A Grounded Theory of the Transition from a High-Risk Pregnancy to Motherhood among Women in Northern Thailand

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Abstract: The transition to motherhood of pregnant women deemed to be of high-risk is a critical period in their lives. They may be confronted with the transition from a woman with a health condition or a healthy pregnancy to being pregnant with complications, and who requires professional and self-care to prevent harm or complications that may occur to both themselves and their fetus. This grounded theory study aimed to explore and develop a theory about the transition experiences from pregnancy to motherhood of such women in Northern Thailand. A purposive sample of 21 women with high-risk pregnancies from the antenatal clinics of two hospitals in Chiang Mai, Thailand were interviewed in-depth during December 2015-August 2016. Interview data were collected and analyzed using grounded theory methodology.

The core category that emerged from data analysis was *Struggling to have a healthy baby*. This transition experience during pregnancy consisted of three phases: Facing a high-risk pregnancy, Hoping for a healthy baby, and Facing the unexpected, and the women underwent many struggles to have a healthy baby. Our findings revealed significant cultural and spiritual beliefs and activities that the women engaged in to ensure a healthy pregnancy, such as eating and drinking traditional herbs, warding off evil, and praying. Midwives and other health care providers can utilize our findings to have a deeper understanding of such women's feelings, concerns, and strategies to provide comprehensive care for them. They can provide support and encouragement, information about a high-risk pregnancy and its management, and quality nursing care that promotes a good transition experience during pregnancy in this group.

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Introduction

A high-risk pregnancy (HRP) jeopardizes the health and safety of both mother and infant[1] as it is the main cause of maternal morbidity and mortality.[2,3] According to the World Health Organization, about 808 women die daily due to complications of pregnancy and childbirth.[4] For infants, HRP contributes to a higher incidence of prematurity,

congenital defects, death at delivery, and learning disabilities in later infancy and childhood.[3] Estimates of the global prevalence of HRPs range from 20-50%, varying from country to country.[5] Increased numbers of HRPs imply a greater number of poor pregnancy outcomes.[3]

The transition to motherhood is a time of critical change in women's lives.[6] Women with a HRP are confronted with the transition from being a woman with a health condition or a healthy pregnancy to becoming a pregnant woman with complications. They face the same physiological and psychosocial changes during pregnancy as do women with normal pregnancy do, but also experience psychological stress, physical discomforts, and other various problems; and severe maternal complications may be life-threatening and end with mortality.[7] Psychological stress may involve feelings of vulnerability because of HRP, resulting in greater exposure to stressful feelings such as anxiety, low self-esteem, guilt, frustration, inability to function,[8] uncertainty in maintaining pregnancy, loss of control, and hostility in HRP.[9] Maternal psychological functioning also influences heart rate and motor activity of the fetus.[10] Mothers with HRP can also have parental attachment issues and a lower accomplishment of pregnancy tasks.[8] They may need more time to adjust to their pregnancy and the situation of being at high-risk, and more time to express feelings to support others. These factors indicate the need for extra vigilance.

Most of the knowledge on the transition to motherhood in HRP women was developed from studies of Western women's transition experiences.[11-15] In Thailand, no studies have specifically explored HRP transition experience although there are studies about the experiences of normal pregnancy and teenage pregnancy.[16-18] Since a transition experience differs according to social and cultural traditions and processes, the knowledge developed based on Western women's HRP experiences may not apply to northern Thai women with HRP. Moreover, the transition experience in HRP may be different from teenage pregnant women. Therefore, the transition experiences of women with HRP in northern Thailand is an area requiring research for there is a rising number of such women in this region with possible health complications for both mother and child. For example, a university hospital in northern Thailand reported increasing yearly proportions of pregnant women identified with HRP and complications relative to the total number of pregnant women: in 2017 (69%), 2018 (75%), and 2019 (84.9%).[19-21] Pregnant women require advanced diagnostic investigation and nursing care, thus, it is necessary for nurses to have a deep understanding of this group of people and to develop some theory about this that can be further researched. Since the transition experience during pregnancy is a significant period for women, health care providers should understand this well, and provide specific quality nursing care.

Study aim

To explore the transition experience during pregnancy of women with HRP in northern Thailand

Theoretical framework

Symbolic interaction (SI) is a philosophical orientation underlying grounded theory (GT),[22] and formed a part of the theoretical framework of this study. Symbolic interactionism seeks to understand how participants' behaviors are shaped through social interaction in particular contexts.[23] People learn the meanings and symbols essential for expression of thoughts through social interaction, and they modify these meanings and symbols in their situation interpretation.[24] An exploration of the transition experience during pregnancy among women with HRP needs to describe their behaviors and the

meanings they ascribe to their experiences. Symbolic interactionism has good capability to extend the exploring of the transition process among such women by learning of their lived experiences shaped by social interaction in their daily lives.

Methods

Study Design: A qualitative study employing grounded theory

Sample and setting: A purposive sample of 21 northern Thai women with HRP were recruited from the antenatal clinics of two hospitals in Chiang Mai, Thailand. The inclusion criteria were pregnant women aged 20 years or older, expecting the birth of their first child with a single pregnancy, and having been diagnosed with HRP due to either medical or obstetrical complications.

Ethical considerations: This study was approved by the Research Ethics Committee, Faculty of Nursing (study code: FULL-057-2558) and Faculty of Medicine (study code: NONE-2558-03524), Chiang Mai University, Chiang Mai, Thailand. All informants were invited to participate after receiving information on the study purposes, procedures, risk, and benefits of participation. They were given opportunities to ask questions and could withdraw from the study at any time, and all signed a consent form. Their confidentiality and privacy were protected throughout. All information about the participants will be destroyed in five years.

Data collection and analysis: Data were collected during December 2015-August 2016 by in-depth interview using an interview guide and theoretical sampling techniques. Each interview began with initial broad, open-ended questions, such as "How do you feel about being a pregnant woman with complications?," "Tell me about changes in your life when you found out you had a complication?," and "What do you do to get through such complications?" The interview guide was modified more specifically according to the emergent findings. During the interviews, the researcher encouraged them to clarify and elaborate the details of their experiences by probing techniques or focus questions (e.g. "Could you explain what you mean by...?," "Could you tell me why...?," and "When was that?"). Recruitment was stopped when the emerging data became redundant and substantive theory was completed. For theoretical sampling, the researcher recruited more informants based on the emergence of categories and their properties. Voice recording was used with participants' permission and was conducted by the researcher in Thai. Each participant was interviewed 1-3 times and each interview lasted approximately 45-65 minutes. All participants preferred to be interviewed in the antenatal clinics.

The data analysis process was conducted according to Glaser's techniques and procedures for developing GT and was undertaken concurrently with interviewing. The interviews underwent transcription, then were open-coded line-by-line. The participants' actual words were used in labeling the codes to ensure that the concepts identified from the data accurately represented participants'intended meanings, and the differences and similarities of data were examined and compared. Codes were repeatedly grouped and compared until the concepts pertaining to a similar incident were re-grouped and conceptualized into a category. Each category was further compared with others, as well as their properties, until the main concern among the participants was identified as the core category.

Findings

There were 21 women with HRP, and their demographic characteristics are listed in **Table 1.**

Table 1 Demographic characteristics of participants (N=21)

Characteristics	Number
Age (years)	
20-25	7
26-30	7
31-35	6
> 35	1
(Range = 21-42 years, Mean = 29.10, Standard deviation = 5.00)	
Religion	
Buddhism	20
Christian	1
Duration of marriage (years)	
1-5	15
6-10	6
Education level	
Secondary school	3
High school	2
Primary vocational certification	1
High vocational certification	2
Bachelor degree	13
Occupation	
Employee	11
Government officer	2
Own business	6
Housewife	2
Family monthly income (baht) (US$)	
< 10,000 (US$321)	1
10,001-20,000 (US$322-$642)	9
20,001-30,000 (US$643-$964)	5
30,001-40,000 (US$965-$1285)	3
> 40,000 (US$1286)	3
Type of family	
Extended	14
Nuclear	7
Type of pregnancy	
Planned	10
Unplanned	11
Gestational age (weeks)	
28-36+	16
37-42	5
Medical complications	12
Thyroid dysfunction	4
Thalassemia	1
Heart disease	2
Hypertension	3
Systemic lupus erythematosus (SLE) with Evan's syndrome	1
Epilepsy	1
Obstetrical complications	9
Gestational diabetes (GDM)	5
Pregnancy-induced hypertension (PIH)	3
Polycystic ovary syndrome	1

Data analysis revealed that the essence of the transition experience of the northern Thai women with HRP was the core category of *Struggling to have a healthy baby*. This process comprised three phases: *Facing a high-risk pregnancy*, *Hoping for a healthy baby*, and *Facing the unexpected*. In each phase, the women applied different strategies to have a healthy baby. (Figure 1)

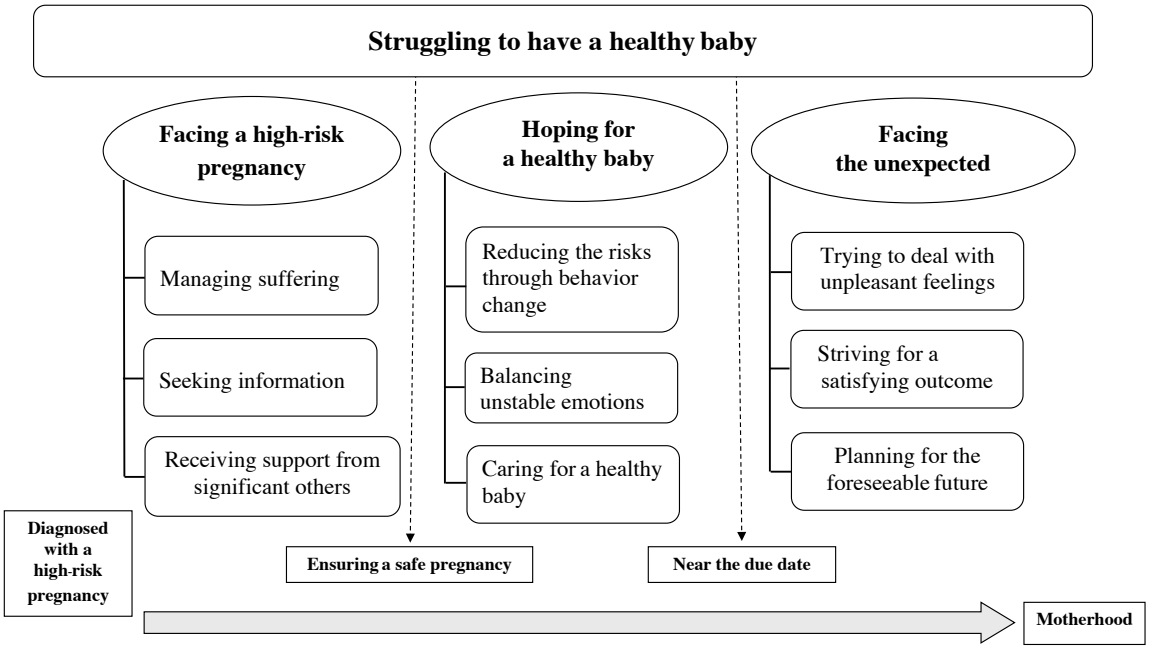

Figure 1 The transition experience of *Struggling to have a healthy baby*

Phase 1: Facing a high-risk pregnancy

When diagnosed with having a HRP, the participants were confronted with feelings of suffering, including fear, stress, and anxiety. Most of this psychological suffering was about whether their baby would acquire the disease like themselves; whether the disease or the drugs might affect their baby's development; or whether it would cause miscarriage, abortion, harm and be unhealthy for their baby, or may even cause death.

> *I feared that my baby would be diabetic like me. The doctor said that the limbs might be disabled or abnormal. If he had diabetes he might have problems with his organs. I feared that his limbs might be disabled, and he could not live like others.* (C9)

> *I feared that my disease would affect my baby. It was like blood disease, I feared that my baby would be pale and have anemia because she got it from me.* (C14)

There were ten women with a planned pregnancy and 11 with an unplanned pregnancy. Most in the unplanned pregnancy group could accept and decide to continue their pregnancy after becoming pregnant and being diagnosed as high-risk. The feelings of suffering in both planned and unplanned pregnancy groups were not different. They were concerned about the health of their baby, about whether the disease might affect their baby and result in miscarriage.

> *At first, I thought what should I do? My disease would affect my baby and I feared that my baby was unsafe and might be aborted.* (C12)

In this phase, they used three strategies described below:

Strategy 1: Managing suffering

At first, upon diagnosis with HRP, participants were worried and anxious about the well-being and the health of their baby. They rushed to see the doctor for antenatal care in the early stages of their pregnancy. They consulted doctors about the problems, who provided them with some advice to help them feel better and relieved. Sometimes they released their feelings of suffering with intimates, particularly their husbands, mothers, and close friends. They tried to calm down or relax in order not to worry about the problem. They did not want to be stressed or take it too seriously. Instead, they opted to do some relaxing activities such as listening to music, singing, playing mobile games, watching television, surfing the Internet, traveling, performing daily life activities or sleeping because they did not want their disease to recur. Additionally, they used Buddhist methods such as praying and meditation, which helped them to calm down and feel happy.

> *At first, it was stressful …worried more than stressed. Ah, … would my baby be healthy? After seeing the doctor, I got advice and I read it … then, I was happy. When I had something of concern, I would consult a doctor … I tried not to be too stressed. Singing, praying, and performing daily life activities. I tried not to think of anything … consult a relative near my home.* (C16)

> *Do not think too much. Good mood at first, otherwise, the pressure would be high. If I got easily irritated, the pressure would be rising. We are also afraid of a toxic pregnancy. The doctor told me not to stress too much. Whatever the child will be, we are afraid. We tried not to be worried. Sometimes I would play mobile games, and call someone to relieve the stress … sometimes I would go to the temple, sit in a quiet place. It made me calm down.* (C10)

Strategy 2: Seeking information

All of the participants were first-time expectant mothers who lacked knowledge of what to do for their healthy baby and with their diagnosis of HRP. They needed more information about their pregnancy (e.g. how to care for baby's health and how to behave or act) and about the diseases, drugs, and childbirth. They sought information by consulting, searching, talking, asking, watching TV, and reading. They received information from many sources such as the Internet, physicians, people with similar diseases, nurses, acquaintances, mothers, antenatal pamphlet, leaflets, television, and books. The findings showed that most of them were searching the Internet for information and liked to ask or talk to their doctor.

> *I 'd be looking for information, searching the Internet to find out about the result of my illness, and what I shouldn't eat or do. I consulted doctors about changing the time to take the medication.* (C1)

> *I checked the Internet. I found out about someone with this disorder, what kind of symptoms they had, and how they were. I asked my brother-in-law who was a doctor, my husband, a friend, and someone with this condition.* (C8)

Strategy 3: Receiving support from significant others

The support of significant others made them feel better and have good transition experiences to motherhood. They received emotional, informational, and instrumental support from their husbands, mothers, fathers, relatives, and friends. These significant people would take care of their discomfort, providing them with anything they wanted to eat, consoling and motivating, and not allowing them to do anything other than resting.

At first, it was stressful. I couldn't sleep. I was motivated by the people around me. My family and my husband talked to me; it made me feel good. ... My husband has given me support. My mother told me I should rest in the afternoon and not walk a lot. My husband said I shouldn't walk a lot and I need to be more careful. He comforted me. He said I've maintained it (the pregnancy) this far. However, the doctor was going to support me by telling me that the doctor is here and it's fine. (C2)

When my husband's mom cooked, she had to make a dish for me that did not contain monosodium glutamate or seasoning powder. She and my husband had another pot. She was worried about me. If she didn't care about it, she wouldn't do it for me. (C10)

Ensuring a safe pregnancy

Participants would feel assured about a healthy baby and a safe pregnancy if they went to the doctor regularly and got reassurance about their baby and their health. They also believed that their diseases were in stable condition, so this impacted on the transition to motherhood into the next phase.

My blood pressure was stable. My body was okay, so I was okay ... So, I was satisfied, although my blood pressure was a little high, I could get it... But now it is stable ... The doctor told me that my baby was healthy. I felt that my baby had good movement and is healthy, I'm okay. This means that when my blood pressure was okay, I was okay. I felt so good. (C5)

Phase 2: Hoping for a healthy baby

In this phase, the data revealed that participants were trying to do everything they could to have a healthy baby. They might change their behavior by doing something they did not want or stopping doing something they liked. They had to manage their unstable emotions. Additionally, they had to find out how to take care of themselves and their baby to be healthy, using three strategies described below:

Strategy 1: Reducing risk through behavior change

The participants tried to change their behavior in many ways to not only promote the health of their baby but also to reduce potential risks to their baby. They changed their eating pattern and the kind of food by consuming the recommended foods and avoiding prohibited foods. They became more careful about a lot of things such as exercise, sleeping early and more sleep, having no sexual intercourse, and planning on spending. Besides, they had to find out how to take care of their baby's health.

I cut down on eating rice. Sometimes, I bought five baht of rice for two meals. Previously, I didn't know. I ate sticky rice and then my blood sugar increased. Doctor told me to reduce sweet fruits and change to eat the brown rice. Every time, I liked to eat some fruit after a meal. Now I have changed from drinking sweet milk to fresh milk. I should select to eat of useful food. I had to stop eating snacks and take a lot of calcium, milk, and eggs. (C9)

I sleep more and more because I fear that my baby would lose oxygen. If I did not have enough rest, I might become pale, have low oxygen, and my baby would receive less oxygen. (C7)

Strategy 2: Balancing unstable emotions

The participants encountered mood swings, especially in the early stages of their pregnancy. They had unstable emotions without any causes, but some people believed that it was caused by their pregnancy. These unstable emotions included being edgy, moody, testy, furious, variable, and petulant. They used strategies of balancing unstable emotions, including trying not to get too stressed, feeling optimistic, trying to joke or stay in a good mood, chilling out, calming down,

relaxing, listening to music, eventually praying and meditating.

> *I was trying to have a good mood. When I was so mad, I tried not to be too intense, and at the same time, I tried not to be stressed or frustrated. I have a positive thought that my child should be born healthy and have a pleasant temper.* (C5)

Strategy 3: Caring for a healthy baby

The participants wanted to do whatever they could to have and care for a healthy baby. They always followed-up on a doctor's appointment for fetal monitoring and did everything following medical advice.

> *The doctor set fetal monitoring appointments every week because I was at high-risk, so I had to monitor well-being, heart rate, and the health of my baby. I have never missed an appointment.* (C1)

> *In the morning, I did my daily life activities. I drank milk, and in a few moments, I had breakfast, took medicine, and took my blood pressure to see whether the blood pressure was normal or high. I had to control my blood pressure so it didn't rise. I didn't want to worry much about it, and I had to follow the doctor's advice.* (C10)

Also, participants tried to follow traditional Thai beliefs about the Do's and Don'ts for pregnant women to protect their babies from harm. The Do's include eating foods for a smooth delivery, for example eating 'slippery' vegetables such as *phak pung* or drinking coconut juice that is believed to make childbirth easier. Moreover, bathing with herbs or walking past a *phak dtam-leung* helps to give birth easily. (This is a snare made from a plant, ivy gourd, used to trap animals).

> *They said the pregnant women were supposed to eat phak pung as it was good and it helped to give birth easily.* (C16)

> *Drinking coconut juice. ...they said that drinking it would help to make your childbirth easier, as the baby's body had a lot of lipids.* (C19)

Moreover, the participants were always worried about the health of their baby and themselves. They sought traditional care, such as herbs and supplements, which they believed would allow them to control the disease and result in healthy babies. They believed that blood pressure could be lowered by eating certain herbs such as phakonkum (moringa gymnema), chengda (sylvestre), and bibaubok (centella asiatica). Someone participants believed that they should find out about some supplements or extra nourishment for their baby. One woman thought that algae oil could help the baby's well-being as it has docosahexaenoic acid or DHA (an essential fatty acid in the Omega-3 group that can be obtained from eating cold-water, deep-sea fish).

> *I ate a lot of phakonkum curry (curry with moringa), I cooked phakonkum with chengda vegetables (gymnema sylvestre). Many people with high blood pressure said they didn't want to take medicine because they thought that it had side effects. They thought that if they had to take medicine all their life, they would seek the folk medicine or eat fruit. They said they were supposed to eat bibaubok. I bought bibaubok and brought it to the blender and filtered it for drinking. I put some honey or boiled water in it, and I drank for 7 days.* (C10)

> *So, I went to a doctor's office to see if there is any supplement. Can I eat some fish oil? She said that it would be risky for it was a mercury hazard. The doctor told me to eat algae oil. It*

had DHA. It helped me sleep easily, and it was my baby's nourishment. (C16)

Participants also believed that wearing a brooch could help protect them from ghosts or evil things that could harm their baby. However, sometimes this was used as a symbol that others could see, so they could avoid bumping into them as pregnant women.

On some of my dresses I wore a brooch. Brooch wearing protects against ghosts. I didn't want to get scared when I was pregnant, so I would take a brooch to protect myself from evil things (C17)

Further, some participants believed in praying, paying respects to monks, listening to sermons, and doing a lot of philanthropy or merit-making. They felt that if they did that, it would enable their baby to be healthy, ordinary, easy to rear, and become a good child.

I tried to pray, pay respects to the monks, offer food to the monks, and make a lot of merits. These made my baby healthy and normal. (C16)

While the participants believed that following certain traditional Thai rituals could be useful for their baby and themselves, some could not undertake these because they thought they might affect their disease or their baby.

My colleague told me that eating slippery food made delivery easier. There are various beliefs about this. My mother wanted me to drink a lot of water, while someone wanted me to drink a lot of coconut juice, but I couldn't drink too much of it because I am diabetic. (C9)

They had several other beliefs that could be harmful to their babies or affect the well-being of their pregnancy, such as taking a bath late at night, chopping a coconut, hammering nails, mistreatment of animals, and not preparing baby clothes and others.

Upon sunset, do not take a bath. If I want to take a bath, I'll have to do so in the daytime when it's still light or after 8 pm. If during the sunset, they said that it was about amniotic fluid. (C16)

They believed that I should not chop a coconut because the baby would have a big head like a coconut. Nor should I hammer nails. I did not know why. It might be difficult to give birth because the baby has a big head, something like that. (C1)

Near the due date

When the participants were assured of a healthy pregnancy, they tried to do whatever they could to adjust themselves for the well-being of their babies. They realized that their due date was approaching, around one month before delivery. The second phase passed and the third phase was about to start.

Phase 3: Facing the unexpected

This phase began when participants realized that their pregnancies were approaching their due date. They used three strategies described below:

Strategy 1: Trying to deal with unpleasant feelings

For them, it was time to return to face unpleasant feeling again. They feared or were worried about the baby's health, the delivery, and their stubborn or chronic illness. They feared that the baby might have low birth weight, and be small in size, deformed, abnormal, premature, or dead. Moreover, they were worried and feared about the delivery in terms of a membrane rupture, labor pains, cesarean section, and recovery after cesarean section. Finally, they feared that their stubborn illness or their diseases could not be controlled, and the complications during labor such as ovarian cyst rupture, induced hypertension, and even epilepsy or shock. They used strategies

including consulting with doctors and expressing their unpleasant feelings to intimates.

> *It was approaching my due date, so my illness may have an effect on my kids. I was so nervous and anxious that I couldn't handle it. I thought that if I had a cesarean section, it would be safe for both the mother and the baby. So, I discussed with my husband, and I believed the doctor because if it really wasn't possible to have normal labor, the doctor would have a cesarean section for me. I didn't care whether it's natural or cesarean section. I wanted my child to be safe. I thought so much about my baby and childbirth. I've been worrying about the labor too, ...like what complications are there? At first, I wasn't worried, but the due date was approaching this time. My illness could be recurring at this time. I need to observe myself a lot more. If I have a cold, I needed to go to the nearest hospital.* (C14)

Strategy 2: Striving for a satisfying outcome

The participants realized that they might face unexpected outcomes and unpleasant feelings again, so they attempted to do everything for a satisfying outcome. They changed the behavior they had ignored and went back to practicing it strictly. If they had a problem with their baby's health, they would consult doctors about the problem, and would regularly and strictly follow up on doctor's appointments. In the past, they often neglected to take their medications, but they were now taking their medications strictly daily. They had periods of fasting in the past, but now they had every meal on time. They ate eat even though they did not feel hungry or ate foods they did not like. For example, a participant was diabetic and required injections. Although she was terrified of needles, she had them for her baby's health. Some checked their blood pressure at home every day as they were worried that this would rise and develop into preeclampsia.

> *Now I was afraid because the doctor said that my blood pressure could go up, always in the last trimester. I tried to measure it at home every day. The doctor was worried and afraid ... pre-eclampsia. At home, I would take blood pressure measurement ... every day.* (C5)

> *The doctor said that my baby could be two kinds. If he was not a small size, he might be a big size. I feared both of them, so I need to control my diet and not forget to get injections. I did not want to get injected. I'm scared of needle injection, and I feel nervous, but I had to do it. Even when I like to eat something, I did not eat it for my baby. I was diabetic. I did not eat sticky rice, sparkling water, tea, and coffee.* (C18)

Strategy 3: Planning for the foreseeable future

They planned for the foreseeable future during this phase, such as preparation for labor, and planning on giving birth, for the cost, and the postpartum period.

Preparation for labor: They believed they might face membrane rupture, labor pain, emergency birth, and their chronic illness, or uncontrolled diseases so they prepared for labor in the event of these emergencies. They also visited an antenatal care clinic near their home, moved to Chiang Mai when the due date was approaching and went to the nearest hospital when having labor pain,

> *At first, I would give birth in Mae Taeng because of the distance and the care during admission. It's near my husband's house. After I talked to my husband about my diabetes, it was better to give birth here (hospital A). The history of treatment, antenatal care, and necessary medical care are all there. My husband said okay and I would go to my husband's house after birth.* (C9)

Planning on giving birth: Even though the participants did not know how to give birth or when to give birth, some of them still decided to give birth naturally because they wanted to experience how painful the labor would be. They believed that regular labor was safer for the baby's immune system and well-being, less painful, shorter in the recovery period and wound healing, and less expensive. In contrast, some of them thought they had a disease, so a cesarean section would allow both them and the baby to be safer than with vaginal delivery.

> *I read the book, which said that the baby with normal labor would have better immune, be healthier, and mother's wound would be faster to heal. I wanted my baby to be healthy, so I wanted to give birth by myself. My husband wanted me to have a cesarean section because he said that I was a small woman, so he was afraid that I could not give birth on my own. I asked the doctor, and he said that it was possible for me to give birth naturally.* (C11)

> *I was worried because I had high blood pressure. If I gave birth by myself, will that be dangerous? Will a cesarean section be better? However, when it was close to the due date, I would consult the doctor again, whether I should have a cesarean section or whether I should give birth on my own.* (C5)

Planning for the cost: They thought about saving, seeking financial support, social security contributions, or the universal health coverage program for their baby and labor.

> *The cost of delivery, I already prepared for that. I had a little problem. I might save and use social security benefit. If it isn't enough, I would like our relatives to help me.* (C16)

Postpartum planning: They planned about child-rearing, breastfeeding, and following traditional Thai practices. Most thought that they would take care of the baby, but some participants would do this for the first three months. Afterwards, their mother or other relatives would babysit, because the women had maternity leave for only three months.

> *I plan to leave the work three months for rearing my baby, and after that, my mother will take care of my baby. My mother will care for my child during the daytime, and when I return from work, I will do it in the evening.* (C7)

Most of the participants intended to breastfeed as much as possible or until they could not. They believed that breast milk was the best; it had more immunity than formula milk, and breastfeeding could save money. They thought if they had more milk, they would continue breastfeeding, and when they had to go back to work, they would express their milk by hand or using a breast pump to keep milk for their baby, however some thought that they would feed their baby with formula milk when returning to work, and they would breastfeed after work.

> *However, I intended to breastfeed for at least one year, as I find that breastfeeding is the best thing for baby, so I will attempt to keep my baby breastfeeding as long as possible. Every time I go to work, I will pump and freeze it because I can keep the milk frozen in my office.* (C14)

They planned to follow traditional Thai beliefs that were relevant to the Do′s for postpartum women. A Northern Thai traditional belief during the postpartum period is called *u-deaun* or *u-fire. U-deaun* includes actions such as not going out, keeping the body warm all the time, dressing properly, wearing helmets, long sleeves, socks and gloves, and not using any perfume. New mothers should not be exposed to cold air, nor should they wash their hair because it could make them unhealthy. They should take a bath

with warm water or herbs, and eat hot and bland food. They should not eat forbidden food, such as spices or foods with a strong smell. If they did some forbidden actions, something bad might happen, and this is called *pid-deaun*. The example of *pid-deaun* was when they got cold and seemed to shiver into their bones. The duration of *u-deaun* or *u-fire* depends on the child's sex. If their child was male, they might *u-deaun* for about a month, but if female, they might *u-deaun* for more than a month.

> *After the birth, I would u-deaun. ...did not go anywhere, put on socks and gloves, covered up with dress during the u-fire period, and not eat the prohibited foods.* (C2)

> *After birth, I had to u-fire in herbal steam. I did not eat fish without scales or catfish. It was a belief that I should not eat spicy but bland food, and I should drink warm water.* (C5)

> *After birth, I had to u-fire. ...did not get exposed to the cold because it would make my body unhealthy. ...yin-yang would be imbalanced. The body elements would be imbalanced, so I had to adjust the body first because next, you would feel chilled into the bone. It was called pid-deaun.* (C8)

Discussion

The finding of this study, Struggling to have a healthy baby, was the basic social process that described the transition experience of Northern Thai women with HRP during pregnancy period. It was based on the perspective of symbolic interaction to interpret the behavior and the meanings have been formed through social interaction which women with HRP gave to their experience within the context of Northern Thai society. Throughout their pregnancy period, they perceived that they were abnormal, requiring specific care to prevent harm or complications that might endanger their health and their baby. They were concerned about this, and needed a healthy baby, as a result, they tried to do everything focusing on their healthy baby.

At first, the participants perceived that their pregnancy had been diagnosed as high-risk. They underwent a developmental transition and were also confronted with health conditions and disease transitions at the same time.[25] They moved from being a woman with a health condition to being a pregnant woman with complications, that required specific self-care to prevent harm or complications that might endanger their health and that of the fetus, and they had to take medicine. They knew that both their illnesses and drugs could affect their baby, leading to anxiety about their baby's health, fearing harm and that the effects of their disease or drugs might even cause death. Similar to the findings of Pilaikiat and Lamloung,[26] the major emotional impacts included feeling frustrated that a high-risk to their pregnancy had occurred, fearing that their baby and themselves would be harmed, difficulty and limitations in living, and feeling unsure about pregnancy outcomes.

The participants used the strategies of managing suffering, seeking information, and receiving support from significant others to handle their feelings and concerns in this phase. They employed diverse methods to deal with feelings of suffering[28] and multiple sources to seek information. They used the information gained from professionals, laypeople, and media sources in assessing their degree of risk, and followed the advice of healthcare professionals because they thought this was best for themselves and their infants' health.[27-29] This occurred in an era of digital communication where access to data can be done easily and quickly via their mobile devices. However, most information needed by the participants was related to complications of pregnancy, investigations, and follow-up visits to physicians, appropriate diet and information about medication and supplements.[30] They received emotional, informational, and instrumental support especially

from their husband, mother, father, relatives and friends that helped them feel better.[26,31]

They were assured by a physician that their pregnancy, and thus baby, were well and safe and they felt that their diseases were in stable condition, so this gave them reason to move to the phase of Hoping for a healthy baby. They attempted to do everything they could to have a healthy baby. They changed their behavior and lifestyles, which often meant doing something they did not like or to stop doing something they liked.[16,32] They had to manage their unstable emotions to care for themselves and their baby's health. Moreover, Buddhist perspectives strongly influenced their beliefs and the strategies that they used to manage their concerns. This study also found that traditional pregnancy and childbirth beliefs and practices have generally been passed on from between mothers and daughters, or mothers-in-law and daughters-in-law, across generations of women from northern Thailand. Participants followed these traditional beliefs because they believed that these would ensure the health of the pregnancy and protect babies from risk.[33,34]

Finally, facing the unexpected phase began from when they realized that their pregnancy was close to the due date, and they were once again confronted with unpleasant feelings. They dealt with these by consulting with doctors about their issues and expressed these to significant people in their lives. They were women with a HRP who knew that their disease might recur or be out of control near the due date, and which might harm their baby's health and themselves.[35] The best practices that would make their illness stable were also good for their health and that of the baby. They attempted to do everything for a satisfying outcome by changing their health behaviors. They had plans for the foreseeable future such as preparation for labor, for associated costs, and the postpartum period.[16] The majority of women considered the mode of birth would be based on their needs and the complications associated with maternal illness were very influential in their decision-making processes.[36]

Conclusions and Implications for Nursing Practice

This study provides new knowledge that focuses on exploring, transition experience during pregnancy of Northern women with HRPs. Based on the understanding gained from this study, nurses can assess women with a HRP, plan appropriate strategies with them, and design an appropriate nursing plans with them. Our findings were rich regarding the influence of spiritual, religious and traditional beliefs of Northern Thai women, and add to nursing knowledge about this little researched area about women with a HRP. From their transition experiences, Struggling to have a healthy baby emerged as the core category. This was a process of three phases: Facing a high-risk pregnancy, for which they used the strategies to manage suffering, seeking information, and receiving support from significant others to manage their feelings and concerns in this phase; Hoping for a healthy baby with three strategies that they used the strategies of reducing risk through behavior change, balancing unstable emotions, and caring for a healthy baby; and Facing the unexpected with three strategies including trying to deal with unpleasant feelings, striving for a satisfying outcome, and planning for the foreseeable future. A greater understanding of the feelings, concerns, needs, strategies, and efforts to do everything to have a healthy baby of women with HRPs will help midwives and health care providers render and facilitate information about the HRP problem and its management, and quality of nursing care that promotes a good transition experience during pregnancy in this group.

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การเปลี่ยนผ่านจากสตรีที่มีการตั้งครรภ์เสี่ยงสูงสู่การเป็นมารดาของสตรีที่อาศัยอยู่ทางภาคเหนือของประเทศไทย: การศึกษาโดยใช้การสร้างทฤษฎีจากข้อมูลพื้นฐาน

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บทคัดย่อ: การเปลี่ยนผ่านสู่การเป็นมารดาของสตรีที่มีการตั้งครรภ์เสี่ยงสูง ถือเป็นช่วงวิกฤตของชีวิตช่วงหนึ่ง เนื่องจากสตรีตั้งครรภ์ต้องเผชิญกับการเปลี่ยนผ่านจากสตรีที่มีภาวะทางสุขภาพหรือสตรีตั้งครรภ์ปกติไปสู่สตรีตั้งครรภ์ที่มีภาวะแทรกซ้อน ผู้ที่ต้องการการดูแลตนเองและการดูแลจากผู้เชี่ยวชาญเพื่อป้องกันอันตรายหรือภาวะแทรกซ้อนที่อาจจะเกิดขึ้นกับตนเองและทารกในครรภ์ การศึกษาวิจัยครั้งนี้มีวัตถุประสงค์ เพื่อศึกษาและพัฒนาทฤษฎีเกี่ยวกับประสบการณ์การเปลี่ยนผ่านในระยะตั้งครรภ์สู่การเป็นมารดาของสตรีที่มีการตั้งครรภ์เสี่ยงสูงที่อาศัยอยู่ทางภาคเหนือของประเทศไทย โดยใช้วิธีวิจัยแบบการสร้างทฤษฎีจากข้อมูลพื้นฐาน (grounded theory) ผู้ให้ข้อมูลเป็นสตรีที่มีการตั้งครรภ์เสี่ยงสูงที่มารับบริการที่หน่วยฝากครรภ์ของ 2 โรงพยาบาลในจังหวัดเชียงใหม่จำนวน 21 ราย ซึ่งได้จากการคัดเลือกแบบเฉพาะเจาะจง (purposive sampling) และถูกสัมภาษณ์แบบเจาะลึกในช่วงเดือนธันวาคม พ.ศ. 2558 ถึงเดือนสิงหาคม พ.ศ.2559 ข้อมูลการสัมภาษณ์ถูกเก็บรวบรวมและวิเคราะห์ตามวิธีวิจัยแบบการสร้างทฤษฎีจากข้อมูลพื้นฐาน (grounded theory)

ผลการศึกษาพบว่า “การพยายามต่อสู้ เพื่อให้บุตรมีสุขภาพดี” เป็นประสบการณ์การเปลี่ยนผ่านที่ได้มาจากข้อมูลหมวดหมู่หลัก กระบวนการนี้ประกอบด้วย 3 ระยะ คือ ระยะที่ 1 การเผชิญหน้ากับการตั้งครรภ์ที่มีความเสี่ยงสูง ระยะที่ 2 การคาดหวังให้บุตรมีสุขภาพดี และ ระยะที่ 3 การเผชิญกับผลลัพธ์ที่ไม่สามารถคาดเดาได้ ตลอดประสบการณ์การเปลี่ยนผ่านนี้สตรีตั้งครรภ์เสี่ยงสูงจะมีการใช้หลากหลายกลวิธีเพื่อช่วยให้บุตรมีสุขภาพดี ผลการศึกษาแสดงให้เห็นถึงวัฒนธรรม ความเชื่อด้านจิตวิญญาณ และการปฏิบัติที่สตรีตั้งครรภ์เสี่ยงสูงนำมาใช้เพื่อนำไปสู่การตั้งครรภ์ที่มีสุขภาพดี เช่น การรับประทานและการดื่มสมุนไพร การปัดเป่าความชั่วร้าย และการสวดมนต์ เป็นต้น พยาบาลผดุงครรภ์และบุคลากรทางการแพทย์สามารถนำความรู้ที่ได้จากการศึกษานี้ ใช้เป็นข้อมูลพื้นฐานที่จะช่วยให้เข้าใจอย่างลึกซึ้งถึงความรู้สึก ความห่วงกังวล ความต้องการ และกลวิธีต่างๆที่สตรีเหล่านี้นำมาใช้เพื่อให้บุตรมีสุขภาพดี สามารถให้การสนับสนุนและให้กำลังใจ ให้ข้อมูลเกี่ยวกับปัญหาและการจัดการกับปัญหา รวมถึงนำไปใช้ในการวางแผนการพยาบาลอย่างเหมาะสมที่จะช่วยส่งเสริมให้เกิดประสบการณ์การเปลี่ยนผ่านที่ดีในระยะตั้งครรภ์ของสตรีไทยในภาคเหนือที่มีการตั้งครรภ์เสี่ยงสูง

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คำสำคัญ: ประสบการณ์ การสร้างทฤษฎีจากข้อมูลพื้นฐาน ภาวะเสี่ยงสูง พยาบาลผดุงครรภ์ การพยาบาล การตั้งครรภ์ เชิงคุณภาพ ทฤษฎีปฏิสัมพันธ์เชิงสัญลักษณ์ การเปลี่ยนผ่าน

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