participants were being made to consider their circumstances in a way that was never expected. The theme of facing the loss of hope developed from two sub-themes, the awareness of the loss of hope and psychological/physical consequences. These sub-themes are described in the following section.

4.3.1.1 The awareness of the loss of hope

The sub-theme, the awareness of the loss of hope, was used to display the participants' perception of having a miscarriage which ended the pregnancy and took away their expectation of having a baby. This perception brought the participants in this study into an awareness of the loss of hope.

For participants, having a miscarriage meant their hopes of having a baby were disrupted and they were unable to continue with their dreams as before. For some, the awareness of loss of hope came slowly as the process of information giving unfolded. For others it was a rapid and sudden realisation that hope was gone. An awareness of loss was expressed by M01 who gave the following account of when she was given the diagnosis of miscarriage:

> *I had so much hope in my pregnancy. But the more I listened to what the doctor informed me, the more my hope became lower and lower, and then was gone.* (M01, p.13)

M03 also said in her story that:

I never believed that the little happiness which happened when I knew that I was pregnant would be followed closely by tremendous suffering. I felt like my whole hope was crashing down in front of me. (M03, p.6)

The awareness of the loss of hope occurred when the results of examinations were confirmed. This occurred to M04 at the moment she was given the diagnosis of incomplete miscarriage. She said to me:

He (a doctor) concluded that my baby had miscarried. At that moment I felt like my hope, my dream, and whatever my wish to have a baby slipped away with his words. (M04, p.10)

M02 also echoed:

During the repeat ultrasound scan, I prayed to the Triple Gem that we (I and my husband) wouldn't lose the baby. But then we lost all hope when the doctor told us that I certainly was in the process of miscarriage. (M02, p.7)

The sub-theme of awareness of the loss was expressed by the participants in a number of ways and from different triggers. For some of the participants, this awareness of loss was sudden, while for others it was slow and vague.

Some participants, in particular those for whom this was the first miscarriage and who had no warning signs, explained their miscarriage was not a gradual situation for which they had warning or could prepare. Instead, all participants expressed feeling that they found themselves in a situation they had never considered. M06, for example, acknowledged:

It was definitely beyond what I thought and dreamt. I never thought that I would face such an event. (M06, p.7)

M09 also related that:

I didn't understand. Everything was going well but it all got destroyed in the blink of an eye. (M09, p.12)

M02 also explained her miscarriage was unbelievable and unacceptable to her. She recounted:

I really didn't think about miscarriage because it was just spotting, I wasn't bleeding thoroughly. So I decided to observe and wait until my appointment date for antenatal care. I never thought that I would have miscarriage. I never thought that I would face such an event. (M02, p.4)

On the other hand the participants who had recurrent miscarriages explained they were constantly worried that they would have the same experience again and observed every moment of their pregnancy. When they found some symptoms of miscarriage that had happened to them previously, their awareness of loss was actually raised and then was confirmed when a miscarriage was diagnosed. M03's story is a typical example of this issue. She described how her previous miscarriage affected the awareness of loss in her current pregnancy:

I had more hope in my current pregnancy, my hope became much stronger when the doctor said that my baby was normal by doing an ultrasound. But I was still afraid about miscarriage. On the day I found something wrong with my pregnancy. I thought of having miscarriage immediately. And then it was true, I was given a diagnosis of miscarriage. I lost my hope to have a baby again because the doctor was sure my pregnancy was ending. (M03, p.12)

M07 who experienced her second miscarriage also related her previous experience of miscarriage to an awareness of loss in her current pregnancy:

I found myself in the same situation as the previous miscarriage, same time and same symptom. I knew I was miscarrying. I realised my hope for this pregnancy was dim. I tried to restrain my mind to not crying. But I finally cried when it was confirmed that my pregnancy had ended and my hope ended as well. (M07, p.11)

M01's account is another typical example. She admitted:

As I had one miscarriage, when I felt a gush, the first thing I thought was it was happening again. During the journey to the hospital, I tried to pray to the Triple Gem to protect my pregnancy. But when a doctor told me the ultrasound result, I then lost all my hope and was certain that I was in the process of miscarriage. (M01, p.8)

The awareness of loss triggered by the miscarriage stimulated in participants the loss of hope. It also aroused a range of feelings that could be encapsulated as psychological and

physical responses. The next section details the sub-theme of psychological and physical reactions.

4.3.1.2 Physical and psychological reactions

When facing loss, the participants experienced a wide range of physical and psychological responses. For some participants who had no signs and symptoms initially, these reactions happened at diagnosis of miscarriage while for others these reactions happened at the identification of miscarriage symptoms.

In relation to physical responses, some participants experienced a variety of physical manifestations as part of the emotional states. They were described in dramatic and strong terms signifying the importance of these feelings as part of the experience. The participants expressed the sensations of feeling as if their hearts would stop or disintegrate; they described being suddenly cold as if washed with cold water or feeling disconnected and faint. These are the sensations that they described on hearing the diagnosis of miscarriage and which they associated with this early news.

In describing the physical manifestations of the emotions, M09, for example, described a dramatic physical reaction of feeling as if her own heart would stop beating. As she related:

> *When I heard that my baby's heart had stopped beating, I felt like my heart was going to stop beating.* (M09, p.5)

M08, who had her third miscarriage after having a healthy four-year-old daughter, expressed feeling that she was faint and felt disconnected to the situation. As she recounted:

> *... my heart immediately sank. I almost fainted when the doctor told me. I just couldn't believe this was happening again. I also was in disbelief and wonder how it happened.* (M08, p.4)

M07's story is another example. Although she had prepared herself for a possible third miscarriage when she started gushing bright red blood, she expressed the physical manifestation of feeling shocked and frightened after the diagnosis. She narrated that:

> *I felt a cold pail of water just flushed down on me. I couldn't even cry. I felt numbed.* (M07, p.4)

And M01, who was worried about the effect of her advanced age on fertility and pregnancy, described the feeling of a crumbling heart as the physical responses associated with the extreme sadness of facing her second miscarriage.

> *He (the doctor) confirmed to us that my baby was certainly gone. I then cried and cried with my husband. I was so devastated. My heart was about to crumble,..., I was full of sadness until I barely found proper words to explain it.* (M01, p.8-9)

M05 also related such feeling in her story:

> *When the doctor said that my baby's heart had stopped beating... my heart then disintegrated.* (M05, p.5)

In addition to the physical responses, the participants described how they were overwhelmed with a range of psychological reactions associated with the loss including feelings of shock, denial, regret and sadness, doubt, despondency, and lack of self belief.

Feelings of shock were expressed in a number of ways by all participants in this study. Some demonstrated this shock at diagnosis but for others these feelings occurred when they identified the symptoms of miscarriage and realised what was happening to their pregnancies. As M04 said to me that:

> *The first thing was I was frightened and shocked to see a lot of bleeding. I just felt like my bladder let loose but when I went in the bathroom and looked down, I found a lot of bleeding. A thought of miscarriage occurred to my mind. Then the scare of losing the baby suddenly occurred in my mind.* (M04, p.6)

M11 echoed such feeling in her story that:

> *As I had one miscarriage, when I felt a gush, the first thing I thought was it was happening again. I ran to the toilet and found that I had a bit of bleeding, but unlike the previous time it was light blood and almost watery. Although it was a lot, I felt extremely scared. I went to the hospital immediately.* (M11, p.6)

The symptoms were considered as a warning sign but they really could not accept the reality of what was happening. As a result, some felt shock and had a sense of inevitability as they knew what the symptoms meant. M08 expressed this as:

> *I was 7 weeks and 5 days pregnant. I had water-like discharge, white and clear discharge for 2 days but not a lot. On the 3rd day, I had quite a lot of bleeding of brownish blood. An ultrasound was done and a doctor told me that there was no heartbeat and my baby floated in the sac, not attached to the uterine wall. But I had no pain in my abdomen. At that moment, I was in shock and couldn't believe that I was going to miscarry.* (M8, p.6)

M05's story is another example. She related in her story that:

> *I was in tears and shock when the doctor said that I had a miscarriage but it was not expelled completely, I would need to have curettage as soon as possible. Otherwise, I might have a haemorrhage. I never prepared my mind for this news.* (M05, p.8)

Some participants described feelings of denial at the initial news that they were having a miscarriage. As M10, for example, said that:

> *I was in shock, frightened, doubt, and confusion. It was unbelievable, I could believe it. I thought that my baby might be too small and very hard to see. I asked the doctor to check carefully again because I didn't think that my baby had departed.* (M10, p.12)

M02's story is another example of this feeling. She related in that:

> *A few days after miscarriage, I almost couldn't hold it any more. It just stuck in my mind. It seemed like deep in my heart I couldn't accept it. I really wanted to have a baby. It was not easy to tam jai.* (M02, p.11)

Although they refused to accept their loss and deceived themselves that their pregnancies still existed, this deception was not prolonged. As their symptoms indicated the loss, there was no possibility to further deceive themselves. Women described how they tried to rationalise their understanding before accepting the facts. As M02 voiced:

> *I tried to think that the result might be wrong, it was the bleeding from implantation, but my condition was not related to what I thought. I couldn't refuse anymore.* (M02, p.10)

M03 also recounted in her story:

> *During the 1ˢᵗ ultrasound scan, a doctor couldn't see my baby. I felt a bit weary. It was happening again. But I tried to cheer my mind up that my baby might be small, it might be hard to see. In the 2ⁿᵈ ultrasound, the result was the same. The doctor asked me about getting curettage. But I still wanted to give myself a chance. I begged the doctor to wait for two more weeks. If my baby was unable to grow in my womb, it might be miscarried naturally as my previous miscarriages. And I finally miscarried spontaneously.* (M03, P.8)

Regret and sadness were expressed by all the participants as the most common feelings caused by the awareness of the loss of hope. They also explained crying excessively as a physical reaction to this emotional state. M07's story disclosed how she felt:

> *I felt I had so much regret. I cried with my husband almost every night in the first week after miscarriage. I cried until my eyes were swollen. I cried until my tears ran dry.* (M07, p.12)

M02 also recounted:

> *That day, our mental states were very bad. Although I tried to Tam jai and soothe myself, anytime when I thought about my miscarriage, my tears always came out.* (M02, p.13)

And M01, who waited and wanted to have a baby, described feeling sad when facing her second miscarriage.

> *I was full of sadness until I barely found proper words to explain it. After I came back from the hospital, I only cried and cried with my husband.* (M01, p.9)

Although the participants were stunned and had many questions, the most important one was why the miscarriage had happened to them. In describing the feeling of doubt, M02 and M01 related their lifestyles and behaviours during pregnancy to this issue. As M02 expressed in her story that:

> *Maybe it was because I didn't take care of myself enough. Or I still worked too hard while I was pregnant. Or I often rode a motorcycle.* (M02, p.11)

And:

> *Probably, it was because of stress, or it was my fault for not being more careful, or it was because of my health…*(M01, p.18)

As the causes of miscarriage were not identified clearly, the participants tried to find the reasons for why it had happened to them. M10 focused on herself and blamed herself for her miscarriage. As she related:

> *I felt bad about myself. I didn't take a very good care of myself. I wasn't very careful with my activities. Finally, my baby was not with me. As I thought that I was healthy, I did everything as usual. I then lost my baby.* (M10, p.16)

While M07 focused on the Buddhist beliefs in karma. She questioned her bad karma in her past life as the cause of her miscarriage. As she narrated:

> *Why am I a very unfortunate person? What kind of bad karma have I done?* (M07, p.18)

As there was no scientific evidence to eliminate the mystery of her recurrent miscarriage, M03 also questioned whether it was related to karma.

> *Even doctors didn't know the causes of my miscarriage because the result of physical exams and blood tests were normal for both me and my husband. They couldn't tell me how I could succeed having a baby, once some doctors suggested me to go to make merit.* (M03, p.20)

Feelings of despondency and loss of self belief were described by most of the participants, in particular, those who suffered from recurrent miscarriage. Repeatedly facing the same situation reinforced their inability to have a baby.

In describing feelings of despondency, M03, who previously had four miscarriages, narrated how she felt when her fifth pregnancy ended in miscarriage.

> *I am just tired to have the same thing that keeps happening over and over again, tired to start again, tired to push forward, tired to have hope, and tired to face the same situation again and again. I tried to have a baby for over 4 years. It was the most stressful thing.* (M03, p.19)

Feelings of despondency and surrendering to the inevitability of not having another child were also confirmed by M08 who had three miscarriages in a row after having one successful pregnancy. She also related such feelings in her story that:

> *I went home defeated. I couldn't believe that it was happening to me again. The thing that I was faced with is too harsh. If I have to lose again, I'm afraid that I won't be able to stand it.* (M08, p.18)

Feeling defeated or let down by their bodies was clear in women who had experienced previous miscarriage. The loss of self belief was particularly voiced by those who had previous experiences of miscarriage. The more miscarriages participants had, the more intense the loss of themselves and realisation of their inability to have a baby. M07 is an example of this feeling. She expressed the effect of having her second miscarriage and comparing her experience to other women.

> *I had two miscarriages within two years. It was the most stressful thing that I had ever dealt with. I felt a bit disappointed and lost my confidence a little when I found the other one who had started to get pregnant at the same time as me and she completed her family.* (M07, p.6)

M07's story is another example of this feeling. Her story disclosed an association of feeling loss of self belief and powerlessness.

> *I was still sad about having a baby. I heard a lot about getting pregnant after miscarriage. People often said that "only for a while, you can get pregnant again". But these words couldn't match with my case. I tried to do everything that I was suggested to do but it was not successes. I felt tried and began to resign from trying to have a baby.* (M07, p.20)

For the participants who considered having a baby as one of the most demanding things a wife should do, they put pressure on themselves to get pregnant again. However, they struggled with emotional stress in facing the loss again. They were concerned that they

might find themselves tired and frustrated from facing the loss, or perhaps, even close to simply giving up hope. In other words, these participants had to face an emotional battle between fighting and surrendering to the attempt of having a baby. M01, for example, recounted that:

> *Although he (her husband) tried to encourage me not to think too much, deep in my heart I felt a bit disappointed that I couldn't make his hope come true. I just want to give him a child.* (M01, p.23)

The following extract of M03's story is an example which explicates how she suffered with the pressures of waiting and wanting to have a baby. She chose to continue fighting to have a baby in order to hold on to her hope.

> *...I tried to have a baby for over 4 years. It was the most stressful thing. I intend to keep on trying for 3 years. I have no choice except fight until the last breath.* (M03, p.19)

Unlike M03's story, M11 had one successful pregnancy. She was under less pressure from wanting to have a baby. She described her decision to surrender to the experience of loss again after facing her second miscarriage.

> *What I feel now is I really give up. I faced two miscarriages. I was almost unable to endure with it. I felt really hurt, it made me hurt both my mind and body. If I have to face the same situation again, I think I am unable to endure anymore. I must give up on having one more baby. Just one daughter is enough.* (M11, p.25)

For the participants in their first pregnancy, the loss of self belief was not described directly. Instead, they expressed their feelings of worry, fear, and uncertainty in getting pregnant and having a successful pregnancy after miscarriage. M02, for example, acknowledged that:

> *I am still in the state of fear of miscarrying again. Nobody can assure me whether it will occur again or not. I am still afraid to face this situation again.* (M02, p. 22)

And M05 said in her story that:

I didn't think before that I would have a miscarriage. But now I have experienced miscarriage. So it can occur with me again. I am really not sure about my next pregnancy. (M05, p.19)

As most of participants in this study had some signs and symptoms of miscarriage, they were admitted and treated by a dilatation and curettage immediately to prevent complications of miscarriage. If they had no complications of miscarriage and treatment, they were discharged the next day or as early as possible. After discharge, the participants realised the first week after miscarriage passed very badly because they were overwhelmed with a variety of feelings. The participants were either numbed in a state of shock or suffering emotional unrest but because they were at home they felt they had to deal with their feelings alone. Their family members were the most important support to help them get over this situation without severe emotional trouble, while healthcare professionals had no involvement in helping the participant during this period.

The two sub-themes of the awareness of loss, and psychological and physical reactions merge into the theme of facing the loss of hope. These two sub-themes are both an expression and consequence of the participants' facing the loss of hope. This theme is the starting point of the experience of loss interrelates with the second theme, gaining emotional balance, which is described in the following section.

4.3.2 Gaining emotional balance

Gaining emotional balance is the second theme of loss experience to be discussed. Facing the loss of hope and being overwhelmed with emotional disturbances force the participants to consider a constant state of their feelings in order to continue their life and exist in the experience of loss. This theme refers to the strategies used by the participants as managed their emotional disturbance during a turbulent time in order to move back to their emotional stability.

The intensity of emotional disturbance tends to decrease if the participants can accept the reality of their situation and try to find peace in living for the moment and cope with their emotional burdens. Participants described their experience of trying to distract themselves from their loss to prevent themselves from surrendering to their painful feelings of loss. As M11 reflected in her story:

> *Nothing was better than accepting what happened. For me, it seemed like nipping it in the bud. If I delayed accepting it and further deceived myself, it was me who would get worse from this situation.* (M11, p.23)

M08 expressed such an issue in her story:

> *I felt so much sadness and regret with every miscarriage, but there was nothing I could do, my baby did not stay with me. What I could do now to make me feel better was let it be. I tried to think that the baby might not be ready to be born with me. I still have hope of having a baby. At least my hope helps me have more will power.* (M08, p.24)

For M05 and M03, who faced an emotional battle between fighting and surrendering to the attempt of having a baby, they tried to use their intention to have a baby to cope with their emotional burdens and move forward. M05 related that:

> *Although I still have fear of getting pregnant again, drowning in the past doesn't help me to achieve my intention. No matter whether it will occur again or not, I have to adjust my mind and recover my body as soon as possible to fight with it again.* (M05, p.21)

And:

> *Although I still feel regret for my miscarriage, I have to tam jai because I cannot call it back. The best thing is Tam jai and start again. I will keep trying for three more years. If I cannot have a baby, within this time, I shall give it all up and we will live together just the two of us.* (M03, p.33)

However, although regaining the balance of emotions is the goal the participants expect to achieve, it takes time to realise and accept the loss, and needed several ways to help the participants cope with their traumatic emotions. M02's story, for example, pointed out that while her mind was full of sadness, receiving consolation from other people,

including her close relatives, and suppressing her traumatic emotion failed to resolve painful emotions. Experiencing and expressing sadness with her husband seemed to be the best way to allow the pain she felt to be released.

> *When I came back home, everyone at home tried to soothe me and my husband. We tried to tam jai (accept). But when we were alone in my room, although we tried to soothe and encourage each other that let it be and we will try again, it was useless because we couldn't force a smile while our hearts were full of sadness. We finally couldn't restrain our tear. We cried together.* (M02, p.13)

In this theme, the two sub-themes were described, which included: gaining self motivation and believing in karma based on the Buddhist belief.

4.3.2.1 Gaining self motivation

The sub-theme, gaining self motivation, refers to the strategies that the participants use to accept the reality of having a miscarriage and try to motivate themselves to deal with their emotional responses which are the consequences of the loss of their hope.

The participants reported seeking emotional support, seeking the truth of the situation, learning from the experience of others, and keeping a positive self attitude. These appeared to be strategies that they actively sought out in order to help them regain their emotional balance.

Seeking emotional support was expressed initially by all participants. As having a miscarriage led the participants to feeling overwhelmed with regret, sadness and despondency and loss of self belief, the participants needed emotional support in order to help them feel relieved and empowered to face their loss. The participants' husbands

were the most important supporter to help calm them and give them encouragement to continue. M07 related in her story:

> *My husband soothed me that whatever will be will be, let my mind relax. If our baby wants to be born with us, it will come. But if it doesn't come back to us, I don't have to think too much and don't be so serious. He always loves me and stays with me. Although there are only two of us, we can get happiness. His words made me feel relieved from worry about having a baby.* (M07, p.17-18)

M08 also acknowledged her husband as the most important supporter and explained how sharing their feelings with each other helped them to provide emotional support for each other.

> *My husband was the most important person to raise me up from sadness and have more will power. We cried together. We felt sympathy to each other. We understood the feeling we had. We helped each other to feel better.* (M08, p.27)

Reassurance from her husband is essential to build confidence to overcome feelings of stress and tension. M03 described an emotional battle between trying to have a baby in order to fulfil her dreams and accepting that they would be a childless family. Amidst this pressure, she expressed feeling relieved after making a commitment to having a relationship without a child.

> *If my husband wanted a baby so much, I may feel so much stress because I am unable to fulfil his hope. But he told me not to think so much, if we had no children, we would live together just the two of us. It helped me feel so much less stress.* (M03, P.34)

Besides the participants' husbands, their family members and friends also played a significant role in giving them emotional support, sympathy, and empathy. The following extract of M07's story shows the advice she received from her mother. As she questioned her lifestyle as the cause of the miscarriage, the advice from her mother helped her feel better about herself. She recounted that:

> *It was good that my mother helped me to have consciousness. She warned me not to worry about the past. She said that even if I made a mistake, I could still start over. I had a lesson once, so I should use it to teach myself and do whatever I wanted to do. Without consciousness, I might be weak or not be strong enough to go through my sadness.* (M07, p.28)

M08 described that she felt relieved when she received encouragement from her family members and friends.

> *Whenever I thought of my baby and miscarriage, I was afraid and worried about miscarriage. But my mother, my relatives, and my friends tried to soothe me that don't be pessimistic. I still had the chance to get pregnant and have a baby. It helped me feel a bit relieved from worried about getting pregnant again.* (M08, p.25)

For some participants, who were uncertain about the reactions of others outside their families to their miscarriage, they tried to keep this situation private. However, receiving sympathy from others was realised as unexpected emotional support. M03, for example, said to me that:

> *Firstly, I didn't think I should tell anyone about what happened. But when I returned to my workplace, my colleagues were concerned and asked about my condition. Are you feeling better now? Why don't you rest for a few more days? Your face still looks pale. I would like to thank you for trying to make me feel better. I really have strength of will power.* (M03, p.23)

In addition to the sympathy from other people outside their families, the other participants reported that it was helpful to talk to someone else who had experienced miscarriage. Understanding how other women had gone through the journey and dealt with it appeared to give them hope. They recognised themselves in the stories told by others who had experienced miscarriage. M04 talked about how she learned from a woman who had a similar experience to her and pointed out:

> *It was better that I decided to go to work because when I was alone at home, I got engrossed within my thoughts. But in my workplace, I received encouragement from my colleagues. Someone told me about their experiences of miscarriage and advised me how to take care of myself. I felt more relieved and felt that I had more will power.* (M04, p.26)

M10 told me how she felt after learning the loss experience from other women that:

> *I felt more relieved since I talked to my friend who had had a miscarriage and she really needed to have a baby. We felt sympathy with each other. We understood the feeling we had so well. It made me feel better.* (M10, p.30)

M01 echoed such feeling when talking with her friend who had a similar experience to her.

> *It was my luck to meet and talk with my friend who faced a miscarriage and had to get curettage. The next month, she got pregnant unexpectedly and has a 2 years old son. She also had another friend who had the same experience and could have a baby. She searched the internet and found that 30-40 percent of women had a chance to have a miscarriage. I learned new knowledge from my friend because I had never known anyone who was similar to me. This made me feel much more relieved.* (M01, p.20)

For M10 and M03, learning from their friends' experiences helped them to have hope in having a baby. M10 recounted:

> *Talking with other people helped me see a way out. When I thought alone, I felt my life was gloomy. When I listened my friend talked about what she had done to succeed in having a baby, it helped me have hope. It was the light that might lead me to reach my intention (to have a baby).* (M10, p.22)

And M03 also said to me that:

> *Last week, my friend who was the one like me came to visit me and told me about what she had done to succeed in having a baby. She was advised by a senior monk to make merit by supporting any child who wanted to be a Buddhist monk,…, and she finally had a baby in her eighth pregnancy. I am thinking about this way. I still haven't made up my mind yet. I will probably do as my friend has done.* (M03, p.29)

For M07, talking with her friend who had had a miscarriage was considered as sharing their feelings with each other and giving emotional support to each other.

> *One of my friends had a miscarriage when she was 8 weeks pregnant,…, She tried to do as the doctor advised,…,Around 1 year later, she got pregnant. Now she is 24 weeks pregnant and everything is going well. So she tried to encourage me to never give up because she was the one like me and she understood how I felt with this situation. It helped cheer me up from feeling down and sad.* (M07, p. 24)

Seeking reassurance is a means the participants used to encourage themselves and made them feel they were able to go through their loss experiences.

Some participants described seeking information about the miscarriage as gaining their understanding of the causes of the miscarriage. A better understanding would help them to stop blaming themselves for their miscarriage. The following excerpts from M05 and M09 help to illustrate this issue. M05 recounted:

> *I tried to read many books and search information on internet about miscarriage. At least it made me feel relieved that it did not happen because of me and it wasn't my fault at all. Otherwise, this guilt would stick in my mind forever.* (M05, p. 26)

And M09 related that:

> *I tried to find out what was the cause of my miscarriage. The information I knew made me felt more cheerful to know that there was something good about me. I wasn't the cause of the miscarriage.* (M09, p.16)

Other participants chose to unconditionally accept the reality of the miscarriage and maintain positive thinking and attitude in order to encourage themselves to look forward instead of dwelling on their despondency. M02 said to me that:

> *I had to tam jai (accept) that my baby was miscarried already. My baby could never come back. I couldn't correct what had passed. What I should do was try to take a good care of myself and the good result would happen.* (M02, p.25)

M04 expressed such issue in her story:

> *I couldn't escape the truth that I miscarried already. If I couldn't be strong, I couldn't do anything at all.* (M04, p.3)

M11 added that positive thought in life was important to help her overcome feelings of despair and look forward to a brighter future.

> *What we are is the result of our thoughts. No one can harm us but ourselves. If I still allow myself to be dispirited, even a magician can't bring my pregnancy back. Such acceptance will also enable me to endure the condition and to overcome my despair.* (M11, p.32)

M03 also related in her story:

> *Find me one, among hundreds or thousands of human beings, without suffering. There is none. So live my life for tomorrow. What I have to do today is make it better. One day the rain would be gone, the sky would be clear, and I would see the sun.* (M03, p.31)

Gaining self motivation by realising the truth of the situation, seeking family

involvement and support, learning from other's experience of loss, and seeking

reassurance is the focus in calming down the participants' emotional unrest because the

participants themselves are the centre of their loss experience. However, the Buddhist

belief which underpins the Thai ways of life is also mentioned by the participants as an

approach to relieve them from their emotional unrest. This is the focus of the next sub-

theme which emerged from the participant's experience.

4.4.2.2 Believing in Karma based on the Buddhist belief

The sub-theme, believing in Karma based on the Buddhist belief, refers to using the

religious faith as a source to help deal with their emotional unrest. All participants

considered Karma as a powerful strategy to face the difficult situation.

Firstly, Karma is described as the cause of the loss experience. The participants

mentioned having a miscarriage as the result of Karma. This belief helped them to

accept the fact, and then be able to deal more easily with their emotional response.

M10's account is an example:

> *It might be my own old sin and karma, that's why everything happened. No one*
> *could forbid it from happening. It was unchangeable. I also couldn't resist this*
> *fate of me.* (M10, p.20)

M04 also related in her story:

> *Right now, the outcome of what I had done in the past was displaying itself. It*
> *might be my fate and my baby's fate. I didn't need to find a reason for it.* (M04,
> p.32)

And the following sentences were in M06's story and M03's story:

If our fate was destined already, we can't change it after all. What will happen, no matter how we try to stop it, it will happen anyway. And when it happens, we have to accept the result. (M06, p.26)

And:

Although I didn't totally believe in fate, it might be comfortable to think that my miscarriage was no fault of my present live but the legacy of a far distant past. At least it made me relieve from doubt about the cause of my miscarriage because nobody, not even the doctor, could explain clearly what happened with me. (M03, p.29)

Secondly, traditional practice based on Buddhist beliefs in Karma, in particular prayer to the Triple gem, was used as a means to calm the emotional disturbances. As M01 said to me that:

During the first week after my miscarriage, I was overwhelmed with many bad feelings. The best way to help me have consciousness and feel relieved from these feelings was prayer. I prayed everyday and also made a wish to the Triple gem that Buddha, Dharma, and Sangha, please be my supporters. May all of you help me restrain my mind. (M01, p.12)

M08 was advised and encouraged by her mother to pray every night and she found that it helped her release emotional disturbances.

Prayer helped me a lot. I got rid of all emotional disturbances whilst praying. It might be because I concentrated only chanting. If I didn't do as my mother suggested, I might struggle with my bad feelings. (M08, p.20)

Thirdly, religious practices were used as a superstitious power to make the participants' wishes happen. M02, for example, made a wish to the Triple gem to get away from having a miscarriage again. As she recounted that:

Buddha, Dharma, and Sangha, as well as my ancestors' spirits, if you will show a little more mercy, please destine me not to face to this situation again. (M02, p.27)

M01 also related in her story:

I prayed and consigned merit to my departed baby and khammic fellows every night as my friend suggested. I prayed for my baby's better condition and hoped that the khammic fellows would forgive me and let me to get away from bad things. I didn't know this method would have me more or less, but at least I had done. It helped me get a little bit better. (M01, p.30)

M03 is another typical example:

Even doctors couldn't tell me how I could succeed having a baby,..., Once some doctors suggested me to go to make merit. I went to make merit at a temple as they suggested. I didn't know that it would help more or less. It was better than doing nothing. (M03, p.17)

M03 added a ritual her mother had performed following folk belief to help her succeed in having a baby.

My mother knew that I really wanted to have a baby. She tried to help me by doing a ritual following folk belief. Because rural people believed that having no children or being unable to have children was the result of any bad deed about this issue in the previous life. My mother helped me to do the folk ritual to consign merit for my khammic fellows (anyone who was affected by her bad deed)....If scientific methods can't help me, I probably get help from superstitious methods. (M03, p.18)

M07 also related to her story:

A monk said to me that all living beings were subject to their own karma. It might be my fate and my baby's fate. He suggested me that nobody could correct the past. I shouldn't waste my time in vain. I could make merit, consign merit, and do the goodness or anything to make me feel better. And the good deed will support you to be more successful in life. (M07, p.21)

Finally, making and consigning merit to a miscarried fetus is a means to fulfil the obligations of being a good mother to their babies. There is something that interested me in the participants' perception of their miscarried babies. Although the pregnancy ended in miscarriage in the first trimester of pregnancy, the participants still considered a miscarried fetus as a baby and continued in a maternal role in order to be accepted as a good mother for their babies.

Making and consigning merit for a dead baby is a common religious practice among Thai Buddhists based on believing in rebirth. It is believed that the meritorious deeds carried out by his living relatives will help him to reach heaven or a peaceful place. M04's story is a typical example of this concept. She strongly believed in the principle of life after death and the cycle of reincarnation. She told me about religious practices that had been

done for her baby. She recounted that:

> *I just went to the temple with my mother and my husband 3 days ago to make merit and consign merit to my baby's spirit. My mother suggested me to prepare food, desserts, fruits, flowers, and candles. And I offered it to a monk and then the monk chanted for my baby. Whilst the monk was chanting, I poured the water to consign merit to my baby's spirit and was determined with a prayer. I prayed for my baby's better condition. I prayed for my baby to go to be in a good place and reborn in a good life. If we had destiny together, I thought my baby would be born with me again.* (M04, p.23-24)

Fulfilling the obligations of being a good mother by making merit to the miscarried baby also helped the participants relieve their worry about the baby. As M04 added in her story that:

> *After making merit, I felt more relieved. I thought that my baby might receive all of the good deeds that I did for him. I had nothing else to worry about my baby.* (M04, p.24)

M01 also related such issue in her story:

> *I lost my first pregnancy to a miscarriage. And after miscarriage, I went to make merit and consign merit to my baby's spirit and I always consigned merit to the baby anytime I had the chance to make merit. At least I know that I'm trying to do something for my baby.* (M01, p.17)

Praying and making a wish to the triple gem for the baby was done by the participants in order to improve the baby's karma in the present life and to be better in the next life.

M05 recounted that:

> *Anytime I prayed, I also prayed for my baby and made a wish to the Triple gem. I prayed for my baby to be in a good place and reborn in a good life. And if we had destiny together, I thought my baby would be born with me again.* (M05, p.25)

The two sub-themes of gaining self motivation and believing in karma based on the Buddhist belief merged into the theme of gaining emotional balance; the second theme of the loss experience following miscarriage. This theme described alternative ways to deal with emotional disturbances and maintain a sense of emotional normalcy in their life.

Although regaining the balance of emotions is the goal the participants expect to achieve, it takes time to accept their loss, and they demonstrated several ways to help them cope with their emotional burdens.

In addition, there is something that emerges in my understanding about the theme of regaining the balance of emotions. Firstly, the participants' state of mind and emotional responses dictate the usefulness of support and resources. For example, while their minds are shutting down and unable to accept their loss, encouragement and consolation from other people are considered as a useless support. In contrast, when their minds are open and ready to start, encouragement and consolation seem to be useful emotional support. Secondly, the participants combine several strategies and resources, rather than using any specific method to help them cope with their emotional burdens. They describe personal, social, and spiritual resources to strengthen their minds to deal with their emotional imbalance. Finally, as the participants use different strategies to relieve the emotional unrest, the results are individualised. Accepting Karma as the cause of their miscarriage is an example. Some participants actually accept this concept without question and there is no need to seek out further information. While other participants, who also mention this concept as a means to soothe their emotions, still need to search for further information and medical explanations. This points to the idea that each woman is an individual and their strategies and coping mechanisms will be unique.

4.3.3 The need for interventions

The need for interventions is the next theme to be discussed. This theme refers to the interventions that the participants seek in order to support them when facing the loss of hope and to maintain a sense of emotional normality.

Although the participants themselves, their families, and their friends are the main sources of support, they also required interventions from healthcare staff in order to promote adaptation after loss effectively. As a consequence of having miscarriage, it is necessary for the participants to use services at the hospital in the diagnosis and treatment of miscarriage. Thus, medical and nursing interventions are inevitably involved in the loss experience of the participant.

The following excerpt from M09's story demonstrated how the interventions from healthcare staffs were needed. M09 recounted:

> *I felt that I had insufficient knowledge about the causes of miscarriage. My husband, as well as my family members, also didn't have more knowledge about this issue. I really needed to ask expert doctors. If expert doctors could give me clarity about this, I could plan about my pregnancy in the future.* (M09, p.34)

Another participant said to me that:

> *I didn't clearly understand what happened to me. Before discharge, I was still doubtful about my miscarriage. It might be good if doctors and nurses assessed my condition and my readiness before giving me any advice.* (M06, p.30)

These stories point out that health professionals are considered as important supporters in helping them to go through their loss experiences following miscarriage. However, the interventions they received from doctors and nurses did not completely meet their needs.

The theme of the need for interventions developed from two sub-themes including seeking information, and seeking emotional support. These sub-themes are described in the following section.

4.3.3.1 Seeking information

The sub-theme, seeking information, refers to the information from healthcare staff that the participants need in order to help them to recognise the truth of their miscarriage and to be able to plan for future pregnancies.

Knowledge of miscarriage, in particular the causes of miscarriage, is needed by all participants. This is because feelings of doubt happened to all participants after their miscarriages. A significant question raised by the participants is why this situation happened to them. This is connected to the issue of self blame or the perception of others that the mother in some way behaved in a way that caused harm to the fetus. As a result, the participants need sufficient knowledge about the causes of miscarriage in order to get over feelings of doubt and plan their pregnancies in the future. M05, for example, expressed in her story that:

> *What worries me the most is why it happened to me and my next pregnancy will result in miscarriage again or not. If I have known the cause then I will be not as reckless as before. Or if I know the cause, I will be able to solve it.* (M05, p.31)

M09 also said to me:

> *But I don't understand what the causes are. I won't let it happen a second time. If I know about this information, this probably won't happen again.* (M09, p.33)

Although M10 told me that she was advised by the doctors and nurses about this issue before discharge from the hospital, she still felt that there were many questions that were not answered clearly.

> *I need to know why miscarriage occurs to me. What is the cause of miscarriage? Why does my baby stop growing in my womb? I didn't really understand but I dare to ask the doctor because there were a lot of patients waiting for him.* (M10, p.38)

She added what the doctor should do to meet her needs.

> *It might be better if the doctor had more time to talk with me or spend more time to explain the causes of miscarriage and how I should take care of myself to prepare myself for the next pregnancy.* (M10, p.38)

Most of participants accepted that they had known about miscarriage from reading books and listening to the experiences of other people. However, they were not concerned about it, until they themselves faced it. Then, they recognised that knowledge was most important in preventing miscarriage. They needed deep and clear knowledge from both

doctors and nurses who were experts in miscarriage. They expressed a need to have this information but also stated that the information was not forthcoming from the doctors or nurses and this led them to seek information elsewhere. Some of this is tied up in the fact that very often, particularly in the first miscarriage, cause cannot be identified and even when told this the women still seek reasons. As M08 narrated that:

I felt worried about the causes of my miscarriage. The doctor said that it was probably because my baby was unhealthy, it was a natural choosing. It was too general. I want to know the specific cause. If there is any special method to find the real cause, I would like the doctor to inform or offer me. Or if there is no any special method, I need the information about how to prevent having miscarriage again. (M08, p.37)

M09 also echoed:

But right now what I need to know and care for is the causes of the miscarriage. If I know exactly about it, I can prevent before or I can plan what I should do with my life about having a baby. (M09, p.35)

From the participants' stories, it can be concluded that sufficient and clear knowledge from the expert health care providers is needed to help the participants to overcome their feeling of doubt, despondency, and loss of self belief in having a baby.

4.3.3.2 Seeking emotional support

The sub-theme, seeking emotional support, means the participants need to receive emotional support and sympathy from healthcare staff in order to help them to face the loss of hope and maintain a sense of emotional balance. This sub-theme relates to the experience of caring that the participants receive from health care providers during admission to the hospital.

The participants explained that they felt cared for when health professionals showed that they were concerned for their patients' feeling and appreciated health professionals who were interested in their feelings.

Receiving close care from a nurse was explained by M08. She was given a diagnosis of incomplete miscarriage and had a dilatation and curettage immediately. She described that this nursing intervention helped her feel comforted whilst being in a state of shock.

When the doctor told me that I had to have curettage immediately, I was stunned by the result. But it was good that a nurse didn't force me. She stayed beside me and told me softly and clearly what I should do. She always came to see me when I slept in a recovery room. When she assessed my condition, she asked me how I felt. She told me to relax my mind and suggested that I should recover my body first. Although she didn't talk much, I felt comforted from having the nurse beside me. (M08, p.37)

Empathetic intervention was needed by M04. She demonstrated how she felt relieved when she received caring interventions from a nurse. She recalled that:

I cried and cried when I knew the result. A nurse took me and my husband to a small room. She said to me that my condition wasn't urgent to treat, I and my husband could stay in this room until we felt relieved from sadness. If we needed any help, I could call me any time. This is the nursing care that I need. (M04, p.38)

M09, who came into hospital having vaginal bleeding, confirmed caring interventions were required. She felt unsatisfied with the way a nurse behaved to her as if she was a case of illegal abortion. She needed caring behaviour from nurses to help her cope when she was frightened. As M09 recalled:

…Although they (some nurses) didn't say anything about this but their behaviour presented what they thought. She asked me what I had done with my pregnancy and looked at me as if she didn't believe me. But when she knew my diagnosis, she took good care of me. What I needed when I was feeling frightened with my bleeding was caring behaviour. Why you didn't soothe me or concern about my feeling. (M09, p.39)

M01 also related in her story:

…when I knew the result, I felt depressed, I was very disappointed…I wanted to escape to stay silently with myself…What I need the most is a time to ease my mind. I need a private area to be alone or with my husband, only a short time to ease my mind. I don't like the bustling atmosphere in the hospital. (M01, p.36)

Empathetic intervention was also confirmed by M01. She felt unsatisfied that doctors and nurses appeared to treat her without any concern for her feelings. She needed

compassionate intervention, not routine intervention. She said to me that:

> *Doctors and nurses didn't seem to be concerned about my feelings. Nobody asked much about how I felt with my miscarriage. They just asked me only about my condition after curettage, such as, feeling giddy and palpitation. No, a nurse asked me about what I felt, but she asked me in the issue of admission and that was it all. I needed them to be concerned about what I felt and please took care of me with your heart, not duty. (*M01, p42)

Flexible intervention is necessary to help the participants deal with their feeling

effectively. As M06 recalled that:

> *The doctor helped me a lot to decide something. If my condition was not too severe to harm my life then I could delay curettage, I could then have enough time for preparing my mind. Could you please give me time to ease my mind. (*M06, p.37)

M10 also told me that:

> *The doctor gave me 2 options, getting curettage on that day or wait until my body would expel my baby spontaneously. I was still in shock and sad at that time. I didn't know how to think about this. Why didn't they give me more time to realise what happened and calm down my mind before. (*M10, p.21)

M01 focused on a nurse. She added that:

> *I cried and cried because I was really extremely sad. A nurse tried to ask me many questions, she said she needed my information to admit me to the hospital before doing curettage. At that time, I was not ready to say anything. If it was possible, let's wait until I felt a bit better, I would tell you more. (*M01, p.41)

It might be important to remind the reader that the three themes in this study are

components of the one experience. Although they are presented as individual

components in order to provide clarity for the reader, they are interrelated to each other.

This means that they may influence and be influenced by each other.

Summary

This chapter described themes and sub-themes which were developed from the

interpretative analysis. Three themes emerged from data analysis of the phenomenon of

the loss experience following miscarriage. The first theme, facing the loss of hope,

consists of two sub-themes including the awareness of loss of hope and psychological and physical reactions. The next theme, gaining emotional balance, consists of two sub-themes including gaining self motivation and believing in karma based on the Buddhist belief. The final theme, the need for intervention, comprised two sub-themes, which include seeking knowledge and seeking emotional support. Within each theme and sub-theme, the meanings attributed by the participants were described. In the next chapter, the findings from the interpretation of the women's experience of termination of pregnancy for fetal anomaly will be presented.

CHAPTER 5

THE WOMEN'S EXPERIENCE OF TERMINATION OF PREGNANCY DUE TO FETAL ANOMALIES

5.1   Introduction

In the previous chapter, the women's experiences of miscarriage were presented. This chapter aims to present the experiences in the second group of participants involved in the study, the women who experienced a termination of pregnancy for fetal anomaly.

The first section of this chapter provides a summary of the demographic details of the participants who experienced termination of pregnancy for fetal anomaly. The snapshots of two participants' experiences related to the phenomena are also presented in this section in order to provide some examples of participants that contextualise them within the focus of the study. The second section explains the interpretive activities which were undertaken for the thematic analysis of participants' lived experience of miscarriage. The third section presents the themes that emerged from the participants' stories and expanded my understanding of the phenomenon. The final section describes comparisons of women's experiences in the two groups.

5.2   Introducing participants: Overview

The participants were twelve Thai women, aged between 18 to 42 years. Each person was assigned a reference number to ensure anonymity and preserve confidentiality. Table 5.1 provides a summary of the demographic details of participants.

Table 5.1: Demographic characteristics of participants

Age	
<20	2
20-30	3
31-40	5
41-50	2
Religion	
Buddhist	12
Marital Status	
Married	9
Living together	3
Length of Marriage	
1-5 ys	3
6-10 ys	4
11-15 ys	3
16+	2
Education Level	
Primary	3
Secondary	5
Tertiary	4
Occupation	
Home Duties	2
Self-employed	2
Employee	4
Farmer	1
Casual/Part-time job	3
Number of Children	
0	7
1	2
2	3
Number of Previous Therapeutic Termination	
0	11
1	1
Family Members in the household	
Spouse and Children	7
Spouse, Children and other Relatives	5
Family Income (in Baht)	
5,001-10,000	3
10,001-20,000	4
20,001-30,000	4
30,001-40,000	1

In order to gain some insight into the experiences of loss among the participants to contextualise them within the focus of the study, two brief stories from two participants are presented here.

TT04's story

TT04 is a thirty-three-year-old woman, married for 5 years to an engineer and they had no children. The interview was undertaken in TT04's house at two weeks and five days after she was discharged from the hospital. On the interview day, I had a chance to meet and explain the research to TT04's husband. I was made to feel very welcome in their home. TT04's husband agreed with her decision to be involved in the study. The interview took place without the presence of her husband in the living room. During the interview, anytime she talked about her baby, she became tearful and cried for a while before continuing. Sometimes she cried and sobbed dreadfully, so I had to continually observe her feelings and ask her if she would like to take a break. However, she confirmed to me that she wanted to continue telling her story and her crying was a way of relieving her sadness.

She described her family as a nuclear family but she still had a close relationship with her mother, brothers, and close relatives. She and her husband planned to have only one child and they waited for five years after marriage to focus on their careers and to be financially secure before trying to start a family. They had high expectations with the pregnancy because they were not a young couple that could get pregnant again and again. TT04 had perceived that getting pregnant at an advanced age increased the risk of having both maternal and fetal complications. Her pregnancy made all family members feel very happy because her baby was the first child in the family. On the day that an ultrasound examination was performed, all her happiness was replaced with sadness.

The diagnosis of fetal abnormalities was unbelievable and unacceptable to her.

> *At the time the doctor told me the diagnosis, he said that "Mrs A (pseudonym), I am sorry to tell you that in this case, you have to terminate your pregnancy, I can tell you that your baby is unhealthy, would you like to terminate your pregnancy today?, there is only one way". In fact, it was not the fault of the doctor, it was my fault that I can't accept it, I can't accept the truth that had happened to me, I was not strong enough to accept the truth what the doctor said…I was unable to accept it. At that time, I can't explain in words, it was not reality, I still deceived myself sometimes that it was not my baby's anomaly, it was my own anomaly, it was not anomaly in my baby.* (TT04, p.7)

She was referred to a university hospital to confirm the diagnosis and receive further management. The results were confirmed by a team of obstetricians; her baby's abnormalities were too severe to treat and they recommended termination of the pregnancy in order to protect her from any complications. She asked for advice from her husband, aunt, and brothers. Everyone encouraged her to be concerned with her own health and supported her to accept the treatment at the doctor's discretion. She made the decision to terminate her pregnancy but she was still overwhelmed by sadness. She realised that receiving emotional support and encouragement from trusted family members or friends could help her to get over this event.

> *I called my aunt to ask for her advice; she told me that nowadays people did sin a lot, although I had no sin but there were many people needed to be born for redeeming. I had to take the Dharma into my heart; the people who had short life would have a little bit of sin; the longer we were alive, the more suffering we got. My aunt gave me encouragement and support,…, and she also told me not to watch my baby from the first time if I was not ready to see his face because his picture would be fixed in my heart. My aunt told me about herself when she gave birth that immediately after birth, the doctor would let her to see her newborn baby; although nowadays, her children grew up, the first sight images of her children still were fixed in her mind. So I decided to terminate my pregnancy and I would tell the doctor that I was not ready to see my baby.* (TT04, p.18)

TT04 gave birth safely the next day after induction of labour. She chose not to see her baby. She felt glad for having a safe birth but at the same time she felt extremely sad at losing her baby. The Buddhist belief in karma, was a main source of help to relieve her sadness.

I always talked to my baby, I talked to him that if we had our own fate that was being connected to each other, I wished that the strings of fate would be ended in this current life; if I had ever done bad deeds to him before, I wished him to forgive me my wrong deeds; if I had never done any bad deed to him but this was caused by his fate from the past life, I wished to forgive you; if next life was a fact and my baby was ready to be born healthy, I wished my baby to be born with me again, I would always wait for him. (TT04, p.21)

TT04 was very thankful to doctors and nurses for giving her so much information. She realised that explaining everything clearly and thoroughly helped her to understand the reality of the situation, suffer less from fear and worry, and be able to prepare herself properly to face possible problems that might occur.

TT01's Story

TT01 is a forty-two-year-old woman, married to a farmer, and is the mother of two sons, a nine-year-old and a seven-year-old. Initial contact with TT01 was made 2 days after her giving birth and she indicated she was eager to be involved in the study. She asked me to interview her on the afternoon of discharge instead of being interviewed at 2 weeks after discharge. Her reason was she really needed to share her experiences, but she had to go back to her home province, which was far away from Chiang Mai province, after discharge. So, the interview took place in a private room on the postpartum ward. Whilst telling her story, she became tearful at times and cried quietly for a while before continuing.

She lived in a northern province with her family which consisted of her mother, her husband, and her sons. She described her family as having a close relationship with each other. This pregnancy was her third and was an intended pregnancy. Her pregnancy was a happy event for all family members. She expected to have a healthy baby. So, she tried to take good care of herself, she always prayed for her baby to be healthy, she went for antenatal check-ups regularly, and she was willing to follow the doctor's instructions.

Initially antenatal care was provided at a local clinic. As she was 42 years old, she was considered a high risk pregnancy and needed to be referred to a district hospital for additional tests. An ultrasound examination was performed to screen for fetal anomalies and found that there was a large amount of fluid in her fetus's abdomen. She was referred to a tertiary hospital in Chiang Mai province for final diagnosis and proper management. The second and third ultrasound examinations were performed at the tertiary hospital and at 23 weeks gestation her fetus was diagnosed as having fetal frank hydrop. The doctor informed her that her baby's condition was too severe to treat. She described her reactions and the overwhelming feeling of hopelessness, sadness, and sorrow that happened to her when she knew the result.

I felt like my heart jumped out of my body, it was gone, everything became gloomy, it was badly frightened, I was struck dumb, I was unable to think of anything, I felt like I had nothing in my life. (TT01, p. 18)

At that time (2nd September), I still had hope but my hope was gone when I knew the result at 16th October, I had the overwhelming feeling of hopelessness, sadness, and sorrow because my baby couldn't be kept in my womb and had to be terminated. (TT01, p. 16)

As discussed with her husband and her mother, they realised that the fetus could not survive for long, so they agreed to end the pregnancy to relieve her from problems that might occur. The problems they were concerned about related to her physiological and psychological health, her family's financial condition, and a much bigger burden that family members had to carry. However, she described an overwhelming feeling of sadness that she felt from this inevitable decision.

TT01 was admitted to the hospital and labour was induced on the same day that the decision was made. Her baby was born the next morning and passed away within minutes of birth. Although in general her experience of giving birth was extremely positive, she described some hurried clinical practices, such as immediate separation of

mother and baby after birth, obstructed her from taking the maternal role and keeping

memories for her baby.

> *My baby might be alive only a few minute and then passed away; I didn't know when he passed away because at that time the placenta still attached to my body,...During that time, a nurse put my baby in a crib and placed the crib close to my bed but I can't see my baby because I was lying down. After the placenta was born, I begged to see my baby again but he was dead, I didn't know what time he died and I had no chance to say anything to him before he died...Firstly, I intended to see my baby again before going back home but it was impossible. The nurse brought the baby to me for seeing and hugging two times and she said it should be enough. At the second time she brought him to me, both I and my husband cried so much until our tears became dry and I felt like I was going to faint. Because the nurse was afraid that I and my husband would get worse, we were not allowed to see my baby again.* (TT01, p.6-7)

However, she still intended to take other maternal roles for her dead baby by following

traditional practices based on Buddhist beliefs in rebirth and karma including calling out

her baby's *Khwan* (soul: a spiritual essential part of a person staying within the body) to

go back home, *Thambun and Kruat Nam* (making merits and pouring water slowly onto

the ground or a vessel), *Sang Ka Tann* (Dedicating merit to the soul of the deceased), and

donating the lifeless body of the baby for research. TT01 also used the Buddhist belief in

the power of karma to explain her experience and relieve her sorrow and grief.

> *I feel proud of my baby to be the source of knowledge, he will get merit and will be in the good place. Although he has gone away from me, he has been in the good place, he goes to the heaven, he got the great merit from being the source of knowledge. I have done the best thing for him. I didn't kill him, the doctor didn't kill him, he has gone on behalf of himself, because he did something before, so he has to get trouble like this,..., it is his previous Karma, nobody killed him, nobody got sin, both I and doctors didn't get sin, it is his karma, he brought it on himself, because he came with incomplete organs,...I don't blame anyone, he did it himself, everyone has their own karma, such as me, I don't know what karma I have, the ancient words said that everything is up to karma, so it might be that.* (TT01, p. 44)

Having carefully read each participant's story and summarising their contextual

relationship to the phenomena allowed me to become emerged in the 'parts' of the

phenomenon which was the first step in the data analysis process. After further analysis, the 'whole' picture that describes the women's experiences of loss following termination of pregnancy for fetal anomaly was formed.

Although in table 4.9, the three themes, **facing the loss of hope, gaining emotional balance**, and **the need for intervention**, are separated as individual components, they are all components of the experience of loss through pregnancy termination for fetal anomaly. In the interpretive process, I acknowledge that the three themes have a strong connection to each other and that one influences the other. Figure 4.1 demonstrates the relationship between these three themes which represent the experience of loss felt by Thai women who have terminated a pregnancy for fetal anomaly.
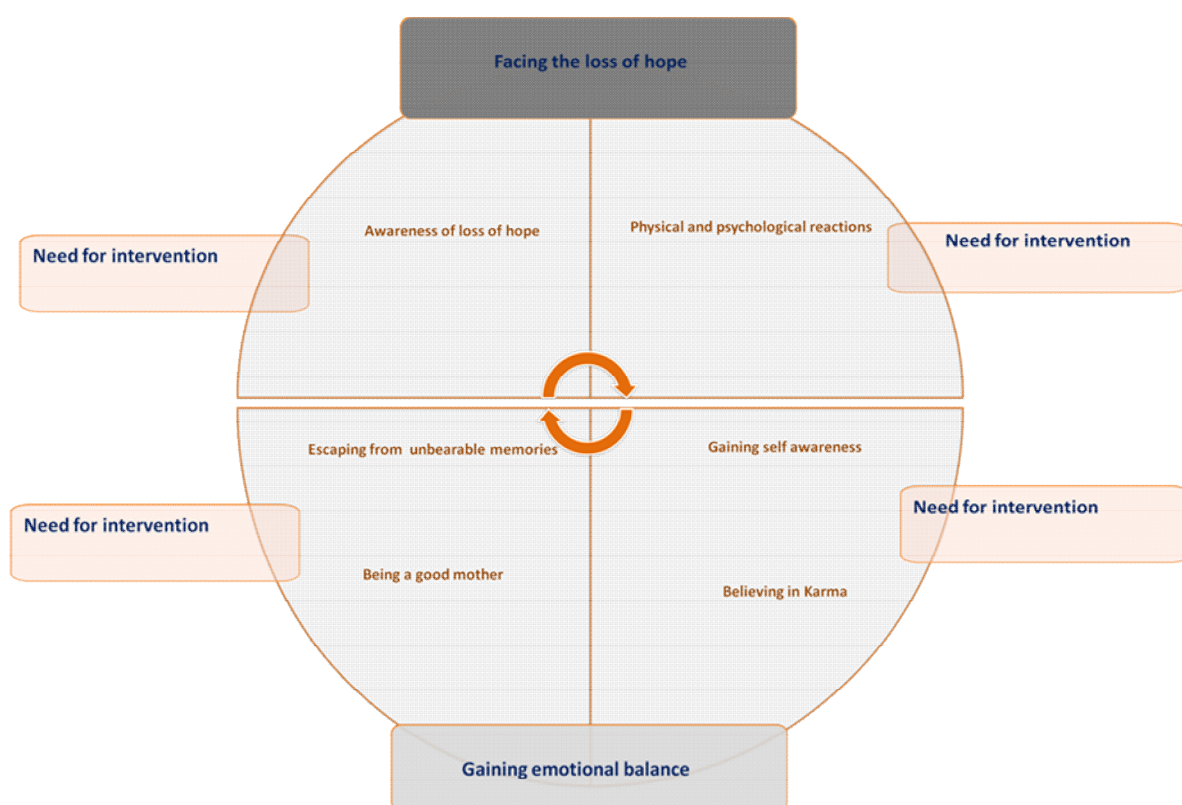
Figure 5.1: The experience of the termination of pregnancy for fetal anomaly

In figure 5.1, the three themes are represented as a process in which each theme is related to another. In order to get through the situation, one must continue to gain emotional balance. Suffering psychological and physical imbalance and gaining emotional balance are viewed as spiralling circles which are the dynamic movement to seek a sense of balance. The need for intervention is involved in a part of the loss experience because it is explained as an important factor to support the participants to overcome the loss of hope and gain their emotional balance.

5.3 Understanding the women's experience of the termination of pregnancy for fetal anomaly

As the interpretation process is an hermeneutic circle which considers the parts in relation to the whole and then considers the parts again in light of emerging themes (Annells, 1996), my presentation of the interpretive findings begins with a brief description of the whole and then proceeds to parts from which the core meaning emerged and then concludes by returning to the whole.

The three themes, **facing the loss of hope, gaining emotional balance**, and **the need for intervention**, emerged from the process of interpretation. The themes are presented and examined as individual components. However, they are all components of the one experience so they are interrelated and one theme always calls forth the other.

5.3.1 Facing the loss of hope

This theme means the loss of hope associated with the pregnancy, which resulted in a form of emotional instability for the participants.

In the process of interpreting the text, it became obvious that the first issue experienced by all the participants was facing the loss of hope. Participants were not prepared for the

news that their baby had an abnormality and described this as unexpected event. As

TT02, first gravid with fetal beta-thalassaemia/haemoglobin E disease, revealed this in

the following excerpt:

> *I didn't prepare my mind before coming to the hospital, I had never thought that my baby would have disease because the doctor told me that my baby was healthy and had complete organs (from ultrasound result).* (TT02, p.5)

TT07, reflecting on her experience also related:

> *I knew that the risk of having fetal anomaly was high in women who got pregnant after they are 35 years old but I didn't think that this event would happen with me, I didn't prepare my mind before that my baby would have an anomaly like this, everything was normal both my health and blood test results, I didn't prepare my mind for fetal anomaly, I wished only that the result might be normal and my baby was healthy, but the result was not what I expected, everything that I planed and expected was suddenly gone.* (TT07, p.4)

The stories of these participants also described how they perceived and acknowledged

the loss of hope. This was because when a fetal anomaly was diagnosed in the

pregnancy, all their hopes about their pregnancies and their future were also terminated.

The perception of loss of hope contributes to their emotional instability which is the

subjective experience of having emotional feelings responding to the loss of hope.

The theme of facing the loss of hope developed from two sub-themes of the awareness of

the loss of hope and psychological and physical consequences. These sub-themes are

described in the following section.

5.3.1.1 The awareness of the loss of hope

The sub-theme, the awareness of the loss of hope, was used to demonstrate the

perception that participants found themselves in when faced with a situation they had not

anticipated and was absolutely different from their expectation. As TT01 said to me:

> *I wished to have a daughter,…, I prayed for my baby to be healthy, I didn't want him to have anomalies like this, I wanted to take the role of a mother in looking*

after him. Suddenly, all my wishes had slipped away and never came back,...
(TT01, p.8)

TT06**,** Gravida 3 with the diagnosis of Frank hydrop fetalis, also related:

Although it might be dim hope, I still prayed and expected that the result was mistaken. Finally, my hope did not come true. My baby was too severe to treat.
(TT06, p.3)

TT04 described how she felt when she perceived that her hope of being pregnant was

being uprooted.

The doctor did the ultrasound and said that my baby had an anomaly,…,at that time, only I heard the doctor who did the ultrasound said this, I then felt dispirited; at that time, I began to lose my willpower, I felt despair (TT04, p.5)

By being engrossed in the transcription, translation, reading and analysing of each

participant's story for one year, I began to understand that for participants, being

pregnant is more meaningful than just carrying a developing offspring within the body.

All participants had robustly expressed the hope that came along with their pregnancies.

The hope was established from planning for pregnancy to getting pregnant and firmly

increased with advancing gestational age. For some participants who were having a baby

for the first time, their pregnancies were related to having a complete family. The

pregnancies were a happy and hopeful event, as TT04 who waited for five years to have a

baby said:

…for me when I got pregnant, I was very glad that I would have a baby; not only me, but my relatives, my friends, and everyone around me were glad as well, they were very excited about my baby because he was the first child of my family.
(TT04, p.28-29)

For some participants who had difficulties in having a baby or were considered as a high

risk pregnancy, being pregnant was very meaningful because their chance of getting

pregnant again was low. As TT10 who was infected with a disease that could be

transmitted to her baby, said:

> *I and my husband had only one chance to have a child. This pregnancy might be our last chance. So I tried to do everything to be a healthy pregnant woman and prevent my baby from inheriting our disease.* (TT10, p.2)

Having insight into the implication of being pregnant described by the participants allowed me to realise how important the pregnancy had been to them. This meant that they developed a feeling that they found themselves within an unexpected event that was outside their expectations. TT03, Gravida 1 with the diagnosis of fetal trisomy 18, gave the following account:

> *When I searched for the information on the internet, I had known that it might be a chromosome abnormality, but I just wanted to have hope even through it was hope against hope, I wished for a miracle to happen, but there was no miracle, the result confirmed that my baby had a chromosomal abnormality, then my hope to have a baby faded away.* (TT03, p.22)

TT11 got pregnant for the second time when she was 39 years old and had experienced therapeutic termination for fetal anencephaly in her first pregnancy. She described how important the pregnancy had been to her.

> *I hoped to have a child, only one child. Firstly, I was very glad when the doctor who did an ultrasound test told me that my fetus didn't have the anomaly like my first baby, I felt relieved and thought that my hope would come true. This was my last chance to get pregnant, this was because I was not a young woman, I might not be able to get pregnant again.* (TT11, p.3)

The awareness of the participants of loss after finding out their baby had an abnormality was the starting point of the whole experience of loss. Further consequences of the loss are the result of the acknowledgement that their hope was threatened and destroyed. The next section details the sub-theme of psychological and physical consequences which was the result of the awareness of the loss of hope.

5.3.1.2 Psychological and physical consequences

The sub-theme, psychological and physical consequences, is the reactions which were a consequence of the loss of hope. These reactions happened at diagnosis of a fetal

anomaly and lasted for an unspecified time. As a human body and mind are connected to each other, psychological reactions and physical reactions are the interrelated consequences that cannot be separated and physical reactions are inevitably influenced by psychological reactions.

In relation to psychological consequences, all participants described having a fetal anomaly and making a decision to terminate the pregnancy as a very painful and emotional event. Their emotional reactions represented how they suffered painful emotions which were the result of the awareness of the loss of their hopes. The participants described the stage of their feelings from perceiving the diagnosis of fetal anomaly to accepting termination of pregnancy. These feelings included the feeling of shock, sadness, ambivalence, self-guilt, and becoming accepting. However, some participants expressed their emotions as mixed up feelings because they were overwhelmed with a variety of feelings at the same time and in no particular order, for example, being overwhelmed with ambivalence, worry, and confusion and being overwhelmed with despondency, questions, and worry.

Initially, when the participants were confronted with the unexpected diagnosis of fetal anomaly, all participants described the feeling of shock. This feeling of shock was accompanied by a physical reaction which appeared to be the body shutting down in some way.

When the participants were confronted with the diagnosis of fetal anomaly which was unanticipated, their hope was destroyed suddenly. Although the situation had not yet been actually realised, the participants had recognised that their hope was threatened. TT01 described her first physical response as if everything was shut down to an unexpected ultrasound result.

> *(When knowing the result) I felt like my heart jumped out of my body. Everything became gloomy. I was badly frightened, I was struck dumb, I was unable to think of anything, I felt like I had nothing in my life.* (TT01, p.18)

TT04 and TT11 also related in their stories:

> *when I heard what the doctor said, I suddenly felt Meut Bpaet Daan (to be dark with eight sides; it means be utterly mystified, to be completely in the dark, or see no way out), I could think nothing, I had no idea at all how I should start, where I should start* (TT04, p.7)

> *I can't do anything at all at that time, I can't say anything at all, I don't think that he will get a much more severe like this,* (TT11, p.3)

A condition described as weightlessness was the other physical response to the feeling of shock. In the following excerpt, TT05 narrated how she experienced the feeling of weightlessness when she recognised that there was something wrong with her fetus.

> *At that time, I felt like my body was weightless, I felt like my body was being deflated, my heart felt like a deflated balloon; I went out the room like floating to call my husband, he asked me what happened but I couldn't say anything, I could only shake my head because I really didn't know, but one thing raised in my mind was the doctor had to find something abnormal.* (TT05, p.11)

Afterwards, when the participants realised they were losing the babies they loved and their hope had gone, this resulted in overwhelming mixed feelings of sadness, questioning, ambivalence, and self-guilt.

All participants described feelings of sadness, which related to the awareness of loss. TT01's account is a typical example:

> *At that time, an overwhelming feeling of sadness happened to me because he was my baby and I loved him so much, he can't be with me even though I tried to do many things to help him to become healthy but he didn't get better, the results of ultrasound showed that my baby got worse and worse…*(TT01, p.4)

TT03 also explained:

> *After hanging up the phone, I asked my husband to confirm again what the doctor said, my husband said I had to terminate my pregnancy. At that time, I couldn't*

say anything, I felt extremely constrained in my mind, he was my baby, I can't explain in words how much of my sadness…(TT03, p.9)

TT11 also recounted such feeling of sadness in her story:

I felt very very sad, I wished to look after my baby but no chance to do so, my baby couldn't stay with me, I felt sad that he had this disease and I had to lose him. (TT11, p.24)

There was something that interested me about the participants' perception of the baby. The participants considered the fetus as a baby, who was important to them even though it still was in the womb and less than 24 weeks of gestation. This reflected their emotional attachment to their pregnancy. As they perceived that being pregnant was having a wanted child, losing their pregnancy meant losing the one who was important to them which led to the feeling of sadness.

The feeling of sadness also represented the emotional instability of the participants. This was because the feeling of sadness occurred once they were given the diagnosis of fetal anomaly, remained in their mind, and was ready to be expressed at anytime it was stimulated. This means that as long as the participants are overwhelmed with the loss of hope, their sadness still remains. TT09 expressed this as:

I feel better, I can Tam jai (accept), but I still think of my baby, when I think of him, I still feel sad,…,but I am not yet able to forget, the sadness still remains. (TT09, p.33)

TT05's story is another example of this issue. She related that:

Now my sadness still exists and I don't know how long I can be in normal emotion, I feel not only sadness, but also I still have a fear of getting pregnant again. (TT05, p.32)

All participants in my study explained that crying was the response they used to express their sadness and pain which happened when the participants realised their hope was gone. TT07, for example, said that:

While I was waiting for my husband, I began to recall the result that the doctor told me, when I had thought that my baby had died, my baby was gone, my baby didn't stay with me anymore, I then felt flashed into my heart, I felt like my heart was falling, I felt tight in my heart, my tears dropped automatically, I didn't know where my tears came from, I cried silently alone until my husband came to me and told me to go home. (TT07, p.16)

TT04 also echoed:

I cried all the time since I was in the ultrasound room; when I sat outside the room, I still cried; while waiting for the doctor's diagnosis, I still cried; I was unable to accept it. At that time, I can't explain in words, it was not real story, was it? (TT04, p.7)

The data illustrates participants cried not only when they received the diagnosis of fetal anomaly, but also anytime they recalled their terminated babies. During the interviews, all participants cried or got teary eyed from talking about their lost babies. I acknowledged that recalling memories of the baby led the participants to return to a state of emotional instability.

This situation raised many questions about all participants. They were preoccupied with unanswerable questions since they were given the diagnosis of fetal anomaly. Many questions were raised in their minds, but they could not find the answer to explain what had happened to them. TT03 disclosed how she felt:

At that time, I didn't have any knowledge about chromosomes, I knew only what the doctor said, I tried to think what the abnormality came from, whether it was the result of my behaviour, or because I had morning sickness, or because I ate anything wrong, my husband also thought about why we had to have this problem. (TT03, p.19)

Another participant said to me:

What I had done at that time was sitting quietly in that room, I sat and thought about my pregnancy, what was happening with my pregnancy? What was happening with my baby in my womb? Was it true that my baby had a severe anomaly? Was it true that I had to lose my baby? (TT04, p.15-16)

TT05 described her feelings of being preoccupied with questions and related this feeling to her religious beliefs:

> *I still questioned why this event had to happen with me, I was not a sinner, I had never done anything seriously wrong with other people, why I had to face with this problem, why my baby had to face with this destiny.* (TT05, p.24)

TT12 also questioned the cause of the fetal anomaly in her baby, and even though she had taken care of herself during the pregnancy.

> *I intended to have him, it was very unlikely to happen, why it happened to me, since I got pregnant, I didn't work very hard, why it happened, I was careful for everything because my age is advanced and I was not completely healthy, I tried to be careful for everything, why my baby wasn't healthy.* (TT12, p.12)

It was noticeable that a significant issue for the participants was why this event happened to them. Although the participants perceived that fetal anomaly could occur in any pregnancy, they had never imagined it would happen to their babies and tried to find out the reason why it happened to them. They expressed difficulty in accepting their loss. Thus, the meaning of this emotional reaction was the participants could not accept what had happened to them.

> *when this event happened, I and my husband had talked to each other why we had to face the event like this, why our baby had severe abnormalities like this, I had never seen anyone like this before, some pregnant women drunk alcohol and didn't take care of themselves but their babies didn't had abnormalities like this, why our baby got too severe like this.* (TT03, p.18)

The participants who faced the decision to terminate their pregnancy described feelings of ambivalence and confusion. For the participants who had to make the decision whether or not they should terminate their pregnancies, they described the difficulty in making the decision. There were two conditions that created emotional ambivalence for the participants who were considering the termination of the pregnancy. Firstly, their pregnancy was wanted and the termination was an end to all their hope. Secondly, the severity of the fetal anomaly was not exactly identified, so the participants were not sure whether their children would have severe physical problems or a life-threatening

disability in the future. TT02, for example, had to make up her mind to terminate the

pregnancy, spoke of her experience of the feeling of ambivalence and confusion:

> *If I kept him, I feared that he would get tortured, he would be born tortured, he must have more severe than me, and he had to require blood transfusions. I was thinking what I had to do about my baby. At that time, I was in my thought, I was worried all over what I had to decide about my baby, …, I was confused, I can't make decision what I had to do…* (TT02, p.8)

TT11 also disclosed how she felt:

> *It was very hard and very difficult to do like this. It was a sin because I knew that she was alive and I was damaging my own baby. I will never know the severity of disease until she was born. If she was born with severe anaemia and need blood transfusion every week, she might be short-lived and agonized.* (TT11, p.16)

For TT02 and TT10, they had a difficult struggle with the moral issue and emotional

conflict to terminate their pregnancies.

> *…I give him a life, he might want to be born and stay with me, it seems like whether I am harming him or not, but if he is born, he must have suffering, I don't want to see him has suffering at that time, so I decided to terminate my pregnancy.* (TT02, p.13)

And:

> *I can't sleep all night. I thought and asked myself whether the decision I made was truly right. I should end or go on my pregnancy. If my baby was not too severe, I had to have the guilty feeling of sin. But if I let my baby be born with severe anaemia, he might suffer from disease and treatment.* (TT10, p.7)

Feeling of self-guilt was consistent with the moral issue in making a decision about the

termination. For the participants who needed a therapeutic termination for severe fetal

anomaly and/or intrauterine death of the fetus, although they did not suffer feelings of

ambivalence in making the decision to terminate the pregnancy. They felt sorrow as they

could not help their babies live. As TT07 stated:

> *I felt pity and sorry for my baby but I didn't know how to help him, I had no choice.* (TT07, p.20)

TT08 also related:

I still felt pity for him, he is my baby, but I must terminate him. (TT08, p.4)

For TT03, although termination of her pregnancy was performed because the fetus had died inside the womb, she also mentioned sin in her story.

> *It seemed like that my baby still was alive, if I terminated my baby when he was alive, it seemed like I was harming him, but it was great that he passed away inside my womb, this meant that I had to terminate him unavoidably,…, I didn't hurt him directly because he himself passed away before.* (TT03, p.16-17)

Some participants described their physical symptoms which were the result of drowning in painful feelings and being overwhelmed with despondency and worry. TT04 said to me about her difficulty in sleeping:

> *I was unable to fall asleep all night, I felt edgy, when I was nearly asleep the anxiety woke me up, the anxiety made me unable to fall asleep; normally, I got deep sleep through the night until morning but in that night I was unable to fall asleep.* (TT04, p.16)

TT05 also had this to say:

> *At the time, I found that the more I thought, the more headache I got, so I spoke to myself to stop thinking and I tried to force myself to sleep, I thought that it might help me to forget this event even though only a few hours, but it didn't work, I still couldn't sleep, I still thought only whether it was true.* (TT05, p.23)

There is something that interested me in the participants' emotional reactions. All participants described their attempt to calm their emotional troubles and make their emotions return to normal. The cycle of calming down happened anytime when they suffered with emotional unrest. This means that whilst suffering from emotional unrest, the participants tried to deal with their feeling at the same time by realizing the reality of their situation and trying to accept it in order to motivate themselves back to emotional balance and be able to live with the loss of hope.

The two sub-themes of the awareness of the loss of hope and psychological and physical consequences are both an expression and consequence of the participants being thrown into the loss of hope and suffering from emotional instability. This theme is the starting

point of the experience of loss and is interrelated with the second theme, gaining emotional balance.

5.3.2 Gaining emotional balance

This theme refers to the means that the participants attempt to use in order to recover from their emotional unrest. As long as they drowned in their loss, their emotional unrest still remained and influenced their life. To return their lives to normality, they needed to find ways to recover from the emotional trauma and continue life's journey. As TT07 and TT09 reflected on their stories:

> *I have to Tam Jai, if I have more sadness, I may get worse and worse, it is over, from this time forth I have to improve myself to be cheerful and try to accept that it is over.*(TT07, p.37)

And:

> *...when I think of him, I still feel sad, but I must Tam jai because my life must continue, it might be bad if I only feel sad,* (TT09, p.33)

However, for the participants, it was impossible to forget this traumatic situation. Thus, overcoming their emotional troubles does not mean they forgot the experience but it means how they accepted the truth of loss and how to be able to live with their memory of the loss experience. As TT08 stated:

> *It is the most difficult to Tam jai (get over), I don't know whether or not I can forget this event all through my life, he is my baby, there is no way to forget him,...,I have to be able to stay even though this event still is fixed in my mind.* (TT08, p.36)

In this theme, the four sub-themes were described, which included: gaining self awareness believing in karma based on the Buddhist belief, fulfilling the obligation of being a good mother, and escaping from unbearable memories.

5.3.2.1 Gaining self awareness

The sub-theme, gaining self awareness, refers to the way that the participants used to confirm that pregnancy termination was the right thing for their babies and themselves. The participants needed strategies to develop a strong mind in order to overcome their feelings of ambivalence in making the decision to terminate the pregnancy.

The need for an accurate diagnosis and finding out the truth of the situation is described by the participants. It helped the participants understand the condition and to reduce their suspicions around the diagnosis. The following excerpts from TT03 and TT08 help to illustrate this issue. TT03 recounted:

> *On that day, when I went back to my workplace, I tried to search the internet for what chromosome was, why abnormalities happened, what the symptoms were. After reading the information on the internet, a number of symptoms were similar to the ultrasound results that the doctor told me,…, deep in my heart I had partially prepared my mind before getting the result.* (TT03, p.7)

And TT08 related that:

> *I had done ultrasound screening again and again, it was good that there were a number of doctors in checking ultrasound again and again, I began to be confident that the ultrasound results were not wrong because the ultrasound was not done by only one doctor.* (TT08, p.4)

All participants wanted to involve their wider family when considering the termination, in order to get their opinion and support. As making the decision to terminate a pregnancy was very hard, the participants needed the acceptance from their family members in order to help them feel empowered and confident in the decision. The most influential person in the decision-making process was their husband or partner. If the

termination was accepted and supported by their husband or partner, they tended to have self confidence to accept the termination and get over the emotional unrest easier. TT01, for example, said that:

I and my husband turned to one another to make decision which way to go, ... we decided to end the pregnancy because if we delayed and then he was dead in my womb, many problems might happen to me, if we chose to terminate at this time, the gestational age was still young, we can Tam Jai (getting myself to accept) earlier with many problems that caused my heart to be hurt.(TT01, p3)

It seemed that what the participant needed from her husband was for him to take mutual responsibility in making the decision, in other words, to confirm that the termination was the right thing for them. TT04 also added:

I then called to my husband, he said that it should depend on the doctors' discretion, what he was most concerned about was me,...,he didn't want me to be in trouble, he told me that it might be better if we terminated this pregnancy and tried to get pregnant again,....,Then I and my husband agreed to terminate of my pregnancy. (TT04, p.13)

The participants also explained that family support was needed in order to deal with this complicated situation, preparing the mind for facing the possible situations, and to encourage the ability to cope with the loss. The participants described that emotional support from their family was required not only to give them the advice but also to help them gain relief from their painful emotions. TT11 is a typical example of this concept. She postponed the pregnancy termination for 1 month after receiving the result. The main reason given was the difficulty in accepting the loss of the baby and the social pressure to have child. She perceived that having a baby was the expectation of her husband and his family and she might not have another chance. She finally got over this conflicted feeling because of sympathy from her husband and support from her family. She recounted:

I feel better, I can accept it better, my father, mother, and everyone in my family told me that it was better than I let him born and suffer with torture. If he is born, he will suffer with more pain, letting him depart at this time is better. (TT11, p.2)

She added:

My mother and my sister tried to encourage me to think about many big burdens that I had to face if I let my baby be born unhealthy, this issue was more important than having a child for my husband, it might be better than having a unhealthy child for my husband, and my husband tried to reassure me to not be serious too much about having a child, I should concern about my own health and safety. (TT11, p.20)

TT09 also related in her story:

I called to consult my mother; she told me that if my baby couldn't be alive, if my baby was born unhealthy, I would undergo trouble, my baby might not be happy, she gave me encouragement and support, she tried to call me and always contacted me, she told me to put up with this event… (TT09, p.5)

These stories described empathy and encouragement from family members who acted as a support system to help the participants gain some relief and will power to struggle with the feeling was of loss. Conversely, being blamed by family members caused the participants to be dejected. The following extract of TT05's story demonstrated how she felt unhappy at being blamed by her mother-in-law during an emotional time. She recounted that:

My mother-in-law said to me in front of my husband that it (having a fetal abnormality) was because of me, it was because I was pale. I felt so angry and upset with what she said. At that time, I was very sad. Didn't you feel sad for me? I didn't want to hear things like this. You shouldn't come to visit me if you would say things like this. (TT05, p.32)

Most participants found that learning from other's experience of loss was very helpful, as it enabled them to change their perspective on the experience of loss. From listening to stories of other women who had experienced pregnancy loss, the participants could obtain information which led them to recognise their condition. TT04 talked about how she learned from a woman who was worse off, the downtrodden, for being less fortunate than her.

Firstly, I thought that there was only me who faced this event, but while I was admitted to the postpartum ward, a patient told me, there was a case similar to me but she was 7 months pregnant and her baby died in the womb; when I heard this story, I felt that oh! was there such a trouble like this happened, 7 months pregnancy was very critical situation to give birth because the baby was big; I was only 4 months pregnant, it was not as severe as that woman, ..., when I compared with my own event, I was still much better than her. (TT04, p.3)

TT10 also told me how she felt after learning the loss experience from other women that:

...if I kept my baby, he would have many problems in the future, my friend told me about other pregnant woman who had ever had the experience of terminate her pregnancy because her baby was not unable to be born healthy. This case was similar to me, so it might be better to terminate my pregnancy. I had listened to the experiences of other people and I had to think about the real condition of life, these helped me feel more relieved. (TT10, p.6)

The following excerpt from TT12 is another typical example. She related in her story that:

Firstly, I thought that there was only me that had to meet this event, I thought that there was no one else like me, there was no one getting worse than me, I felt totally hopeless,..., but after I had heard from the doctors and nurses that in fact, some cases of fetal anomaly were more severe than me, ..., After I heard this information, I felt that there were still other people that had the same problem as me, it was alright, I was not the only one in a hundred or one in a million, there was still other people that has the same condition as me, so I had to get over it. When I thought like this, it helped me be able to accept more and get better. (TT12, p.16)

TT03 added that:

such as a pregnant woman, her gestational age was 5 months, it made me realise that I had to let it be, her gestational age was older than me, I had to get over it, when I compared myself with someone who got more trouble than me, I felt more relieved than comparing myself with other normal pregnant women. (TT03, p.26)

Keeping a positive self attitude is a means the participants used to encourage themselves to accept the decision to terminate the pregnancy in order to overcome their feelings of ambivalence in making this decision.

As the experience of loss was very painful, the participants needed enough willpower to continue. The participants used positive thoughts to overcome the struggle and survive

through the emotional troubles. TT02, for example, tried not to let herself become

distracted so she would not return to a state of emotional pain.

> *I didn't want to change my mind because although the baby would be born, he was not healthy, I had decided, so I must let it go on. (TT02, p.17)*

TT04 described how she motivated herself to be strong to go through with what she had

decided. In her account she said:

> *One thing I tried to do was I encouraged myself that if my baby had no fingers or had no arms, I could take care of him, I could support him, but the brain was the most important part of the body, if the brain was not functioning, how could he live? (TT04, p.12)*

TT08 also related in her story:

> *If I continued my pregnancy, my baby might made me at risk; or if the baby was born, he might stay with me only a short time…if he was born unhealthy, I was unable to make more money to take very good care of him.* (TT08, p.11)

TT05's story is another typical example of this concept. She included in her birth plan

her intention not to look at her baby after giving birth. Unfortunately, she unexpectedly

gave birth alone in the toilet. She dived to catch her baby in order to protect it from

hitting the floor. Unexpectedly, she had the chance to look at her baby and hold it on her

palms. She recounted how she changed her point of view by trying to think positively

about this horrible event. This positive thinking helped her become calmer. The awful

feelings surrounding the memory of the birth changed to more joyful feelings. She

recalled that:

> *At the time, I felt very awful about what had happened with me, it was a frightening event. In fact, I didn't want to look at my baby because I was afraid that its image would be fixed in my memory, but finally I had a chance both looking at and holding my baby. This might be my baby's intention that it wanted me to take care of him even though it was just one chance to do this. I feel less sad when I think that at least I have the chance to take care of my baby. Until now, I still remember warm feeling in my hands.* (TT05, p.29)

Gaining self awareness by realising the truth of the situation, seeking family involvement and support, learning from the other's experience of loss, and keeping a positive self attitude enabled the participants to confront their emotional instability. However, the Buddhist belief which most Thai people follow as a way of life is also mentioned by the participants as an approach to bring relief from their emotional unrest. This is the focus of the next sub-theme which emerged from the participant's experience.

5.3.2.2 Believing in Karma based on the Buddhist belief

The sub-theme, believing in Karma based on the Buddhist belief, means using the religious faith as a source to help the participants calm their emotional unrest and relieve the feelings of disillusionment. The word Karma is mentioned by all participants.

For Buddhists, the Buddhist belief is considered an emotional and spiritual anchor. Karma is commonly used by Thai Buddhists as the best explanation for events which cannot be controlled. In Buddhism, where the dead one will be born is a result of the past and the accumulation of positive and negative action, and the resultant Karma (cause and effect) is a result of one's past actions. Thus the participants tried to acknowledge this concept in order to calm their minds and accept the loss.

In this study, most participants described their loss as the result of Karma. This belief helped them to accept the fact of an abnormality in the baby, get rid of suspiciousness, and hope more easily with emotional unrest. TT01's account is a typical example:

> *As for my decision to terminate my pregnancy, I believe that my baby might understand me why I have to do, I don't hurt him and nobody hurt him, this is the result of his deeds in the past life, both he and I also have Karma (the accumulated merit or demerit of past incarnation reflected in happiness or suffering in this life) and the bad thing that happens to us is a result of past Karma. (TT01, p.9)*

TT03 also related in her story:

I tried to think that it might be the fate of me and my baby that made him unable to stay with me, my senior relatives told me that if Karma indicated that my baby would be stayed with me and born with me. (TT03, p.27)

And the following sentences were in TT12's story and TT06's story:

As I and my baby had never made merit together in the past life, we had chance to be together only for a short term (TT12, p.18)

And:

My unborn baby might not make enough merit to be born healthy. (TT06, p.6)

For TT05, believing in Karma was used as an inspiration for doing the best thing for her dead baby that would help relieve the feeling of self-inflicted guilt in making the decision to terminate the baby. She pointed out that:

If I still thought of my baby, it seemed like I made the circle of sin with my baby, it seemed like I tried to pull and hold my baby with me, so my baby couldn't go to the good place with good condition, so I had to Tam jai, and I had to have compassion for my baby in order to help my baby to go to the good place; my baby had helped me not to do any sin, so I had to help my baby to be in the good place. (TT05, p.26)

TT07 also related in her story:

My relatives told me that if karma indicated that my baby would be stayed with me and born with me, he would stay with me, but this might be my baby's karma that made them have an anomaly like this. If I wanted him to be born with me again, I should pray and made a wish for my baby to be born healthy and please don't come back again with abnormality like this. (TT07, 20)

The next sub-theme draws immediately from the belief in Karma. This is because fulfilling the obligation of being a good mother is related to the belief in Karma based on the Buddhist belief.

5.3.2.3 Fulfilling the obligations of being a good mother

The sub-theme, fulfilling the obligations of being a good mother, refers to the help participants needed to adopt the maternal role for their dead baby in order to help the participants overcome the self-inflicted guilt felt at the death of their baby. As TT07 said to me that:

> *If my baby perceives the good things I did to him…Then we don't owe each other.*
> *Otherwise, this guilt will stick in my mind forever.* (TT07, p.30)

Although the pregnancy ended with a lifeless baby, all participants retained a maternal role for their babies in order to be accepted as a good mother for the baby. However, as they could not take the maternal role in taking care of and nourishing their babies, taking the maternal role was then related to the Buddhist belief in Karma and the belief of life after death.

In Buddhism, life does not end in death. After death, the spirit will still remain and wait for a new body and new life. TT01's story is a typical example for this concept. She strongly believed in the principle of life after death and the cycle of reincarnation. She told me about religious practices that should be done for her baby. She recounted that:

> *I will call my baby's Khwan (soul: a spiritual essential part of a person staying within the body) to go back home with me, I intend to Thambun and Kruat Nam (make merits and pour water slowly onto the ground or a vessel) for my dead baby at my local temple to consign merit to his soul, I will also Thambun with clothes for him because he is wrapped with only a floral printed sheet from the hospital, he has not yet received anything from his mother, I will dedicate all appliances for him such as baby powder, baby soap, and toothbrush, I must do everything the same as he stays with me. I pray and make a wish that whenever my baby will be born in his next 500 or 1,000 lives, I wish him to be my baby forever, be healthy child, and have no any disability. (TT01, p8-9)*

The reason she gave for performing these practices is being accepted as a good mother for the baby. As she said:

> *If I call his Khwan back with me, It means that his soul will exist in his family, but his soul might go back and forth between home and hospital, this is usual for everyone, wherever you die, your soul will be there, my baby is also the same as other people so he has to go to and fro between my hometown and here. But, he didn't wear any cloth after he was born, I have to buy new clothes and dedicate these to him, if I don't do like this, he will be undressed through his present life, if I do good things to him, he will be proud of me that he has a good mother, he might impress in my kindness, at the same time. (TT01, p.12-13)*

All participants talked about making and consigning merit (*Thambun*) for their dead babies. It is considered a responsibility of the mother towards the dead baby. Making

and consigning merit for the dead baby is a common religious practice among Thai

Buddhists based on the belief of life after death. It is believed that the departed one will

receive whatever his living relatives have dedicated to him. Moreover, the meritorious

deeds done by his living relatives will help him to go to heaven or a peaceful place.

The participants perceived this as a strategy to improve their baby's karma in the present

life to be better in the next life which was part of the maternal role towards the baby.

TT05 recounted that:

> *After going back home, I made merit at the temple and consigned merit to my*
> *baby, I think that it might help my baby to go peacefully without any torture.*
> *(TT05, p.20)*

TT07 also added:

> *Although I had no chance to take care of my baby, one thing that I could do, and*
> *for me, I had to do and I had already done for my baby was make merit to him, I*
> *wanted my baby to go peacefully, and I didn't had to worry about my baby at all.*
> *(TT07, p.3)*

Praying and making wishes to the triple gem continually is another traditional practice

based on Buddhist beliefs in rebirth and karma. As TT03 recounted that:

> *I tried to pray to the triple gem continually. I should pray and make a wish for my*
> *baby to be born healthy and please don't come back again with an abnormality*
> *like this. I had done as they suggested, I had prayed for him, because I didn't*
> *know what can help me get better, this practice seemed like my emotional anchor.*
> *(TT03, p.27)*

TT12 also related in her story:

> *I always prayed to my baby, I made a wish to the triple gem that if I and my baby*
> *had our own fate that was being connected to each other, I wished that the strings*
> *of fate would be ended in this current life; if I had ever done bad deeds to him*
> *before, I wished him to forgive me my wrong deeds; if I had never done any bad*
> *deed to him but this was caused by his fate from the past life, I wished to forgive*
> *you; if next life was a fact and my baby was ready to be born healthy. (TT12,*
> *p.21)*

As making and consigning merit (*Thambun*) for the dead baby is considered part of the

maternal role for the dead baby, donating the baby's body to the hospital for research is a

way to make and consign merit for the baby. All participants had decided to donate their baby's body for research. TT01, for example, strongly believed in her baby's goodness to other people. Donating her baby for research was related to the Buddhist belief in Karma. She wished that this deed would be a strategy to improve her baby's karma in the present life to be better in the next life. As she said to me that:

> *He (the baby) is useful to other people so he will receive a great merit, he will get the merit because he is as a consultant for the doctors, he is as a teacher of the doctors, I feel proudest with this point. (TT01, p.23)*

She also added how she felt with this deed.

> *I feel proud of my baby to be the source of knowledge, he will get merit and will be in a good place. Although he has gone away from me, he has been in a good place, he goes to heaven, he got great merit from being the source of knowledge. I have done the best thing for him.* (TT01, p.44)

The following excerpt from the stories of TT03 and TT09 are another example of taking the maternal role by donating their babies for research. They also described that this deed had positive effects on their babies. TT03 told that:

> *It would be great if my baby would be a benefit for other people, my baby would get merit because he helped other people who had abnormalities like him, this merit might help him to be free from this suffering, he would be born again without any abnormalities. (TT03, p.37)*

And:

> *One thing that I am not worried about is the doctor has taken my baby to study and will arrange the funeral rites for my baby, this is because my baby has died and he doesn't stay with me anymore, if he will be useful to the doctor and other cases in the future, it is possible that he may not be like this again in his next life (TT09, p.34)*

5.3.2.4 Escaping from unbearable memories

The sub-theme, escaping from unbearable memories, refers to the way that participants avoided facing an unbearable situation that might induce painful feelings and make it

more difficult to overcome emotional turmoil.

The participants explained that seeing the baby after giving birth possibly marked the
unforgettable memory in their lives and made it difficult to overcome their sadness.
Thus, when the nurses asked their intention to look at their babies after giving birth, all
participants except one refused to do so.

For TT02, described how the doctors and nurses told her that her baby looked normal
and this induced feelings of self inflicted guilt for the termination. She felt that is she
saw the baby this was make it more difficult to recover emotionally. As she said:

> *I feared that if I saw him, I would not be able to Tam Jai because at the first
> ultrasound test, the doctor told me that he was healthy. If I saw him, it seems like
> I did harm to my baby, I can't Tam Jai, I didn't want him to be born and have
> suffering later, but I didn't want to see him at that time, I feared that it would be
> impressed in my eyes for a long time, he was a person, he had full organs, on one
> side of my mind I had Tam Jai that if I let him be born, he might have suffering
> more than this, but I didn't want to see him in a healthy condition at this time, I
> didn't want to do harm to him, but he would have torture if he was born. (TT02,
> p.15)*

TT06 explained looking at and making an attachment to the baby was an unbearable
experience. This was the significant reason she chose not to see her baby. As expressed
in words of TT06:

> *At the time my baby was born, I was not sure whether I should see him or not; but
> I felt that my baby's image at my first sight still was fixed in my mind; I didn't
> want to have his image fixed in my mind, so I decided not to see my baby,…, But
> if I saw him and touched him, I might be unable to endure anymore, it might be
> very difficult to get over this event, and I might take an extremely long time to get
> over it. His image might be forever fixed in my mind; but I didn't see him, I was
> still OK. (TT06, p.16)*

Some participants described looking at the baby as an unbearable experience which they
did not expect to face. As TT10 said:

> *When my baby came out, the doctor asked me that I wanted to see the baby or
> not, but I didn't want to see my baby because…um… I feared, I feared that if I*

> *saw my baby, might be unable to tolerate it, if I saw my baby, I might cry a lot, I didn't want to see my baby, I feared that his image would be fixed in my mind and that made me think a lot later. (TT10, p.22)*

TT04 also related in her story:

> *I didn't want to see him, it was not because I loathed him, or I was angry with him, or I resented him; but if I looked at him, his image would be fixed indelibly in my mind, I would be hurt so much and might be up to the most. (TT04, p.23)*

In the theme of attempting to calm the emotional troubles and continuing the life's journey, a variety of strategies used by the participants to achieve this aim are presented in order to illuminate the aspect of the experience of coping with the emotional unrest of loss.

5.3.3 The need for interventions

The need for interventions is the next theme to be discussed. After having a pregnancy with a fetal abnormality, the participants needed to have medical investigations and to be hospitalised for pregnancy termination. As a result, the participants' experiences of receiving care and treatment from healthcare staff were also involved in the loss experience. The theme, the need for intervention, refers to the intervention that the participants need from healthcare staff in order to support them to deal with the loss of hope and gain their emotional balance.

Although the participants' families and friends are main sources of help and support in coping with the loss of a baby, they had limitations in clearly understanding the medical issues of fetal anomaly. They could not give clear explanations about this issue. Thus, more information from healthcare staff is needed for the participants.

> *I felt completely alone; first, my husband was not here, and I couldn't tell my mother anything, I could talk only with my older brother, younger brother,*

younger sister, and my boss, but they didn't have any knowledge about this issue. (TT04, p.15)

I needed to meet someone who was more skilful, perhaps there might be someone who could help me, I needed to meet the expertise who could help me, who could tell me clearly, who could diagnose exactly; if I knew the truth, I didn't have to deceive myself . I had many people support me and give me encouragement, but when there were questions raised in my mind, I would then ask and talk to my colleagues, but they couldn't answer me, they had no idea about this, they couldn't give me the answer. (TT04, p.32-33)

From these stories, healthcare staffs are considered as a factor in supporting the participants to cope with their emotional unrest.

The theme, the need for interventions, developed from three sub-themes including seeking information, seeking emotional support, and seeking security. These sub-themes are described in the following section.

5.3.3.1 Seeking information

The sub-theme, seeking information, refers to the information from healthcare staff that the participants need in order to help them to recognise the truth of their situation, prepare themselves to face the unknown situation of pregnancy termination, and make up their mind for their future. This sub-theme related to being faced with an abnormality in the baby and the consequences of this.

Firstly, all participants had many questions about the nature of the abnormality. This is because information about fetal anomaly is not provided to all pregnant women. Only high risk pregnant women would receive information and counselling about this issue from healthcare staff. As a result, most of the participants had never considered this issue. Thus when they were faced with this situation, they recognised that information was the most important factor to help them know what to expect. TT04, for example, discussed her experience of seeking information in order to understand the reality of the

situation. She expressed in her story that:

I think that information is the most important, when I knew that my baby was unhealthy, I felt extremely sad; when I asked myself what happened to me, I had no answer for myself; when I asked others, they were unable to answer my questions as well; so I had to meet and ask directly the doctor, the most important thing for me at that time was I needed to meet the doctor as soon as possible in order to know the most reliable result, I needed to know the truth in order to prepare myself, prepare my heart that was what I had to do next. (TT04, p.39)

Another participant said to me that:

I think that the information is the most important, I need to get information as much as possible, because at the time I knew the result, there were many question raised in my mind; firstly, I didn't know what I had to confront, how my future would be. (TT07, p.37)

Seeking information is also expressed by TT11 who suffered with feelings of ambivalence in making the decision to terminate the pregnancy. She did not fully understand the consequences of the baby being diagnosed with fetal beta-thalassaemia/haemoglobin E disease. She realised that having a clear explanation helped her to understand the reality of the situation.

What I need the most is that please tell me clearly and thoroughly about the disease, the unknown is really my problem, I didn't know how my baby would be, I just didn't know what to do, please give me more information, please don't wait for me to ask you because I don't know anything about this disease. (TT11, p.35)

Secondly, all participants had to face the unknown situation of having to undergo a termination of pregnancy. This was because all participants, except one, had no experience of pregnancy termination. Consequently they suffered feelings of anxiety and fear of the unknown. As a result, information about the process of pregnancy termination is needed for the participants in order to help prepare them for the termination. As TT02 narrated:

I want to know what the doctor will perform on me, how to do the procedure, if it will take a long time, how it will affect me, if I will have pain, how long I have to stand, how long I have to stay in the delivery room…

> *...the doctor also told me that it is the same as giving birth, normal birth or something like that, but I don't know what normal birth is like because this is my first baby.* (TT02, p.30)

TT12 also described her worry about the termination process because her first birth was delivered by Caesarean section. As she said to me that:

> *The information is the most important, the biggest worry I had at that time was that I didn't know long I would give birth, how it would hurt, how I could tolerate the pain, how I would be safe, how I would know that my baby was coming out, I felt worried about everything. If the nurses or doctors give me information step by step, it would make me feel free of worry, I have known everything and realised what was going on, I don't have to be worried with anything.* (TT12, p.32)

Thirdly, the participants had to struggle with the feeling of uncertainty and fear for the next pregnancy. They needed adequate and clear information from health care providers in order to make up their mind for their future. As an example the following extract of TT03's story demonstrated what information she needed after treatment. She accounted that:

> *Oh! one more thing I need is I want to know how long I should take birth control after doing curettage (due to retained placenta), can the curettage affect my future pregnancy? Is there any effect on my baby? Is there any effect on my future pregnancy and birth?* (TT03, 39)

TT07 indicated the importance of health care providers in providing the information that she needed to know for her future pregnancy. As she said:

> *I was so lucky that I met the doctors and nurses who were very kind; they were willing to answer every question I asked. Although I still fear getting pregnant again, at least what I have known from them helps me to prepare myself about what I should do next if I want to get pregnant again.* (TT07, p.36)

From the participants' stories, it would seem that the more information the participants received about the procedure before having it, the less severe their emotional reaction would tend to be.

5.3.3.2 Seeking emotional support

The sub-theme, seeking emotional support, refers to the emotional support and sympathy from healthcare staff that the participants needed in order to help them cope with emotional disturbance in each period of their experience.

Initially, when the participants were confronted with the diagnosis of fetal anomaly, they were in a state of shock because of this unexpected event. Although the participants did not directly mention the emotional support they needed from healthcare staff, they indicated the importance of health care providers in attempting to meet their needs. TT06, for example, felt satisfied that the doctor and nurse left her in a private room for a long time with her husband until she felt ready to get more information. As she recalled:

> *During the time that the doctor told me the result, I wanted no one to talk to me, at that time I only wanted to cry, I only felt a great sadness at that time, I didn't think that I needed anyone to help me, my husband was beside me at that time so I didn't want anyone else, I felt thankful that the nurse didn't force me to do anything at that time, it was great that she let me stay quietly with my husband.* (TT06, p.30)

TT03 also said to me what she needed at this stage:

> *I was not ready to say and talk anything to anyone, I didn't want anyone else to talk to me or ask me because I can't say anything, please don't ask me to make a decision or ask me about my plan, I wasn't ready to listen or do anything.* (TT03, p.31)

Some participants said what they needed the most was sympathy from healthcare staff. TT09 described feeling unsatisfied with her care which led to emotional turmoil; she would have liked more sympathy from the healthcare staff.

> *The doctor told me that I had to be admitted at that day, it was the day that I just had been given the result, it was certainly unbearable, I was feeling frightened with the result, could I have a bit of time to prepare my heart.* (TT09, p.36)

TT04 also related in her story:

> *I want the doctor to speak more softly,…,at that time I was not able to accept anything. In fact, the doctor had to exactly inform the patient because it was a*

severe case, the doctor had to tell the truth to the patient, but my feeling at that time, I could accept nothing; regardless of how interesting and how well the doctor spoke, nothing came in my head; although the doctor tried to speak well and tried to explain reasonably, I still felt that no no it didn't at all. (TT04, p.29)

TT05 also said what she needed was sympathy from the nurses. She described feeling

unsatisfied when a nurse asked her a question she felt was unacceptable. As she recalled

that:

A question I don't like is "do you feel sad?" Why did you (a nurse) ask me with this question? Didn't you think this was my baby? Why did you think that I wouldn't feel sad with the loss of my baby? It will probably be better to ask me with an indirect question, such as, "how are you feeling?" I was a mother and it was my baby, I had to have sadness. You shouldn't ask me I feel sad or not. It was unacceptable to ask me like this. (TT05, p.37)

During hospitalisation, the participants explained that they had a variety of emotional

support from health care providers to help them to cope with the emotional unrest of loss.

For example, TT01 recounted:

What I need is someone who comes to ask me how I feel, lets me release my stress, makes me feel comfortable and become free from stress, if I am still depressed, I might over think and become nervous, if I have someone I can talk to, everything is relieved. (TT01, p.41)

TT07 pointed out how emotional support from health care providers helped her cope

with her sadness.

The nurse always came to see me and told me to relax my mind, they tried to soothe me and give me encouragement, she told me about the other cases who had to terminate their pregnancies, I felt comforted and relieved from feeling sad. (TT07, p.27)

TT09 also confirmed the importance of emotional support from healthcare staff. She felt

unsatisfied with the care she received because she was left to suffer with her sadness

alone.

I felt really bad, I was left alone, nobody tried to talk with me, nobody asked me how I felt, they might be afraid that I would be worsen if they asked me how I felt, but if I had a chance to express my feeling, it might be better than keep it in my mind and still have intense sadness. (TT09, p.36)

Not only coping with sadness, TT04 mentioned about how emotional support from health care providers helped her to cope with suffering during the birth.

> *The nurse would come to see me and palpate my abdomen every 30 minutes, when she found that my uterus contracted frequently, she encouraged me that it was nearly there, it made me feel relieved and have a will power to tolerate with the much more pain, because I tried to think that it was nearly there.*(TT04, p.27)

Whilst on the postpartum ward, participants still indicated the need for emotional tranquillity. However, the needs of each participant varied. Some participants mentioned that staying in the atmosphere of mother-baby bonding triggered sad feelings. As TT02 stated:

> *I wanted to stay in private, I didn't want to stay in the same room with others who have their babies, when I saw that I also wanted to have my baby, I had had my baby but had no chance to have him beside me, I had to let him go. I had seen when they were breast feeding their babies but I didn't have my baby, it made me feel bad, I didn't have my baby like them.* (TT02, p.26)

However TT10 argued that:

> *I didn't want to stay in a separate room or private room, I didn't want to be alone, I was afraid to be alone, it might make me feel lonely because the hospital didn't allow relatives to stay with me, I felt lonely to be alone; staying with other patients made me feel relieved.* (TT10, p.45)

In addition, for some participants, some clinical practices were described as obstacles to meeting their emotional needs. TT01 explained that separating the baby from mother for a long time, which was routine care in the ward, meant she missed the chance to say goodbye to her baby. For TT01, saying goodbye to the baby based on the Buddhist belief was an important practice in sending the baby to heaven. As she was unable to achieve this practice, she still worried about her baby and this issue still played on her mind.

> *I had a chance to hold my baby only for a minute and then I sent him back to the doctor, after that I didn't know anything about my baby…the nurse brought my baby back to me again (after placenta was delivered) but he had no life, I didn't know when he departed… I felt so sad that I had not told him the words for going to heaven, these words were Put Tho, Tham Moh, Sang Kho.* (TT01, p.28-29)

Although TT01 did not express directly her need for this, she described her sadness as if her spiritual needs were not met. This is similar to TT02's story. She stated that the care she received did not meet her needs due to the lack of communication between health care providers. The doctor tried to encourage her to see her baby even though she had informed the nurse before that she did not want to see the baby after birth.

> *Everyone took very good care of me, but there was one thing whilst giving birth, the doctor who was the birth attendant would raise my baby up in order to let me see, the nurse must tell him that I didn't want to see it, this point is what I don't like, I can't accept it because he raised my baby up, he wanted me to see my baby but I didn't want to see.* (TT02, p.37)

From these stories, it could be concluded that the needs of participants are varied and depend on the personal concern of each woman. However, it is clear that sympathy and understanding from healthcare staff for their emotional need is required for all participants.

5.3.3.3 Seeking security

This sub-theme, seeking security, related to facing the unknown situation of the pregnancy termination for fetal anomaly. During admission to the hospital for the termination, all participants suffered feelings of anxiety and fear. Their main concern was fear of the unknown. They had fears about their safety because the process of pregnancy termination was perceived as childbirth. In order to overcome these feelings, besides seeking information, the participants needed other interventions to help them feel safe.

All participants, especially those who were pregnant for the first time and had no experience in giving birth, were afraid of being unable to give birth and having serious complications which might endanger their lives. TT08 described how health care providers made her feel safe and secure during the birth process.

I felt fear and frightened with everything, I feared that I would have trouble from giving birth, I thought a lot because I had never had this experience before…but I felt warm and safe as the doctors and nurses didn't let me alone for long time, they came to see me frequently, if I had any trouble, they could help me in time. (TT08, p.28)

TT02 also related in her story:

…and I also want the doctor to stay with me because I don't know what will happen to me, I am afraid that I can't stand, I am afraid that if I give birth and there is no doctor stay with me, I am afraid that I will get in any trouble, I want the doctor to stay with me, while the doctor stayed with me, I felt good, because of worry, I need the doctor to be near me,… (TT02, p.31)

TT10 added:

I want the doctor or nurse to stay with me, while they stayed with me, I felt secure, I didn't have to worry if I would get any trouble, I was afraid that if I got any trouble while they didn't stay with me, no one can help me. (TT10, p.32)

As a result, when they were helped by the treatment, it seemed like their physical needs were met.

Although most participants felt satisfied with receiving attention from health care providers, they felt lonely and insecure when left alone. As TT01 pointed out:

I needed someone to stay with me, to talk to me…,anybody, nurse, just makes me feel that I have someone stay with me, it will help me feel relieved and secure. (TT01, p.39)

This is because the policy of public hospitals in Thailand does not allow any family members to attend the women during labour and delivery. Thus, giving birth in a public hospital causes some emotional distress because women in labour have to face unfamiliar environments and unknown situations alone. This situation made the participants feel insecure when left alone. As TT02 said to me:

At that time (during admitting to delivery ward) I were alone, my family members couldn't come in, I wanted to meet my father and mother but the doctor didn't allow them to come in. I must Tam Jai to be alone. I wanted to talk with father and mother in order to make me feel relieved that I might not get in any trouble. (TT02, p.14)

The following excerpt from TT08's story is another example of this issue. She would

like to have had her mother with her during the birth process. TT08 told that:

I want my mother to be with me, after I gave birth, the doctors and nurses left, and then I have to be alone, I want my mother to be with me. This will help me feel good, relieved, I will never be alone, this also will help me feel encouraged, because they have to take care of other patients, they have no time to be with me all the time. After giving birth, I was alone, I was afraid that I would get any trouble. If there is my mother to be with me, I will feel more comfortable. (TT08, p.29)

TT05 felt unsatisfied with the care she received from an inexperienced nurse because she had to face the frightening birth experience alone in the toilet. She described that trusting and skilful health professions were essential for participants to feel safe.

In the day time, I was attended by a senior nurse, she managed the care for me very well, I felt safe, but in the night time, I was attended by a young nurse, she looked confused and could not make any decision, she told me only wait for the doctor, she made me felt insecure, and finally I had to give birth in the toilet. (TT05, p.30)

The lack of communication between health care providers is a factor that makes the participants feel dissatisfied and unsafe with the care they received. TT03 is a typical example for this issue.

It is about shift change report, some doctors didn't know any information about me, they asked me again and again, and then for a while another one asked me again with the same question, it made me wonder why they didn't give the report at shift change about the patient's detail, I was not impressed by this point. In fact, they should have all my details in their hands, they should know all details thoroughly and accurately, I wondered how they can give me a good care if they didn't know about my details. (TT03, p.30)

She added another example to confirm that good coordination between health care providers is needed to make her feel safe and secure.

But there was only a little bit of a disappointment about coordination of doctors, ...after my baby came out completely, but the placenta didn't deliver, so the doctor who attended me had to consult another doctor what should do next, that doctor told her to wait until tomorrow morning...she then asked for help from another doctor to make decision what to do next because my blood pressure gradually became low, it can't wait anymore, I was glad that this doctor came to help me, I didn't have to wait for the first doctor, if everyone waited for that doctor I might get into any trouble . (TT03, p.34-35)

For this sub-theme, seeking security, the participants' narratives indicated the importance of the health care providers in helping them to be assured of their physical and emotional security. Moreover, the participants tended to feel satisfied with the interventions they received if their security was achieved.

5.4 Comparisons of women's experiences of miscarriage with women's experiences of termination of pregnancy for fetal anomaly

Although the exact expression of any one woman's experience of miscarriage and therapeutic termination was unique, there were aspects common to each phenomenon and there were both similarities and differences between these two pregnancy termination events. The themes that emerged from these phenomena, facing the loss of hope and gaining emotional balance, are used to structure the comparisons.

5.4.1 Facing the loss of hope

There were both similarities and differences in facing the loss of hope among these two pregnancy termination events.

5.4.1.1 Awareness of loss of hope

Firstly, both groups of women had in common the fact that they were recognised as pregnancy termination events and they demonstrated a sense of the loss of hope. Nearly all the women who suffered a miscarriage and therapeutic termination had wanted and planned their pregnancies and they had all looked forward to becoming mothers. They expressed their loss not only as the loss of their baby but also they lost their hopes for the expectation of having a child. Although each woman had their own unique set of expectations about their pregnancies, it could be concluded that pregnancy and

motherhood were viewed as fulfilment in their lives. It seems to be that the women in this study are also expected to achieve this task. As a result, when they lost their pregnancies, all hope that went with their pregnancies was also terminated.

Although receiving an adverse diagnosis, either miscarriage or fetal anomaly, was traumatic for all participants, the findings of this study also found a difference between the experiences around confronting the loss. While women who suffered a miscarriage confronted the inevitable loss and experienced the sudden termination of pregnancy, the women who underwent a therapeutic termination had to confront the process of making the decision to terminate their pregnancies. By comparison with the miscarriage group, the harshness of loss in therapeutic termination group seemed to be intensified by the fact that there was no other choice and the decision to terminate the pregnancy was made by themselves. The women who experienced therapeutic termination due to fetal anomaly had to confront moral conflict. Making the decision to terminate their pregnancy was against the moral precept in which Buddhist people should abstain from taking life but they did not want their child to be born with severe disability.

5.4.1.2 *Psychological and physical reactions*

Secondly, this study discovered that both the miscarriage and therapeutic termination groups had psychological and physical reactions which were a consequence of the loss of hope. Although the exact expression of any one woman's reactions to her loss was unique, there were features common to the participants. These features included feelings of shock, regret and sadness, doubt, ambivalence, despondency, self-guilt, lack of self belief, and becoming calmer. The findings also provided or identified differences. These might be explained by contextual differences between them. However, the findings of this study could not identify the different intensities of psychological reaction. This was

because this study was interpretive phenomenological research which aimed to analyse and interpret detailed findings, not to measure the level of psychological reactions and compare the intensity of the feelings between them. In fact, the words used by the women in this study gave. For instance, M09 said that:

> *When I heard that my baby's heart had stopped beating, I felt like my heart was going to stop beating.* (M09, p.5)

And M08 described her feeling that:

> *My heart immediately sank. I almost fainted when the doctor told me.* (M08, p.4)

As one of the women who experienced termination of pregnancy due to fetal anomaly expressed:

> *I felt like my heart jumped out of my body, it was gone, everything became gloomy, it was badly frightened, I was struck dumb, I was unable to think of anything, I felt like I had nothing in my life. (TT01, p. 18)*

The story of TT05 was another typical example.

> *At that time, I felt like my body was weightless, I felt like my body was being deflated, my heart felt like a deflated balloon.* (TT05, p.11)

Although these words could not be measured as high or low level psychological reactions, the language used to express them is powerful. I perceived the women were in complete shock, extremely frightened, and experiencing awful sadness.

Comparing the psychological and physical reactions of the women in the miscarriage group to the women in the therapeutic termination group showed that the findings of both groups were generally similar, for example, the feeling of shock. It was clear that the diagnosis of a miscarriage and a fetal anomaly were unexpected and contrasted with the hope that went along with a much wanted pregnancy. It was not surprising that in both groups of women, the feelings of shock resulted in difficulty in being able to grasp the facts of the situation.

When the loss was recognised and confirmed, the women suffered several emotional reactions including regret and sadness, doubt, ambivalence, despondency, guilt, and lack of self belief. These feelings might be aggravated by the loss of the imagined future. Again, as the loss of hope experienced by women in both groups is not only the loss of their baby, but also the loss of becoming a mother.

Interestingly, the findings of my study demonstrated that gestational age is not considered by the women. They did not mention the debate of being human or not yet human related to gestational age. The most important thing they recognised was that these were their babies. The women are attached to their fetuses as mother to a child. In this study, gestational length at the time of their loss in the miscarriage group was before 12 weeks which might be recognised as early miscarriage, only one experienced a miscarriage later at fourteen weeks. However, their psychological and physical reactions were not different from the termination group whose loss occurred in their second trimester of pregnancy, 14-24 weeks. What related to psychological and physical reactions in both groups of women was the meaning that women place on their pregnancy, along with their fertility histories, and intentions. This meant that if women's pregnancies were wanted and held meaning for them then they suffered emotional instability.

The main difference in psychological reactions between the two groups of women was a feeling of ambivalence around the decision to terminate the pregnancy. As miscarriage was recognised as an inevitable event which needed urgent treatment, it was necessary for the women to accept the treatment. This differed from the women who underwent termination as they were confronted with a number of dilemmas, including the decision whether or not to terminate the pregnancy. This dilemma led the therapeutic termination

women to have a stressful, emotionally painful and frightening experience around the decision itself.

5.4.2   Gaining emotional balance

5.4.2.1   Gaining self awareness

The first similarity between the experiences of miscarriage and therapeutic termination in gaining emotional balance was both groups tried to seek information to re-create a sense of control and predictability about their future. For women who underwent therapeutic termination, they exhibited physical signs of stress, such as sleeplessness in response to an uncertain diagnosis. They described their need for high levels of information in order to cope during the period between discovery of the anomaly and confirmation of the anomaly at their next visit. For women who suffered a miscarriage, they described their need to find a reason for the miscarriage because the information on the causes of miscarriage would allow the women to stop blaming themselves.

The second similarity between the two groups of women was the need to gain emotional balance and the requirement to receive emotional support from their family, particularly husbands and parents. The couples in this study seemed to help each other through this very difficult time. This might be also related to the nature of close-knit family relationships in the Thai context. Most of the women in this study described having a close relationship with their parents and other relatives. When they had problems, their parents and close relatives seemed to play a significant role by provision of emotional, instrumental, and informational support in order to help them redefine an event in a more positive light and be able to overcome their emotional imbalance.

5.4.2.2 Believing in karma

The findings demonstrated that both groups of women used religion to cope with their stressful situation. All women made associative links between their loss experiences and the Buddhist belief. As all women in this study were Buddhist, they were anchored with the Thai Buddhist belief system including the law of karma and life after death. The women in this study used the Buddhists' religious belief of the law of karma to create meaning from the experience of having a miscarriage or fetal anomaly. They defined their miscarriage and therapeutic termination for fetal anomaly as the result of the karma they and/or their fetuses had had before. The finding demonstrated that the belief in karma also enables the women to cope with the painful aspects of their loss. Such acceptance of their losses, as the result of karma, would also enable them to overcome despair and endure the condition of loss.

In addition, the women in my study also used a belief in fate to cope with their loss. They accepted their loss from miscarriage and therapeutic termination for fetal anomaly as "whatever will be, will be". They also expressed "let it be" to encourage themselves to accept that what happened had to happen.

However, some women in this study also reported a tension which is the result of their religious struggle. For the women who had undergone therapeutic termination, the finding demonstrated that they suffered guilt from making the decision to terminate their pregnancy because it was against the moral precept in which Buddhist people should abstain from taking life. Although the women who had undergone therapeutic termination reported the religious tension, the religious belief regarding the law of karma was used to help relieve the feelings of guilt and moral conflict. They tried to develop a new understanding of the law of karma and transform their struggle into comfort.

5.4.2.3   Escaping from unbearable memories

In the theme gaining emotional balance, a strategy that was mentioned only by the women who experienced therapeutic termination was avoiding seeing the baby in order to prevent them forming memories of their babies which might prove unbearable. While women who experienced miscarriage were treated by dilation and curettage (D&C), women who underwent termination of pregnancy were treated by induced labour and delivery because their pregnancies were further advanced. As a result, health professionals only offered women who underwent therapeutic termination, a chance to see their babies after giving birth. However, the findings demonstrated that all therapeutic cases, except one, refused to see their babies because they were concerned about their possible reactions to seeing the baby.

5.4.3   The women's needs for intervention

This section will focus on the participants' needs for intervention from health professionals. The views of health professionals on miscarriage and therapeutic termination care will be explained and compared with the views of women in order to understand how and why the women needed those interventions from health professionals.

In general, women who had experienced a miscarriage and therapeutic termination reported satisfaction in the care they received from healthcare providers, particularly physical care. They seemed to feel that their physical needs were met through the process of hospital admission and treatment. The data from focus group interviews with health professionals confirmed this finding. Both physicians and nurses reported using evidence-based clinical guidelines in order to achieve the best standard of care when

managing women undergoing treatment for miscarriage or therapeutic termination.

These are summarised by the following quotes.

> *For all patients, the main aim is to promote safety and prevent any complication that may occur from their conditions and from the treatment procedures.* (G3, doctor)

> *Nowadays, quality of nursing care is very important. We are forced by the system of hospital accreditation to create evidence-based clinical guidelines in order to make sure that the patients will receive a high standard of nursing care. In our guidelines, we focus on both the physical and psychological issues. But patient's safety is the first thing that we should be concerned about.* (G1, nurse)

The women felt most satisfied with the care they received when their emotional and spiritual needs were addressed by health professionals. For example, a woman who underwent therapeutic termination indicated that she felt satisfied that the doctor and nurse had left her in a private room for a long time with her husband until she felt ready to get more information. Another woman felt satisfied that the nurse allowed her to perform a religious practice as she requested. The view of health professionals was that they attempted to provide holistic support for the women with pregnancy loss and this included providing emotional and spiritual care. One of the nurses said:

> *We try to take care of every patient with holistic care. We also know that these groups of women need more support, not only physical attention, but also emotional and spiritual support.* (G1, nurse)

Another nurse added that:

> *Yes, we also concerned about their feelings. We will try to do whatever will help the women feel relaxed about their loss. The topic of religious and spiritual belief is added in the assessment form. Every patient will be assessed about their belief and about what they plan to do to follow their belief. If their needs are not against the hospital policy, we then allow them to do what they want.* (G1, nurse)

5.4.3.1 The need for information

The women revealed the need for sufficient provision of information from health professionals, particularly information related to the causes of their miscarriage or fetal anomaly, treatment options, and their future pregnancies. The women in both groups indicated that they required knowledge from health professionals but this requirement was not met. For women who experienced miscarriage, they indicated that they felt poorly informed about the causes of their miscarriage. As a result, they were left to feel doubtful and suffer from uncertainty about any future pregnancy. For women who underwent therapeutic termination, they felt poorly informed about the treatment they received. As a result, they were left to suffer with feelings of anxiety and fear of the unknown situation in the process of pregnancy termination. Moreover, they struggled with feelings of uncertainty and fear for the next pregnancy because they did not clearly understand the nature of their fetal abnormality.

However, the data from focus group interviews with the health professionals revealed that they were concerned with the importance of providing information to the women. But the shortage of doctors and nurses meant that they did not always have time for things like detailed explanations and information giving. The urgency of the situation was also an issue which prevented long discussion. Health professionals made the following comments:

> *Providing information to the patients is a role of the doctors, we have to explain both their condition and the treatment they will receive. Sometime we have not enough time to explain in detail because they have an emergency condition or we have to take care of other patients in the ward, not only miscarriage women and therapeutic women but also other high risk pregnancies.* (G4, doctor)

> *We accepted that in some cases, we gave them only necessary information because we had to take care of other patients. If there are more nurses on each shift or there are fewer patients in the ward, then we may be able to give the patients better care or more information.* (G2, nurse)

Nevertheless, there is one thing that is interesting to me from the health professional point of view and the women's point of view about providing information. While health professionals indicated that they provided important information to the women, the women indicated that they felt poorly informed. It could be argued that at the hospital the women were given the information, but they were not capable of accepting the information. This was because they were in shock and felt very vulnerable when they were first told the diagnosis. It seems that areas that require improvement in this situation are the way the bad news is given and the explanations given for why the miscarriage or fetal anomaly has happened.

Moreover, it seems to be that one thing missing in this picture is the lack of assessment of women's concern and needs. Because of the lack of assessment, health professionals did not focus on the information that the women were concerned about. As a result, the information that the women received from health professionals did not help them to understand the situation.

Moreover, the findings in my study also demonstrated that while doctors did their best to treat their patients with empathy and care, some women in this study revealed that they were not given choices about their treatment. They accepted the treatment that was recommended by the physicians.

5.4.3.2 The need for emotional support

The women reported the need for emotional support from health professionals before, during, and after their miscarriage or therapeutic termination. However, as the process of treatment in the women who underwent therapeutic termination differed from the women who had miscarriage, their concerns and needs on the process of treatment were different. It seems that it was difficult to develop rapport between the professionals and the women

in the emergency situation of miscarriage. The priority therefore seemed to be placed on meeting the physical needs of women. The longer process of giving birth following induced labour for therapeutic termination was fraught with concern about complication and how long the process would take. Moreover, the findings showed women in both groups felt dissatisfied when care appeared routine and without any concern for the needs of individual women. They required empathetic interventions that were sensitive to their feelings and needs.

When considering the perception of health professionals in this issue, as pregnancy loss became more common, they also became more concerned about the care they gave. Consequently, they educated themselves about the care women required. However, they revealed some limitations and did not feel competent to take care of women with pregnancy loss. They stated that nurses caring for women with pregnancy loss required further training in dealing with sensitive issues and providing emotional support. One nurse commented as follow:

> *Not every nurse in a labour ward can attend the women with pregnancy loss because we have to take care of them not only their physical safety, but also their emotional and spiritual conditions.* (G1, nurse)

Another nurse added that:

> *Although we have guidelines in providing nursing care for these women, emotional issues are never easy in assessing their problems and needs, providing nursing care that is suitable for their emotional problem, and evaluation. The experienced nurses will have communication skills or counselling skills that can assess the emotional problems and help the women to cope with their loss.* (G1, nurse)

For the physicians who took care of the women during miscarriage and therapeutic termination, they identified their role in relation to the treatment and management of women and genetic counselling and it was only in these respects that the physician was in contact with women during the process of screening and diagnosis.

The women who were admitted for treatment in this ward had received counselling already. The physicians in the ultrasound room have to give information to the women about the condition of their fetuses, prognosis, and the option of treatment. We only follow the treatment procedures that the women have chosen and provide more information for the women before discharge. (G3, doctor)

Again, while health professionals demonstrated that they did their best to take care of the women's needs, the women felt dissatisfied and needed more empathetic interventions. Not even clinical practice guidelines set for women with pregnancy loss could meet the needs of individual women. It seems to be that an emotional needs assessment is one of the most important deficiencies in current clinical intervention.

However, it is interesting to note the language being used by the different health professionals. While the doctors used the words 'fetus'; 'prognosis'; and 'treatment', the nurse-midwives used the words 'baby'; 'holistic'; and 'support'. These different terms may indicate that the main focus of doctors is on diagnosis, treatment, and management of complications, whilst the nurse-midwives focus on supporting and enhancing emotional balance and these words could therefore indicate the model of the care they give women.

In addition, findings from both groups of women were that they not only worried about their safety from the treatment, they also suffer with the feeling of loneliness and insecurity when they were left alone. Although the data from focus group interviews with nurses indicated that they were concerned about providing physical and emotional support for the women, they had to take care of several other women and had various clinical responsibilities and paper work. One nurse commented as follow:

Patients are always the first priority, but if one nurse has to take care of 2-3 patients, it is not easy to give a high standard of care to every patient. We can give only standard care to keep patients safe. We can't stay with any patient for a long time. We have to do many tasks, such as assess uterine contraction, give IV fluid

or drugs, and complete nurse's notes. Sometimes we have to leave some patients if we have to support the woman who is giving birth. (G1, nurse)

Moreover, the policy of public hospitals in Thailand does not allow any family members to attend with women during treatment for miscarriage, and labour and delivery. It seems to be that hospital admission makes them separate from their families. As a result, the women have to face unfamiliar environments and unknown situations alone. This may cause a great amount of loneliness and stress for women during admission. Thus, involving family members on the labour unit to support a woman during admission for treatment should be considered.

Summary

This chapter presented the interpretation of the experience of loss following termination of pregnancy for fetal anomaly from the participants' stories, and described themes and sub-themes which were the result of the interpretative analysis. Two themes were derived from the analysis including facing the loss of hope, gaining emotional balance, and the need for intervention. Within each theme, the sub-themes and the meaning attributed by the participants were discussed. Finally, the similarities and differences between the women's experience of miscarriage and termination of pregnancy for fetal anomaly were discussed.

CHAPTER 6

DISCUSSION

This hermeneutic phenomenological study seeks a deeper understanding of women's experiences of miscarriage and experiences of termination of pregnancy for fetal anomalies in Thailand. In previous chapters, the analytical findings are discrete in the sense that the interpretative account provided is a close reading of what the women have said. This is done without reference to the extant literature. As my primary intention is to reveal conditions that facilitate my understanding of the women's experiences of miscarriage and termination of pregnancy for fetal anomaly, I will engage in a dialogue between my findings and the existing literature. As declared by Van Manen (1990), through the use of existing literature, discussion can provide a clearer understanding of the lived experience.

Before starting to discuss the findings, I would like to clarify that the goal of hermeneutic phenomenology is to reveal a totality of meaning in all its relations through the hermeneutic circle of understanding (Gadamer, 1991). As this study seeks a deeper understanding with regard to the women's experiences of miscarriage and termination of pregnancy for fetal anomaly, my discussion is a part of the hermeneutic circle of understanding which is moving back and forth between part and whole, and between the initial fore-structure and what is being revealed in the data. Heidegger explains that a hermeneutic circle starts by having a fore-understanding and moves on to being open to discover something (Finlay, 2011). According to Gadamer (1991), the hermeneutic circle of understanding as a circular movement of approaching a topic with some pre-conception, examining and revising in the face of what the things themselves reveal, and returning to a further exploration in the light of new understanding.

The three themes emerging from these phenomena, facing the loss of hope and gaining emotional balance, are used to structure the discussion.

6.1 Facing the loss of hope

Nearly all the women who suffered a miscarriage and therapeutic termination had wanted and planned their pregnancies and they had all looked forward to becoming mothers. They expressed their loss not only as the loss of their baby but also they lost their hopes for the expectation of having a child. Although each woman had their own unique set of expectations about their pregnancies, it could be concluded that pregnancy and motherhood were viewed as fulfilment in their lives. This might be related to the Thai society since it values the maternal role of women. In Thai culture, becoming pregnant is believed to be a reproductive task of women. Married women are expected to get pregnant and take care of their children (Nigenda et al., 2003).

Existing qualitative literature in the West on miscarriage supports the idea that women who experienced miscarriage expressed a profound sense of disappointment about the loss of becoming a prospective mother and the future plans for their children (Abboud & Liamputtong, 2003; Adolfsson, 2010; Gerber-Epstein et al., 2009; Harvey et al., 2001; Murphy & Merrell, 2009; Van & Meleis, 2003). Similar to the finding of a previous investigation on a process of coping following fetal anomaly diagnosis in Irish women, this found that the women's expectation of normality was destroyed (Lalor et al., 2009). A study on late-term abortion for fetal malformation (Gammeltoft et al., 2008) also supported facing the loss of hope and indicated that what the women's loss was not only a child-to-be, but also the social recognition that they would have received as the successful mothers of a healthy child.

Receiving an adverse diagnosis, either miscarriage or fetal anomaly, was traumatic for all participants. While women who suffered a miscarriage confronted the inevitable loss and experienced the sudden termination of pregnancy, the women who underwent a therapeutic termination had to confront the constraint in making the decision to terminate their pregnancies and had to confront moral conflict. Making decision to terminate their pregnancy was against to the moral precept in which Buddhist people should abstain from taking life but they did not want their child to be born with severe disability. These findings were similar to a study that reported that when parents considered end-of-life decisions, they experienced both ambivalent and emotional feelings. On the one hand, they were committed to their pregnancy; on the other hand, they wanted to protect their child, themselves and the family from the burden of severe disability (Bijma et al., 2008).

In my study, the main reason given by all women for therapeutic termination was the severity of the abnormality. This may be explained by the fact that severe abnormalities were perceived and associated with many of the following problems, such as an intrauterine death, an inability to survive even with medical measures and an ongoing trouble in caring for their unhealthy children. The women were concerned about the quality of life for their babies and the burden upon the family to deal with the problem in the future. My finding was consistent with a study which found that the diagnosis and prognosis of fetal anomalies was associated with a tendency to end the affected pregnancies (Rauch et al., 2005). Other studies support the finding that the child's best interest, followed by economic issues and the family's best interest were the most frequent reason given by women for therapeutic termination (Marteau & Dormandy, 2001; Raz, 2004; Shoham-Vardi et al., 2004).

Although the decision to sign the consent forms to proceed with the procedure of pregnancy termination was made by the women themselves, it should be noted that their decisions were based on a number of influences, sources and people. Firstly, as Thai people usually respected and depended on their health care providers, they tended not to decline the advice from a medical authority figure. When the physicians recommended the choice of termination of pregnancy due to severe fetal anomaly, the women tended to accept the advice. This reflected the fact that the women had little chance to participate in making the decision because they had no other choice to make. Secondly, family was an important source of the women's decisions. The women's decision to terminate their pregnancies depended on an agreement or a disagreement from their family members, especially from their husbands and parents. This might be related to the close-knit family relationship in Thai culture. If their family members agreed with the decision to terminate their pregnancy, the women tended to accept that decision in order to maintain the good relationship within their families. In addition, the women who received support from their husband and family members felt confident with their decision.

However, the decision to terminate the pregnancy was considered as very difficult to make. The women in my study revealed that making the decision to terminate the pregnancy at any gestational age was not easy to make because their pregnancies were wanted and meant everything to them. Even though the baby still was in the womb and less than 24 weeks of gestation, the women perceived the fetus as a baby. This reflected their emotional attachment to their baby. This contrasts with previous studies which found that early gestational age at diagnosis probably implied less 'attachment' to the pregnancy and more willingness to undergo abortion in case of fetal chromosome anomaly (Britt et al., 2000; Gadow et al., 2006).

6.1.1 Psychological and physical reactions

This study discovered that both the miscarriage and therapeutic termination groups had psychological and physical reactions which were a consequence of the loss of hope. These features included feelings of shock, regret and sadness, doubt, ambivalence, despondency, self-guilt, lack of self belief, and becoming calmer.

It was not surprising that in both groups of women, the feelings of shock resulted in difficulty in being able to grasp the facts of the situation. These findings were supported by previous studies (Bijma et al., 2008; Garcia et al., 2002) which stated that abnormal findings of pregnancy were unexpectedly and intensely shocking for the would-be parents.

When the loss was recognised and confirmed, the women suffered several emotional reactions including regret and sadness, doubt, ambivalence, despondency, guilt, and lack of self belief. These feelings might be aggravated by the loss of the imagined future. The loss of hope was experienced by women in both groups not only as the loss of their baby, but also the loss of hope of becoming a mother. These findings were similar to previous studies that found that the women who had experienced pregnancy loss might have negative feelings typically associated with psychological trauma in general, such as anxiety, grief, anger, loneliness, hopelessness, prostration and guilt (Mitchell, 2004; Statham et al., 2000).

Interestingly, the findings of my study demonstrated that gestational age is not considered by the women. It did not matter to them about the gestational age; they were attached to their babies as any mother to a living child. This confirmed the findings with fertile women that grief after miscarriage was intensified when women strongly desired the pregnancy (Brier, 2008). In contrast, other studies showed that miscarriage could be

considered as an atypical bereavement because the miscarried fetus was of uncertain status between the categories of human or non-human (Frost et al., 2007; Murphy & Philpin, 2010).

When considering the women's psychological and physical reactions identified in both groups of women in this study, their reactions were in accordance with those described in the literature. For instance, some studies viewed pregnancy loss as grief (Adolfsson & Larsson, 2010; Brier, 2008). However, Swanson (1999b) argued the labelling of women's responses to pregnancy loss as grief implied that this was a universal response which might not be true for all women. Some existing studies viewed miscarriage as bereavement (Maker & Ogden, 2003; Adolfsson et al., 2004). Some research suggested that women experienced a variety of psychological distress outcomes following miscarriage, including grief, anxiety, depression, and guilt (Lok et al., 2010; Thapar & Thapar, 1992). A study reported depressive and grief reactions as short-term psychological responses of termination of pregnancy for fetal reasons (Korenromp et al., 2007).

Although the women in my study did not label themselves as depressed and did not use this concept to describe their experience, they expressed feelings of regret and sadness, and despondency to represent the psychological distress following miscarriage and therapeutic termination.

As mentioned before, in Thailand, Grief models, particularly Bowlby and Parkes's stages of the grieving process (cited by Archer, 1999) and Elisabeth Kübler-Ross's five stages of grief (Kübler-Ross & Kessler, 2005) are widely accepted as explanations for patterns of grief as a whole and are taught within the undergraduate nursing programme to explain grief in response to pregnancy loss.

Bowlby and Parkes (cited by Archer, 1999) defined four main stages in the grieving process including 1) numbness, shock and denial which might cause the bereaved to feel a sense of unreality 2) a phase of yearning and protest in which grief might come in waves of crying, sighing, and anxiety 3) disorganization including low mood and hopelessness and 4) re-organisation involving letting go of the attachment and investing in the future. When considering the physical and psychological reactions expressed by the women in this study, it could be assumed that the findings from both miscarriage and therapeutic termination groups confirmed the reactions described in this model. However, in contrast to Bowlby and Parkes's linear grieving process, the women in this study reported their responses as moving backwards and forwards.

Kübler-Ross and Kessler (2005) defined the five stages of grief including 1) denial which responded at first by being paralysed with shock or blanketed with numbness 2) anger which responded to the unfairness of loss 3) bargaining which might take the form of a temporary truce 4) depression involving withdrawing from life and living in a fog of intense sadness, wondering and 5) acceptance including giving the chance to grieve and accept the inevitability to the situation. Kübler-Ross and Kessler explained that this model was a tool to frame and identify what the people who had been bereaved might be feeling. They also suggested that the five stages of grief were not necessarily a linear process and everyone will experience some or all of them but not always in the same order. Although the findings of my study supported the grieving process by Bowlby and Parkes (cited by Archer, 1999) and the five stages of grief by Kübler-Ross and Kessler (2005), these grieving models could not completely explain the reality of phenomena in the Thai context. There were some slight differences between them. It might be due to the differences between the Western socio-cultural context and the Thai context. Firstly, the term of anger was not mentioned by the women in this study. It was possible that in

Thai society anger was considered as misplaced, inappropriate, or a disproportionate feeling. As a result what the women chose to express was a feeling of guilt, which might be anger turning inward on them. The women somehow blamed themselves that the fault was their behaviour during the pregnancy that would have precipitated their prenatal loss. A study confirmed that self-blame and guilt was associated with the anger of loss (St John et al., 2006). Secondly, while the term of acceptance was stated as the final stage of grief process, the women in my study were aggravated by the unavoidable treatments to accept the situation. Besides such unavoidable treatment, the women themselves also needed to accept the situation early in order to gain emotional balance.

In addition, this study discovered the women's experiences of fertility and the meanings attributed to their pregnancies. These experiences and meanings were crucial in shaping the psychological response to pregnancy loss, in particular the loss of self belief and the loss of self confidence in having a baby. It was associated with their past experience of pregnancy loss, not the type of pregnancy loss. The experience of suffering a miscarriage and therapeutic termination made the women insecure about their chances of becoming pregnant in the future and succeeding in having a baby. They perceived a lack of confidence and questioned their ability to become pregnant. For some women, they were afraid of being too old to become pregnant again. Many studies on miscarriage support this finding. Cote-Arsenault and Mahlangu (1999), Harvey et al. (2001) and Adolfsson (2010) found that women were far less confident during a subsequent pregnancy for fear of a recurrence of past events. An anthropological study conducted by Gammeltoft et al. (2008) also showed that a pregnancy loss could begin a process leading to a larger crisis of motherhood and identity. Similar findings related to infertility and multiple pregnancy losses have been identified (Scheffler et al., 2011).

For the women who underwent termination, the decision making process proved to be a stressful, emotionally painful and frightening experience. As Korenromp et al. (2009) found from the data at 4 months after termination of pregnancy, 17% of women undergoing termination indicated that they had had severe feelings of doubt and 12% had perceived pressure during the period of decision making.

6.2   Gaining emotional balance

6.2.1   Gaining self awareness

The findings show that both groups tried to seek information to re-create a sense of control and predictability about their future. This result could be described by the locus of control emerged from Rotter's social learning theory (Rotter, 1990). An internal locus of control refers to the degree to which a person expects that reinforcement or an outcome of their behaviour was contingent on their own behaviour or personal characteristics, whereas an external locus of control is the degree to which a person sees the outcome as related to chance or fate, or other elements over which they have no control (Rotter, 1990). It was shown in my study that both of the internal and the external locus of control had been used as coping strategies to the events. This could be described thus: in the first place, the women felt powerless to control their events; therefore, they tended to pay attention to the effects of fate and uncontrollable power. However, they were still unable to get over their traumatic situations. Finally, the women turned their attention to an action to take control of their situations. Thus, seeking information was a step towards using internal locus of control in order to gain firstly understanding and then to have more control over the traumatic events of a miscarriage or termination of pregnancy.

Those women, who underwent therapeutic termination, described physical signs of stress, such as sleeplessness in response to an uncertain diagnosis. They described their need for high levels of information in order to cope during the period between discovery of the anomaly and confirmation of the anomaly and course of treatment at their next visit. This might be explained because access to information seemed to reduce uncertainty about diagnosis, be able to understand the diagnosis, and increase their sense of control over the situation (Lalor et al., 2008). My study supported other findings (Shiloh et al., 2006) that information-seeking was a strategy to protect the women from painful experiences, particularly when the result was negative.

For women who suffered a miscarriage, they described their need for finding out the reason for a miscarriage. One explanation might be that having information on the causes of miscarriage would allow the women to stop blaming themselves. One study confirmed that women with an identifiable cause of the miscarriage had significantly lower levels of anxiety and self-blame than those with an unknown cause (Nikčević et al., 2007).

The finding of this study discovered that emotional support from family members, particularly husbands and parents, was most helpful for women following miscarriage and termination of pregnancy for fetal anomaly. The couples in this study seemed to help each other through this very difficult time. This might be also related to close-knit family relationships in the Thai context. The majority of the women in this study described their close relationship with their parents and relatives. When they had problems, their parents and close relatives seemed to play a significant role by provision of emotional, and informational support in order to help them redefine an event in a more positive light and be able to overcome their emotional imbalance. This finding is similar

to the findings of two studies. Edwards et al. (1998) examined the relationship between marital quality and the onset of depression following a severely threatening life event and found that marital and social supports were important predictors of the health of bereaved mothers and fathers both individually and as a couple over time.

6.1.2.2 *Believing in karma*

The findings demonstrated that both groups of women used religion to cope with their stressful situation. All women made associative links between their loss experiences and the Buddhist belief. As all women in this study were Buddhist, they were anchored with the Thai Buddhist belief system including the law of karma and life after death. According to a literature by Wortmann and Park (2009), religion/spirituality was considered to be an important coping resource for bereaved adults and helpful for parents who experienced miscarriage. However, this review does not provide an explanation of the interpretations of the loss through the Buddhist view.

In the Buddhist perspective, life is characterized by three important traits including conditionality (cause and effect), impermanence, and insubstantiality, whilst suffering is used in Buddhism as a broader concept to include pain, grief, misery or dissatisfaction (Coward & Ratanakul, 1999; Ratanakul, 2004). The Buddhist perspective on life, suffering and death can partially be understood through the Buddhist laws of karma. The concept of karma is used to emphasise the relationship between an act and its subsequent consequences (Coward & Ratanakul, 1999). Through one's own acts (karma), each person creates their own fate. Regarding ways to cope with death, Buddhism does not condone a melancholic reaction to the death of a loved one. What is necessary when death occurs is that we understand its meaning and cope with it in a realistic and intelligent manner (Ratanakul, 2004).

The women in this study used the Buddhists' religious belief of the law of karma to create the meaning of having miscarriage and fetal anomaly. They defined their miscarriage and therapeutic termination for fetal anomaly as the result of the karma they and/or their fetuses had had before. The finding demonstrated that the belief in karma also enables the women to cope with the painful aspects of their loss. Such acceptance of their losses, as the result of karma, would also enable them to overcome despair and endure the condition of loss. A similar picture was found in a Thai study (Wiriya et al., 2009) which explored Buddhist mothers' experience of suffering and healing after the accidental death of a child. Their findings demonstrated that although the mothers suffered for not being with their deceased children, they gained comfort from the belief that it was the result of their children's previous karma. Moreover, most believed their children had no sin, therefore, would go to a good place for rebirth.

In addition, the women in my study also used the belief of fate to cope with their loss. They mentioned their loss from miscarriage and therapeutic termination for fetal anomaly as "whatever will be, will be". They also expressed "let it be" to encourage themselves to accept that what happened had to happen. Such belief seems to be similar to the concept of fatalism. The meaning of fatalism stated by Whelan (as cited in Solomon, 2003) is a system of beliefs which holds that everything has an appointed outcome which cannot be altered by effort or foreknowledge. The belief of fate used by the women in this study might help reduce feelings of guilt and responsibility for their loss and promote acceptance that nothing could have been done to prevent it.

However, some women in this study also reported a tension which is the result of their religious struggle. For the women who had undergone therapeutic termination, the finding demonstrated that they suffered with the feeling of guilt from making the

decision to terminate their pregnancy because it was against to the moral precept in which Buddhist people should abstain from taking life. This finding could be described by the Buddhist perspective on the sanctity of life. Since life is so worthwhile the first precept in Buddhism prohibits the taking of life. Within this precept all killing for whatever reason is not allowed (Ratanakul, 2004). In the Buddhist view, killing is killing even if it is called mercy killing as contrary to the First Precept, which prohibits intentional killing (Keown, 2005).

To support the idea that the women in this study were anchored with the Thai Buddhist belief system including the law of karma and life after death, the findings demonstrated that all women also followed religious practices for their deceased children by performing merit making. Merit making included practices such as preparing food for the monks, pouring water slowly onto the ground or a vessel, and donating the lifeless body of the baby for research. These activities were done for the purposes of: asking for forgiveness; giving benefits for the rebirth of their deceased babies; and gaining their emotional balance. Buddhist practice after death, such as merit-making is still important to the women in this study. From the review of relevant existing literature, Goss and Klass (2005) described Buddhist notions of merit transfer as maintaining familial bonds with the deceased, a cultural means for resolving grief, and providing an occasion for the living to perform spiritual works to assist the deceased in attaining a favourable rebirth. In this way, grief in Buddhism is redirected into compassionate acts for the benefit of the deceased. A similar finding was reported in a study which explored Buddhist mothers' experience of suffering and healing after the accidental death of a child. The mothers' beliefs in rebirth appeared to have influenced their thoughts and actions, related to dealing with the loss of their children. Most of the mothers regularly engaged in Buddhist practices, such as going to a temple, making merit, giving to charity, and listening to

Dhamma (the gradual instruction of truth taught by the Buddha) in order to give benefits for rebirth to their deceased children, provide themselves with a peace of mind, and develop personal wisdom (Wiriya et al., 2009).

6.2.3   *Escaping from unbearable memories*

In the theme gaining emotional balance, a strategy that was mentioned only by the women who experienced therapeutic termination was avoiding seeing the baby in order to escape unbearable memories. The findings demonstrated that all therapeutic cases, except one, refused to see their babies because they were concerned about their possible reactions to seeing the baby. Although a previous study (Geerinck-Vercammen & Kanhai, 2003) suggested that seeing the baby might help women to accept the loss, the women in my study refused because they were fearful of inducing a memory which would become unbearable. One study in Vietnam (Gammeltoft et al., 2008) supported my finding and suggested that in a social setting where it was often feared that a visual imprint of the deceased fetus might haunt the woman, encouraging women to see, hold or take photographs of the deceased fetal body might not be helpful modes of support.

Escaping from unbearable memories could be described as emotion-focused coping (Folkman et al., 1986). As the women might perceive that seeing the baby following termination of their pregnancy could possibly create an unforgettable memory in their lives, which made it difficult to overcome their sadness, they then attempted to avoid the situation relating to their negative emotional responses.

I have seen that for the women in this study, although they refused to see their babies, the idea of merit transfer provided the means by which they can maintain family bonds. Buddhism in Thailand provides rituals that transform the dead into ancestors so the dead

can remain part of the family. Therefore, merit-making is a strategy to make a memory

for their babies without the discomfort of seeing their babies after birth.

6.3   The women's needs for intervention

In general, women who had experienced a miscarriage and therapeutic termination

reported satisfaction in the care they received from healthcare providers, particularly

physical care. This finding could be explained in two main points. Firstly, most Thai

women now use hospital services because they are concerned about the safety of

themselves (Chunuan et al., 2007). The hospitals are considered very safe places because

they have both the latest technology and well-trained professional health care providers

(Harvey et al., 1999; Wright et al., 2000).

Secondly, the level of satisfaction with care reported by the women might be affected by

their respect for the health professionals. Health professionals are respected because

their roles determined that they helped clients to be healthy (Ekintumas, 1999).

Moreover, moral indebtedness and a sense of obligation are strong themes in Thai culture

(Mulder, 1994).

6.3.1   The need for information

The women revealed the need for sufficient provision of information from health

professionals, particularly information related to the causes of their miscarriage or fetal

anomaly, treatment options, and their future pregnancies. According to one study

(Nikčević et al., 2007), the findings suggested that explaining about the aetiology of the

loss might be important in moderating psychological outcomes, in addition to

determining satisfaction with care. Furthermore, those with an identifiable cause of the

miscarriage had significantly lower levels of anxiety and self-blame over time than those with an unknown cause. Another study supported the idea that although pregnancy loss often occurred in the absence of an obvious explanation, women who had medical explanations for miscarriage had less difficulty coping than women who did not have medical explanations (Simmons et al., 2006).

This finding supports a study in Thailand that found that the shortage of doctors and nurses was the reason that public patients were not offered more options to take part in their own care (Chunuan et al., 2007).

Similarly, McCoyd (2009) studied women who experienced prenatal diagnosis and termination for anomaly and found that the women wanted (a) honest, unbiased information from medical providers; (b) lack of judgement; and (c) as much time as possible to process the information and to assess its impact on their lives.

Moreover, the findings in my study also demonstrated that while doctors did their best to treat their patients with empathy and care, some women in this study revealed that they were not given choices about their treatment. They accepted the treatment that was recommended by the physicians. This might be explained because in the Thai context, particularly the public health care sectors, most patients are still passive recipients. They depend on public health services and that was why they had little chance to participate in their own care.

6.3.2   The need for emotional support

The women reported the need for emotional support from health professionals before, during, and after their miscarriage or therapeutic termination. This finding is supported by a study which stated that an overt expression of concern, being non-judgmental and

showing empathy would allow women to feel someone cares and provides a sense that they were not alone (McCoyd, 2009). According to Gammeltoft et al. (2008), women's distress could be lessened if they were provided with psychosocial care and empathic professional support including the provision of accurate information about the malformation and its probable causes, about risks to future pregnancies, as well as offering women the opportunity to share their feelings.

Finally, from the whole process of this hermeneutic phenomenological study, I have found that the women's experiences are based on a number of influences, sources and people. I have subsequently developed model representing the women's experiences of miscarriage and termination of pregnancy for fetal anomaly in Thailand. This model is given in Figure 6.1.
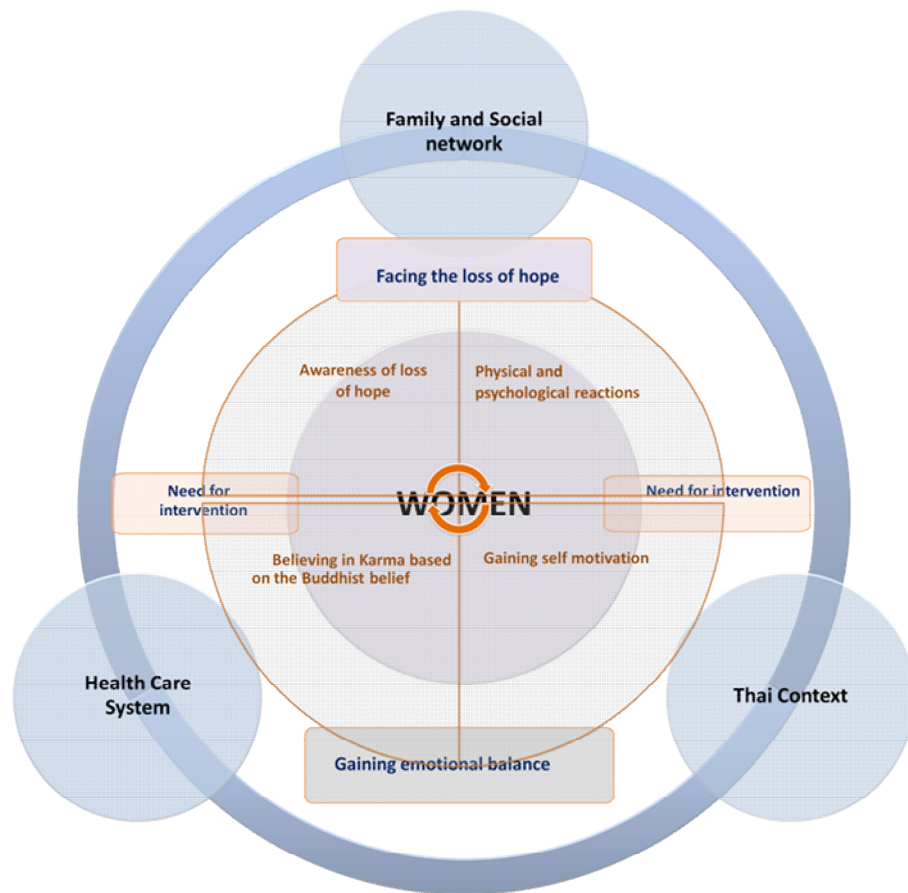
Figure 6.1: The women's experiences of miscarriage and termination of pregnancy for fetal anomaly in Thailand

In figure 6.1, the women are at the centre of the phenomena. The women's experiences are captured by three main components, including family and social network, Thai culture, and health care system. These three aspects are perceived by the women as positive and negative impacts on their experiences of miscarriage or termination of pregnancy for fetal anomaly. Whether the women receive support, these three aspects could affect the women's experiences both directly and indirectly.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

This chapter presents two main sections. The first section is the overall conclusion of this study. Then the strengths and limitations of the study are explained. In the second section, the knowledge from the findings and the discussion are converted to a number of recommendations for education, clinical practice, and further research.

7.1 Conclusion

This study set out to explore women's experiences of miscarriage and termination of pregnancy for fetal anomaly in Thailand. The picture that developed from my study depicted the experience of eleven women who had suffered from miscarriage and twelve women who had undergone termination of pregnancy for fetal anomaly. Data were collected in unstructured interviews and then analysed in a hermeneutic phenomenological way guided by Smith et al. (2009). The three themes, facing the loss of hope, gaining emotional balance, and need for intervention, emerged from the data analysis.

This study reinforces the difficulties that women have from the traumatic events of miscarriage and termination of pregnancy for fetal anomaly. Although pregnancy loss is a unique experience for each woman, the loss of hope is the essence of the women's experiences of miscarriage and therapeutic termination. The loss of hope as experienced by women in both groups is not only the loss of their baby, but also the loss of the hope of becoming a mother that is valued as a reproductive task of married women in Thai society. In addition, believing in Karma based on the Buddhist belief is a main source of help for all women in this study who were Buddhists to regain emotional balance.

Of the women's experiences of miscarriage, three themes emerged from the interpretation, consisting of facing the loss of hope, gaining emotional balance, and the need for intervention. The pattern of these three themes is viewed as spiralling circles which are a dynamic movement to seek a sense of balance. Psychological and physical imbalance responding to the loss of hope is a universal human experience and the women who experienced miscarriage certainly are no exception. Shock is the immediate response to the loss of hope, until one recognises and realises what has happened. Other psychological responses consist of regret and sadness, doubt, despondency, guilt, and lack of self belief and uncertainty. Believing in karma based on the Buddhist belief and gaining self motivation are the strategies used by the women to regain emotional balance. The need for intervention is entwined throughout the loss experience to support the women to overcome the loss of hope and gain their emotional balance.

For the women's experiences of termination of pregnancy for fetal anomaly, three themes namely facing the loss of hope, gaining emotional balance, and the need for intervention emerged from the interpretation. The women expressed their psychological and physical reactions from responding to the loss of hope as mixed up feelings of shock, sadness, despondency, questions, ambivalence, and self-guilt. To regain emotional balance, gaining self awareness, believing in karma, escaping from unbearable memories, and being a good mother are needed. The need for intervention is entwined throughout the loss experience to support the women to overcome the loss of hope and gain emotional balance. The connection of these three themes is the same as the pattern described in the women's experiences of miscarriage.

Although the main findings between both groups of women are similar, the significant difference between them is the context of pregnancy loss. While miscarriage is an

inevitable event and needs urgent treatment, the diagnosis of fetal anomaly leads the women to have a feeling of ambivalence around the decision to terminate the pregnancy.

Finally, this study clearly shows that women have mixed experiences with the care they received. Some women in my study expressed positive experiences of health care and hence felt satisfied with the care received. But for others their experiences were negative and made them feel dissatisfied with the care received from health professionals. The women needed more in-depth knowledge about their situation from health professionals who are sensitive to what knowledge is required. The women also need empathetic care from health professionals who are attentive, kind, and sensitive. Involving family members to support women in the labour unit can reduce the feelings of loneliness and insecurity.

7.2 The strengths of this study

My aim for this research was to gain understanding of the issues of miscarriage and therapeutic termination for fetal anomaly as experienced and articulated by the women who suffered these phenomena. I chose hermeneutic phenomenology as my underpinning methodology as I believe that it is a way to observe the richness and complexity of experience and to provide this knowledge in depth.

While there still is limited knowledge about women's experiences of miscarriage and termination of pregnancy for fetal anomaly in Thailand, this interpretive study could give a more complete understanding of these phenomena. With interpretive phenomenology, the findings of this study can be used to explain the complexity of miscarriage and therapeutic termination in Thai socio-cultural context.

This study is unique as it explored the women's experiences on both a miscarriage and a therapeutic termination based on the same study design. As a result, it allowed a comparison between the women who experienced a miscarriage and those women who experienced a termination of pregnancy for fetal anomaly in Thai context.

All participants I approached agreed to participate in the study. On the one hand, it could be that I am a health professional and women respect professionals in Thai society. On the other hand, it could be that miscarriage and therapeutic termination for fetal anomaly are acceptable in Thai culture. Thus, if the participants were not oppressed with feelings of shame and perceived stigma from the community, they might choose to participate in the study and it gave them a chance to explicitly express their emotions responding to the phenomena.

I collected the data from interviews with the women and focus group interviews with health professionals. These methods gave a better understanding of the phenomena and a more complete picture of women's experiences through miscarriage and therapeutic termination and an understanding of the context in which care was given and received.

To ensure the quality of the research, I attempted to resolve the problems in using phenomenology in research with a thorough grounding of knowledge in the phenomenology approach. Chapter three, Methodology, discussed my approach to this in detail.

7.3   Limitations of the study

There are limitations in this study. Firstly, because of a single specific time of data collection, the findings can show the women's experiences at only one moment in time and cannot explain their experiences over a long time period.

Additionally, this was an interpretive study to gain deeper understanding of women's experiences of miscarriage and termination of pregnancy for fetal anomaly. Thus, the findings may not be able to generalise to other situations and contexts. In addition, the study was conducted in two public hospitals over a time-limited period in one particular province in the North of Thailand and the women interviewed were mainly rural and middle-income women. As a result, the women in this study did not fully reflect the diversity of the population in Thai society and the findings cannot be presumed to apply to all women in Thailand.

The goal of this research is to explore Thai women's experiences of miscarriage and termination of pregnancy for fetal anomaly. As I am a Thai and Buddhist, this may be limiting in that I may bring a specific perspective of an insider to the interpretation. This may create some difficulties for the reader as an outsider from another cultural tradition to engage with the interpretation as I intended.

7.4   Recommendations for education

Until now the understanding of loss through miscarriage and termination of pregnancy among Thai women has not been explored. The understanding of grief processes applied to pregnancy loss is based on western context models by Kübler-Ross & Kessler (2005) and the Bowlby and Parkes' model (cited in Archer, 1999). These are used to teach grief processes in undergraduate nursing programme and used by nurse-midwives as a guideline in assessment of psychological condition and taking care of women who have experienced miscarriage and therapeutic termination for fetal anomaly.

The findings of this study give a better understanding of women's experiences of miscarriage and therapeutic termination for fetal anomaly in Thai Buddhist context. Thus the findings would be useful for education and women's experiences of miscarriage

and termination of pregnancy for fetal anomaly in the Thai Buddhist context from these findings can apply to teaching nursing students. As the findings also demonstrate the need for intervention, nurse-midwives and other health professionals can apply these findings in providing good quality care for Thai Buddhist women who have suffered from miscarriage and termination of pregnancy for fetal anomaly.

7.5   Recommendations for clinical practice

A number of recommendations are evident from the findings of this research. Some of these were articulated by the women who participated in this study and some come from my interpretation of the findings.

1.   Developing nurses' skills in taking care of the women who experience miscarriage and therapeutic termination

This study identified that miscarriage and termination of pregnancy for fetal anomaly were traumatic events. The women experienced the loss of hope and a number of psychological responses. However, the nurses revealed a lack of confidence in taking care of women with pregnancy loss. Thus, development of nurses' skills is necessary. Nurses are significant in promoting quality of care for the women who experience miscarriage and therapeutic termination. It is recommended that hospital policy should support the development of nurses' competency in order to enhance the confidence of nurses in taking care of women with pregnancy loss.

2.   Providing knowledge for each woman's individual needs

Firstly, as the women revealed that they were not capable of accepting the information given by health professionals about the diagnosis of miscarriage or having fetal anomaly. Thus, areas that require improvement in this situation are the way in breaking bad news

to the women. Training in communication skills and techniques to facilitate breaking bad news is needed to improve women's satisfaction and health professionals' comfort.

Secondly, the women showed the need for sufficient provision of information from health professionals, particularly information related to the causes of their miscarriage or fetal anomaly, details about their treatment, and their future pregnancies, but this requirement was not met. As a result, they were left to feel doubtful and suffer with uncertainty about any future pregnancy. Thus, it is suggested that basically, a health professional should provide information about the reasons for the miscarriage or fetal anomaly (including reassurance that the woman's routine activities are not the cause), the effects of miscarriage or fetal anomaly on subsequent pregnancies, and future reproductive capability. Moreover, both groups of women should be given information about the treatment they receive including the plan, the benefits, potential side effects and risks, progression, and any changes of treatment.

In addition, because of the lack of assessment, health professionals did not focus on providing information to the women concerned. As a result, the information that the women received from health professionals did not meet their needs. Thus, it is important for health professionals who take care of women with miscarriage and therapeutic termination for fetal anomaly to assess each woman's individual needs for knowledge and then spend more time in providing as much information as the women need.

However, the shortage of doctors and nurses in labour unit leads them to be unable to provide as much information as the women need. Thus, written information should be offered to the women in order to assist them in accessing accurate information.

3.   Promoting the women's participation in their own care

The findings revealed that when the women were admitted to hospitals, they were perceived as passive recipients. As a result, they were not given choices of treatment and they had to accept the treatment that was recommended by health professionals. Thus, it is a role of health care providers to show respect for individual rights and allow the women to participate in their own care. It might be beneficial for women to feel some control over their experiences and not out of control in their situations.

There are many strategies that can promote the women's participation in their care. Information should be given about options relating to the treatments for miscarriage and therapeutic termination. The women should be encouraged to choose from options and be persuaded to discuss their needs with attending nurses and obstetricians during their treatment. Women then could consider their own priorities and make decisions based on their individual needs instead of having to conform to health professional's preferences.

Moreover, to promote the women's participation in care, friendly behaviour of health professionals seems to be important. Women should feel free to ask any questions and share their concerns.

4.   Providing emotional support and security

For both groups of women, they worried about their safety related to treatment they received. Moreover, hospital admission separated them from their families. This may cause a great amount of loneliness and stress for women during admission. The following recommendations could help guide health professionals to improve the quality of care for women with miscarriage and therapeutic termination and help them to regain their emotional balance:

- Considering the diverse needs of women and providing empathetic care. The findings from both groups of women indicated that they felt dissatisfied when care

appeared routine without any concern for the needs of individual women. Thus, it is suggested that health professionals need to provide empathetic interventions that are sensitive to the feelings and needs of each woman.

- Involving family members on the labour unit to support a woman during admission. The findings of the study identify that emotional support from family is most significant to the women, especially from their husband and their own mother. Thus, it is suggested that hospital policy should allow family members to attend the women during labour and delivery in order to respond to the wishes of the women to have their family members with them in the labour unit.

- Allowing the women to perform religious practices based on their belief. The finding of the study pointed out that believing in Karma based on the Buddhist belief is a main source to help the women to regain emotional balance. Thus, it is recommended that religious belief should be put in a perspective of intervention which requires consideration by health professionals. In addition, health professionals need to provide culturally sensitive care for women (including for a dead baby) to respond to the emotional and spiritual needs of each woman.

- Offering a support group. The women in this study demonstrated that sharing their experience with other women who experienced pregnancy loss helped them to gain relief from their painful emotions. Thus, offering a support group will give the women an opportunity to share and express feelings while listening to how others are learning to cope with their loss.

7.6   Recommendations for future research

A perspective which arose from the women in this study was that the issues of miscarriage and termination of pregnancy for fetal anomaly had an effect on not only the women, but also their family members. Further studies from the perspective of family members, particularly bereaved fathers, are required in order to fully understanding the whole picture of phenomena.

In this current study, all participants were Buddhists. The understanding provided based on their Buddhist beliefs and cannot be extended to the understanding of women with other belief systems. Further study of other cultures and belief systems is needed.

Due to a single specific time of data collection, the findings can show the women's experiences at only a moment in time and cannot explain their experiences over a long time period. Longitudinal study is required to understand the whole process of psychological responses of the women who have experienced miscarriage and termination of pregnancy for fetal anomaly.

Although my findings detailed a better understanding of the women's experiences of miscarriage and termination of pregnancy for fetal anomaly, this study was conducted only in a particular province in the North of Thailand. Therefore, further research in other regions is needed to expand the current findings and generalise the whole picture of women's experiences of miscarriage and termination of pregnancy for fetal anomaly in Thailand. In addition, as different socio-cultural contexts could have an effect on different points of view, therefore, it needs to develop a grieving tool that encompasses culture and social aspect to meet the needs of women following their miscarriage and their termination of pregnancy due to fetal anomaly.

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APPENDICES

Appendices	Topics
Appendix A	Ethical approvals and the permission documents
Appendix B	Information sheets and consent forms B1: Participant Information sheet for the women B2: Participant information sheet for the health professionals B3: Consent form for the women B4: Consent form for the health professionals
Appendix C	Examples of the process of translation of data
Appendix D	Examples of interpretive process from the words of the women who experienced miscarriage

Appendix A: Ethical approval, UEA

Faculty of Health Research Ethics Committee

UEA
University of East Anglia

Nonglak Chaloumsuk
31 Friends Road
NORWICH
NR5 8HN

8th October 2010

Dear Nonglak

Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly-Ref: 2009/10-015

The resubmission of your above proposal has now been considered by the Chair of the FOH Ethics Committee and we can now confirm that your proposal has been approved.

Please could you ensure that any amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the committee. Please could you also arrange to send us a report once your project is completed.

The Chair would like to wish you good luck with your project.

Yours sincerely

Maggie Rhodes
Research Administrator

Appendix A: Ethical approval, Thailand

Certificate of Approval

No. 302/2010

Name of Ethics Committee : Research Ethics Committee **3**,

Faculty of Medicine, Chiang Mai University

Address of Ethics Committee : 110 Intavaroros Rd., Amphoe Muang,Chiang Mai, Thailand 50200

Principal Investigator : Nonglak Chaloumsuk

School of Nursing and Midwifery, Faculty of Health,

University of East Anglia

Protocol title: Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly

Study code : 10SEP010384

Sponsor : -

Documents filed	Document reference
Research protocol	- Version date 23 September 2010
Patient information sheet / Informed consent documents	- Version date 23 September 2010
Principal Investigator Curriculum vitae	- Version date 10 August 2010

Opinion of the Ethics Committee/Institutional Review Board : PLS. CHECK ONE

_____✓_____ Approval

_____ Conditional approval (Specify on space below)

....

....

DECISION : By expedited review process

Date of Approval : September 23 , **2010**   **Expiration Date:** February 27 , **2011**

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

Signed : .... *P. Kulapongs.* ....

(Emeritus Professor Panja Kulapongs, M.D.)

Chairperson, Faculty of Medicine

Signed : .... *N. Nantachit* ....

(Associate Professor Niwes Nantachit, M.D.)

Dean, Faculty of Medicine

GENERAL CONDITION OF APPROVAL:

- Please refer to www.med.cmu.ac.th/research/ethics/inv_sop_announce.pdf article 13.
- Please submit the progress report at least once a year except where required more frequent by the REC.
- In particular, approval of this study must be renewed at least one month before the expiration date if work is to continue.
- Prior Research Ethics Committee approval is required before implementing any changes in the consent documents or protocol unless those changes are required urgently for the safely of subjects.
- Any event or new information that may affect the benefit/risk ratio of the study must be reported.
- Any protocol deviation/violation must be reported to the IRB

September, 29 2010

Institute of Health
Edith Cavell Building, University of East Anglia
Norwich, Norfolk NR4 7TJ
Phone 01603 597094
Fax 01603 597019

Dear Dr Kenda Crozier,

Regarding to your request for approval of conducting research in human subject at
Maharaj Nakorn Chiang Mai Hospital for Mrs.Nonglak Chaloumsuk's project titled "
Women's experiences of loss through miscarriage and termination of pregnancy for
fetal anomaly"

I am please to inform you that the research project was certified by the Research
Ethics Committee of the Faculty of Medicine, Chiang Mai University (REC FOM-
CMU). The length of time of the research project will be as specified in the certificate
issued by the REC FOM-CMU.

Please note that, if Mrs.Nonglak Chaloumsuk wish to initiate any changes in the
research protocol or the consent documents; she should submit the request to REC
FOM-CMU in writing prior implementing any changes.

Sincerely,

(Associate Professor Niwes Nantachit. M.D.)
Dean of Faculty of Medicine, Chiang Mai University

Appendix B: Information sheets and consent forms

Appendix B1: Participant Information Sheet for the women

Study title	Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly
Researchers	Mrs Nonglak Chaloumsuk
	Ph.D. student at School of Nursing and Midwifery, Faculty of health, University of East Anglia (UEA), United Kingdom

This is a student research study conducted under the supervision of Dr Kenda Crozier and Dr Nicola Young from the University of East Anglia, United Kingdom. This project has been approved by the Faculty of Health Ethics Committee, University of East Anglia. The study will help the student learn more about the topic area and develop skills in research design, collection and analyses, and writing a research paper.

Why are we doing this research?

Approximately one quarter of all pregnancies end in pregnancy loss. However, the literature tends to treat pregnancy loss as one entity rather than making distinctions between loss due to miscarriage separately from loss due to termination for fetal abnormally. Understanding women's experiences following a miscarriage and termination of pregnancy for fetal anomaly will be used to produce educational materials and guidelines to enable health care staff to meet the needs of women suffering pregnancy loss.

Why have I been invited to take part?

You have been invited to join our study because you have experienced a miscarriage or termination of pregnancy for fetal anomaly.

Do I have to take part?

It is important for you to know that you can choose whether or not to take part in the study. Choosing not to participate in this study will not affect your status in any way. If you agree to participate, you have the right to refuse to answer any question that you do not want to discuss, and you can stop an interview at any time. If you volunteer to be a participant in this study, you may freely withdraw from the study at any stage of the process, even after you start to answer the questions. It will not adversely affect you in any way.

What will happen to me if I take part?

If you agree to be in this study, I will conduct an interview with you at a time and place that is convenient for you. The interview will take about 60 minutes to complete. With your permission, I would also like to audio record the interview.

What are the possible risk and discomforts and might I have some if I take part in the research?

Talking about sensitive topics might possibly make you feel uncomfortable. If you do feel uncomfortable or find the discussion hard to deal with, you can do any of the following: you can take a break and continue later, you can choose to stop the interview. If you need emotional support, I can give you the contact telephone number of a counselling centre in the hospital. There is no more risk involved in this study except your valuable time.

Is there anything else to be worried about if I take part?

The records of this study will be kept private. Your name and identity will not be disclosed at anytime. When the results of this study are published, I will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researchers will have access to the records. The transcriptions and the recordings will be examined by members of the research team only, and I will destroy the recordings after completion of the research.

What are the possible benefits of taking part?

There will be no direct benefit to you by taking part in this study. No incentives or payments will be offered in return for participation in the study. The information that you give may help the researcher understand women's experiences after miscarriage and termination of pregnancy for fetal anomaly, and this study then may be used to produce educational materials and guidelines to enable health care staff to meet the needs of women suffering pregnancy loss.

Contact details

If you have any question about this research now or later, please contact:

Mrs Nonglak Chaloumsuk   -Mobile phone in Thailand: 0066 (0)859345654

(Researcher)   -E-mail address: pnonglak34@hotmail.com

Appendix B: Information sheets and consent forms

Appendix B2: Information sheet for the health professionals

Study title	Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly
Researchers	Mrs Nonglak Chaloumsuk
	Ph.D. student at School of Nursing and Midwifery, Faculty of health, University of East Anglia (UEA), United Kingdom

This is a student research conducted under the supervision of Dr Kenda Crozier and Dr Nicola Young from the University of East Anglia, United Kingdom. This project has been approved by the Faculty of Health Ethics Committee, University of East Anglia. The study will help the student learn more about the topic area and develop skills in research design, collection and analyses, and writing a research paper.

Why are we doing this research?
We are interested two types of pregnancy loss. However, the literature tends to treat pregnancy loss as one entity rather than making distinctions between loss due to miscarriage separately from loss due to termination for fetal abnormally. Understanding women's experiences post miscarriage and termination of pregnancy for fetal anomaly will be used to produce educational materials and guidelines to enable health care staff to meet the needs of women suffering pregnancy loss.

Why have I been invited to take part?
You have been invited to join our study because you are nurse-midwives or doctors who give care to women who have experienced miscarriage/therapeutic termination for fetal anomaly in the participating hospitals. Your information will be useful to gain the perspective of care that the women receive in the hospital

Do I have to take part?
It is important for you to know that you can choose not to take part in the study. Choosing not to participate in this study will not affect your status in any way. If you agree to participate, at any time you have the right to refuse to answer any question that you do not want to discuss, and you can stop a discussion at any time. If you volunteer to be a participant in this study, you may freely withdraw from the study at any stage of the process, even after you start to answer the questions. It will not adversely affect you in any way.

What will happen to me I take part?
Five nurse-midwives and five doctors who are willing to take part in this study will be

included in the first instance from Maharaj Nakorn Chiang Mai hospital and Nakornping

hospital. Separate focus group of the nurse-midwives and doctors will be conducted in each hospital.

If you agree to be in this study, we will conduct a focus group interview with you. These discussions will focus on professional views on miscarriage and therapeutic termination care. The focus group discussion will last for 60 minutes. With your permission, we would also like to audio-record the interview. At the end of discussion, the researcher will summarise the main issues raised by the group and ask for checking data accuracy. You will be reminded at the end of group that you have agreed to maintain confidentiality.

What are the possible risk and discomforts and might I have some if I take part in the research?

There is a small risk that group members may disclose personal information in the group. Therefore at the end of the group you will be reminded about the importance of keeping everything you hear or see confidential and not disclose it to anyone. There is no more risk involved in this study except your valuable time.

Is there anything else to be worried about if I take part?

The records of this study will be kept private. Your name and identity will not be disclosed at anytime. When the results of this study are published, I will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researchers will have access to the records. The transcription and the tapes will be examined by members of the research team only, and I will destroy the tape after it has been transcribed, which I anticipate will be within two months of its taping.

What are the possible benefits of taking part?

There will be no direct benefit to you by taking part in this study. No incentives or payments will be offered in direct return for participation in the study. Your participation will help the researcher understand women's experiences post miscarriage and termination of pregnancy for fetal anomaly, and this study then may be used to produce educational materials and guidelines to enable health care staff to meet the needs of women suffering pregnancy loss.

Contact details

If you have any question about this research now or later, please contact:

Mrs Nonglak Chaloumsuk   -Mobile phone in Thailand: 0066 (0)859345654

(Researcher)   -E-mail address: pnonglak34@hotmail.com

Appendix B: Information sheets and consent forms

Appendix B3: Consent form for the women

Study title	Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly
Researchers	Mrs Nonglak Chaloumsuk
	Ph.D. student at School of Nursing and Midwifery, Faculty of health, University of East Anglia (UEA), United Kingdom

Please initial box

1. I confirm that I have read and understand the information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and any affect. ☐

3. I am aware of the procedures involved in this study, including any inconvenience. ☐

4. I agree to take part in this study. ☐

5. I agree to voice recording of interview. ☐

6. I agree to anonymised quotations from my interview being used in publications. ☐

………………….....   …………………   …………………………..

Participant's Name   Date   Signature

………………….....   …………………   …………………………..

Researcher's Name   Date   Signature

Appendix B: Information sheets and consent forms

Appendix B4: Consent form for the health professionals

Study title	Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly
Researchers	Mrs Nonglak Chaloumsuk
	Ph.D. student at School of Nursing and Midwifery, Faculty of health, University of East Anglia (UEA), United Kingdom

Please initial box

1. I confirm that I have read and understand the information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and any affect. ☐

3. I am aware of the procedures involved in this study, including any inconvenience. ☐

4. I agree to take part in this study. ☐

5. I agree to voice recording of focus group. ☐

………………….....   …………………   …………………………..

Participant's Name   Date   Signature

CONSENT FORM FOR FOCUS GROUP CONFIDENTIALITY

Study title Women's experiences of loss through miscarriage and termination of pregnancy for fetal anomaly

Researchers Mrs Nonglak Chaloumsuk

Ph.D. student at School of Nursing and Midwifery, Faculty of health, University of East Anglia (UEA), United Kingdom

Please initial box

1. I understand that the information discussed by the focus group member is confidential. ☐

2. I agree to keep the information confidential and not discuss it with anyone else. ☐

……………………..... ………………… ……………………………

Participant's Name Date Signature

…………………….... …………………. …………………………..

Researcher's Name Date Signature

Note: There are two copies of this form-one for the researcher and one for the participant.

Appendix C: Examples of the process of translation of data

	Thai		English		Translator checker
I	นี่คือที่คุณหมอบอกเรา ณ ตอนนั้นที่ฟังผลเลย	I	Is this the information that the doctor tell you after knowing the result?		- Or "this is the information you have got from the doctor…"
R	บอกในห้องที่ทำอัลต้าซาวน์เลย	R	Yes, in the ultrasound room.		- Yes, he gave me information…
I	ตอนที่รู้ผล ตอนนั้นรู้สึกยังไง พออธิบายได้ไหม	I	When you knew the result, what did you feel? Can you explain more?		
R	จิตใจมันไม่อยู่กับเนื้อกับตัวเลย มันไปหมดแล้ว	R	<u>My heart was not stayed with my body, it was gone</u>, everything became gloomy, it was badly frightened, I was struck dumb, I was unable to think of anything, I felt like I had nothing in my life. <u>If after birth he opens eyes, I might have nothing, my life</u>, I might die with him. But he didn't open eyes, <u>I looked at him but he didn't open eyes.</u> This made me can *Tam Jai* that I <u>still had 2 sons at home, I must be fine.</u> If I get any trouble, <u>my husband must make money</u>, and my parents must look after my sons for me, <u>it is burden for them.</u> But I am proud that the <u>doctors take my baby body to study, I feel proud with (of) my baby.</u> <u>The doctors have helped the best they can do with my baby</u> because only 1 in 100 cases will be like this, not often to see this case. The doctors might see my baby as the first case, I don't know, otherwise, they might not want my baby for research.		- I felt like my heart jumped out of my body. - If his eyes were opened when he was born, I didn't know how I can stand anymore,… - his eyes stayed closed the whole time I looked at him. - This made me realise that I needed to get over all of this because I had 2 sons waiting for me to come home. - my husband must earn all of the money in the family,…, it puts too much of a burden on them. - I feel proud of my baby to be the source of knowledge for other doctors. The doctors have done the best thing for him…
	มันตั้นหมดเลย มันวูบ มันอึ้งนึกอะไรไม่ออกเลย มันเหมือนไม่มีอะไรในชีวิตนี้เลย ถ้าตอนเขาคลอดออกมาเขาลืมตา น้องก็คงไม่มีแล้ว ชีวิตน้อง น้องคงจะตายกับเขาไป แต่นี่เขาไม่ลืมตา เฮามองเขาอย่างเดียวแต่เขาไม่ลืมตา เขาไม่ได้เห็นเฮา เฮาถึงทำใจได้ว่ายังมีอีกสองคนที่บ้าน เฮาต้องไม่เป็นอะไร ถ้าเฮาเป็นอะไรไปแฟนก็ต้องหาเงินอีก หมู่พ่อแม่ต้องมาเลี้ยงลูกเฮา เป็นภาระอีก แต่ภูมิใจที่คุณหมอขอลูกไปศึกษา ภูมิใจที่สุดเลย หมอก็ช่วยสุดขีดแล้ว สำหรับตัวลูกเฮานี่นะ เพราะร้อยจะมีแค่คนหนึ่งที่เป็นแบบนี้ แต่เขาไม่เจอบ่อย แต่อาจจะเจอลูกน้องเป็นคนแรกก็ไม่รู้ ถ้าไม่อย่างนั้นเขาคงไม่ขอไว้วิจัย				

Appendix D: Examples of interpretive process from the words of the women who experienced miscarriage

Theme 1: Facing the loss of hope

Words of participants	Initial notes	Emergent themes	Sub-themes
I had so much hope in my pregnancy. But the more I listened to what the doctor informed me, the more my hope became lower and lower, and then was gone. (M01, p.13)	Hope was gone when her pregnancy was miscarried	Facing with the loss of hope	the awareness of the loss of hope
I never believed that the little happiness which happened when I knew that I was pregnant would be followed closely by tremendous suffering. I felt like my whole hope was crashing down in front of me. (M03, p.6)	Hope was crashing down		
During the repeat ultrasound scan, I prayed to the Triple Gem that we (I and my husband) wouldn't lose the baby. But then we lost all hope when the doctor told us that I certainly was in the process of miscarriage. (M02, p.7)	Losing of all hope		
We tried to have a baby for so long and all happiness and dream we had since getting pregnant was taken away from us in a short period of time. (M05, p.5)	all happiness and dream we had since getting pregnant was taken away		
When I heard that my baby's heart had stopped beating, I felt like my heart was going to stop beating. (M09, p.5)	Shock and emotional numbness	Physical reaction responding to shock	psychological and physical consequences
I was in shock, frightened, doubt, and confusion. It was unbelievable, I could believe it. I thought that my baby might be too small and very hard to see. I asked the doctor to check carefully again because I didn't think that my baby had departed. (M10, p.12)	Overwhelming with feeling shocked, frightened, doubt, confused, disbelief	Mixed emotional reactions	
Why am I a very unfortunate person? What kind of bad karma have I done? (M07, p.18)	Questioning	Emotional reaction	
I had two miscarriages within two years. It was the most stressful thing that I had ever dealt with. I felt a bit disappointed and lost my confidence a little when I found the other one who had started to get pregnant at the same time as me and she completed her family. (M07, p.6)	Feeling despondent and lack of self belief (she had no confidence that she could have a baby)	Psychological reaction	

Theme 2: Gaining emotional balance

Words of participants	Initial notes	Emergent themes	Sub-themes
I tried to read many books and search information on internet about miscarriage. At least it made me feel relieved that it did not happen because of me and it wasn't my fault at all. Otherwise, this guilt would stick in my mind forever. (M05, p. 26)	Understanding the truth of condition to get rid of self guilt	Seeking information	Gaining self motivation
My husband was the most important person to raise me up from sadness and have more will power. We cried together. We felt sympathy to each other. We understood the feeling we had. We helped each other to feel better. (M08, p.27)	Husband was the most important emotional supporter		
...my mother, my relatives, and my friends tried to soothe me that don't be pessimistic. I still had the chance to get pregnant and have a baby. It helped me feel a bit relieved from worried about getting pregnant again. (M08, p.25)	Emotional support from family members	Seeking emotional support	
Talking with other people helped me see a way out. When I thought alone, I felt my life was gloomy. When I listened my friend talked about what she had done to succeed in having a baby, it helped me have hope. It was the light that might lead me to reach my intention (to have a baby). (M10, p.22)	Learning from the other's experience of loss		
It might be my own old sin and karma, that's why everything happened. No one could forbid it from happening. It was unchangeable. I also couldn't resist this fate of me. (M10, p.20)	Believing in Karma, birth, and rebirth	Believing in Karma as emotional anchor	Believing in karma based on the Buddhist belief
Right now, the outcome of what I had done in the past was displaying itself. It might be my fate and my baby's fate. I didn't need to find a reason for it. (M04, p.32)			
I prayed and consigned merit to my departed baby and khammic fellows every night as my friend suggested. I prayed for my baby's better condition and hoped that the khammic fellows would forgive me and let me to get away from bad things. I didn't know this method would have me more or less, but at least I had done. It helped me get a little bit better. (M01, p.30)	This deed would be a strategy to improve their baby's karma in the present life to be better in the next life.	Fulfilling the maternal role for the baby	

Theme 3: The need for intervention

Words of participants	Initial noting	Emergent themes	Sub-themes
I felt worried about the causes of my miscarriage. The doctor said that it was probably because my baby was unhealthy, it was a natural choosing. It was too general. I want to know the specific cause. If there is any special method to find the real cause, I would like the doctor to inform or offer me. Or if there is no any special method, I need the information about how to prevent having miscarriage again. (M08, p.37) *But right now what I need to know and care for is the causes of the miscarriage. If I know exactly about it, I can prevent before or I can plan what I should do with my life about having a baby.* (M09, p.35)	The more informed she was about the procedure before having it, the less severe her emotional reaction would tend to be The information is the most important	The information is needed	Seeking information
The doctor helped me a lot to decide something. If my condition was not too severe to harm my life then I could delay curettage, I could then have enough time for preparing my mind. Could you please give me time to ease my mind. (M06, p.37) *I cried and cried because I was really extremely sad. A nurse tried to ask me with many questions, she said she needed my information to admit me to the hospital before doing curettage. At that time, I was not ready to say anything. If it was possible, let's wait until I felt a bit better, I would tell you more.* (M01, p.41) *When I knew the result, I felt depressed, I was very disappointed…I wanted to escape to stay silently with myself…What I need the most is a time to ease my mind. I need a private area to be alone or with my husband, only a short time to ease my mind. I don't like the bustling atmosphere in the hospital.* (M01, p.36) *…Although they (some nurses) didn't say anything about this but their behaviour presented what they thought. She asked me what I had done with my pregnancy and looked at me as if she didn't believe me. But when she knew my diagnosis, she took good care of me. What I needed when I was feeling frightened with my bleeding was caring behaviour. Why you didn't soothe me or concern about my feeling.* (M09, p.39)	Flexible intervention is necessary She felt dissatisfied with routine procedure without concerning her needs She needed caring behaviour from nurses to help her cope with the frightened situation	sympathy from healthcare staff is needed	Seeking emotional support