# Making Amends for Wrongdoing: Thai Women Coping with Pregnancy Termination

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**Abstract:** Pregnancy termination occurs in many countries but without medical indication is morally, socially, and legally disapproved in Thai society, and can lead to substantial mental health issues for the women involved. This qualitative descriptive research aimed to describe coping among the women who had experience in terminating their pregnancy without medical indications. Twelve participants, whose experiences ranged from 10 to 26 years and lived in Nakhon Nayok province, were purposively selected. Data were collected by in-depth interviews between January 2017 to January 2019 and analyzed using a narrative analysis technique. Trustworthiness was achieved through member checking, peer debriefing, and the researcher's reflexive journal. Data analysis revealed rich findings in three themes: *Suffering from wrongdoing, Making amends for wrongdoing,* and *Expecting support.* Suffering from wrongdoing included the feelings of being wrong, being haunted, and having failed in life. Making amends for wrongdoing included accepting one's wrongdoing, protecting self-values, seeking forgiveness from the deceased baby, as well as empowering oneself through learning from mistakes, not being stuck in the past, becoming stronger, and living life in a better way. The last theme, expecting support, included just understanding, men's sharing of responsibility, and restoration of body and mind.

Women who have experienced pregnancy termination have substantial long-term suffering to the point that they devote great time and effort to managing their mental health challenges. To enhance their healing process, their coping methods of making amends for wrongdoing should be enhanced, and the support they want should be provided from health care systems. Further research is needed to understand how accessible and gender-sensitive healthcare services are for such women.

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## Introduction

Globally, the rate of induced abortions is 35 per 1,000 women age 15-44 years.[1] About 25 million unsafe abortions have occurred every year since 2010, most in developing countries.[2] In Thailand, public hospital data indicates that each year approximately 30,000 abortions take place, yet most abortions are carried out in private sector facilities, in unmarked abortion clinics, or by self-induction; consequently, 300,000 to 400,000 abortions likely

to occur each year.[3] A survey in 787 government hospitals by the Department of Health, Thailand, found the morbidity rate at 40% of total abortions with the mortality rate of 300:100,000 abortions, indicating the tremendous public health problems of unsafe abortion in Thailand.[4]

Pregnancy termination without medical indications is illegal and strongly disapproved by Thai society. When an unwanted pregnancy is terminated, a woman is seen as violating the sociocultural norms of motherhood and legal regulations. These judgments are internalized by women who develop suffering and live with psychological pain in silence. A recent study revealed that social support helped the women overcome obstacles post-abortion, while insufficient support was experienced as an obstacle itself.[5] The unavailability of emotional support and mental care services lead to unfair treatment for women following pregnancy termination since these services respond only to the women's basic needs. This unfair treatment leads to women experiencing long-term suffering. Women who are known to have had an abortion, whether or not medically advised, are stigmatized. They report feelings of having sinned, having committed bad *karma*, and have consequent feelings of uneasiness,[6] shame,[7,8] and guilt.[8] In addition, women also reported anxiety[8-12] and grief.[13-16] Unfortunately women are likely to have suffered alone and recuperated by themselves because they feel they could not disclose their painful experience nor access mental healthcare services for fear of further stigma.

Women have used a variety of coping methods to deal with devastating feelings after terminating a pregnancy, and a wide variety of coping methods can be self-employed. Disenfranchised grief is one way to cope: it is grief over a loss that is not or cannot be acknowledged openly, mourned publicly, or support socially.[16] Avoidance or shame resilience might be used to cope with shame and stigmatization; it is a process that transforms an individual's ability to have strong and meaningful relationships with others.[17,18] Guilt from hurting their baby may be dealt with by repairing their mistakes with their aborted baby and future baby. Religious or morally focused coping, may be employed as well, especially in extremely stressful situations in which personal and social resources are limited.[19] Four existential strategies were found among 24 Swedish women who had induced abortion, including detachment, defining social, and symbolic strategies.[20] In terms of dynamic processes, three stages were found including surviving the struggle, beginning the process of healing, and becoming whole.[21]

In Thailand, it was found that after abortion women gave to philanthropic charities and gave devotion to their fetus to reduce their guilt and atone for their sin.[22] In miscarriage and therapeutic abortion, Thai women experienced a loss of hope, and gained emotional balance through self-motivation, a belief in *karma*, fulfillment of the obligations of being a good mother, and escape from unbearable memories.[23] These young women also needed information and emotional support. However, after an unsafe abortion, Thai women likely experience more stressful events than women with therapeutic abortion, but appear to not having been studied in-depth. Empathic understanding of coping from the perspective of woman's experiences is fundamental for helping the women go through their pain quickly. It also protects women from psychological illness.

Coping will be smoother and more effective if an individual has adequate coping resources. These are primarily the ability and resources of a person to handle stress, including health and energy, positive beliefs, social skills, problem-solving skills, material resources, and social support.[24] Support may come from organizations in terms of services provided by professional, trained employees, typically paid for their work. Informal support includes that provided by their partner, family, friends, colleagues, neighbors, and community members. A recent study revealed that

social support helped women post-abortion overcome obstacles, while insufficient support was experienced as an obstacle itself.[5] Women who had first-trimester abortions perceived high support from their partners, families, and friends, and had higher self-efficacy for coping, a trait that predicted better adjustment to abortion.[25] Social support provided by their partners was a key aspect in the psychological recovery after abortion, particularly for women with high coping resources.[26] A qualitative descriptive study with 12 Thai women with unwanted pregnancy termination and 11 partners found that they expected their partners to care for them in the following ways: 1) assisting with pregnancy termination, 2) not abandoning them, 3) affectionate caring, 4) reparation, 5) basic care needs, and 6) financial care.[27] However, coping strategies for managing the women's painful feelings were not a focus and the forms of support from family, friends, and health care providers were not explored. These issues need to be scrutinized to know how to enhance women's accessibility to coping resources. In addition, the aforementioned study indicated that the termination was a mutually gender-shared responsibility and male partners should provide various support to the women.[27]

The individual aspects of women's psycho-emotional responses and coping, and the broader aspects, in terms of sociocultural context, especially values on pregnancy and abortion, need to be taken into consideration on the psychological experiences of a woman with abortion.[28] A woman who regards abortion as conflicting with religious, spiritual, and cultural beliefs has a more stressful experience than a woman who does not regard abortion as contradicting her values or those of others in her social networks. In addition, the ideology of motherhood and nurturance are social controls aimed at preventing children's maltreatment by their mothers. As a mother, a woman is obligated to be morally right, behave with good manners, love and be kind to her children, and to exert all efforts to raising her children. Women's natural capabilities or maternal instincts are often demolished when they choose not to have a child or to have a child out of wedlock.[29] Empirically, a study in Chile revealed that women matured into "real women" through motherhood, and the anti-abortion debate was found to be strongly connected to the discourse on motherhood and the natural body.[30] Psychological care for women in Thailand undertaking illegal or unsafe abortions requires empirical evidence on how they cope with this and the support they need. Until this study, women's experience in coping after pregnancy termination had not been explored for deeper understanding in Thailand so this study was undertaken to try to address this gap of knowledge.

## Research question and study aim

The research question was: *"What is coping with pregnancy termination among Thai women?"* The study aim was to explore the pregnancy termination experiences of Thai women in terms of their life hardship. Understanding was sought of their capability to cope with difficulties after pregnancy termination and the support they received or expected to receive from lay people and health care providers.

## Methods

**Study design:** The experiences of Thai women in coping with pregnancy termination was undertaken using a qualitative descriptive approach. Qualitative descriptive research is practical and less interpretive than other qualitative designs. It does not require researchers to move as far from the obtained data. The findings are presented in everyday language, which hopefully is understandable and applicable among healthcare providers.[31]

**Participants and setting:** The setting for data collection was Nakhon Nayok province. A purposive sampling technique was used to recruit the participants. Inclusion criteria were Thai women aged 20-44 years old, who had terminated a pregnancy without medical indications at least 10 years previously for the most recent termination. The illegality of terminating a pregnancy without medical indication expires 10 years after the termination. The participants were initially approached by invitation letters and announcements in six hospitals. Verbal informed consent was obtained from all participants and recorded in the form with the signature of the witness.

**Ethical considerations:** This study was approved by the Research Ethics Committee of the Faculty of Nursing, Chiang Mai University, No. of IRB 012/2017. Permission to proceed was also obtained from the ethical committees of the selected hospitals. The researcher did not directly access confidential information of women from medical records. In terms of the method of distributing invitations letters or flyers to women in public and women who were admitted at postpartum units or those who visited outpatient units for follow-up, the researcher requested cooperation from nurses to give an invitation letter to every woman and recruited them this way. Sensitive information about pregnancy termination was not asked at that time. After the women agreed to participate in recruitment, the researcher contacted them and described the research objectives and procedures in person. Written information was also provided. Participants were informed of their rights to refuse certain questions and to withdraw from the study at any time, and so 13 women agreed to participate in the study, and only one woman withdrew from the study. All participants gave oral consent.

In-depth interviews were conducted in a private place, such as in the participants' homes or their cousins' homes without interruption to protect the participants' confidentiality and privacy. Confidentiality was assured to each participant by using code numbers on the interview transcripts. The audio recordings were deleted after the completion of the transcribing and participants' information was accessible only by the researcher. If any of the participants felt upset or uncomfortable, the researcher provided emotional support after each interview. Some appropriate and reasonable assistance was provided only when requested by the participants.

**Data collection:** Data were collected from January 2017 to January 2019. Each interview started by inviting the participants to tell their stories: "Please tell me your story about pregnancy termination." Probing questions, such as "How did you feel?," "What made you feel like that?," and "What did you do to get through it?" were used to obtain the breadth of interpretation and meaning or the complete description of the experiences. Reflexive questions were raised aiming to empower the participants to critically review their oppressive conditions, such as "What suggestions would you like to make to other women who have had similar experiences?" and "What support do women who had similar experiences deserve?" Each participant was interviewed 2-3 times, for 40-90 minutes. After each interview, field notes and reflexive journal were recorded.

**Data analysis:** Data collection and analysis were simultaneous. A narrative analysis technique was used and included 3 steps.[32] In the first step, to understand the literal meaning of the women's speech, the researcher read the transcripts and listened to the audio recordings at the same time to check the accuracy of individual transcripts. Codes were assigned to the women's meaningful narratives. The second step is the symbolic meaning. The researcher sought symbolic meaning concerning the reasons provided by the women for the occurrence or unique significance of the events described by the women the symbolic meaning. The last

step, the researchers' understanding of the sociocultural environment that connects themes across interviews or in the literature, was employed to describe the coping of the women. The women's narratives about their pregnancy termination experiences were comprised of all of the women's stories in the form of individual accounts. Next, the researcher simultaneously analyzed all of the codes and descriptions obtained from individual participants to determine common themes and structure in the participants' stories. As a means of focusing on the aforementioned narratives, the researcher classified the core data themes, namely, coping with pregnancy termination through making amends for wrongdoing.

**Trustworthiness:** The strategies to establish trustworthiness consist of credibility, dependability, confirmability, and transferability.[33] Concerning credibility, member checking and peer debriefing were performed; the former by reviewing the tentative findings and the later by having an expert and an advisory committee discuss and examine these. Dependability is reliant on the competency and ability of the researcher's methodological skills and data interpretations.[34] The researcher had practiced interviewing skills with qualitative research experts and analyzed data under the supervision of the advisory committee. Confirmability was achieved through a reflexive journal written situations, subjects, ideas, and conscious thoughts of the researcher to reduce bias during the data collection process and data analysis. In terms of transferability, a thick description of the findings was provided.

## Findings

There were 12 participants, 28-44 years old, living in Nakhon Nayok province. The majority were Buddhists. Three participants had a bachelor's degree, and the others had less education. All were employed and their average monthly income was 12,167 baht (range=5,000-30,000; equivalent to $US 156-937). Eight participants had insufficient incomes. Ten participants were married, two were divorced, and one was single. Seven participants had family members of 4-6 persons. Only one participant had no children. Nine participants reported that they had no illness whereas three participants reported physical illness. The detail is described in **Table 1.** Characteristics of individual participants are shown in **Table 2.**

Following pregnancy termination, the women developed long-term feelings of suffering from their wrongdoing. They liberated themselves through making amends for their wrongdoing by accepting their mistakes, protecting their self-values, seeking forgiveness, and empowering themselves. Religious beliefs and their family were the main sources of support. The women showed that they not only needed someone to comfort their regrets but also men's responsibility was supposed to be shared throughout the situation. Furthermore, health care services were addressed to be available for them to access. Themes and subthemes are summarized in **Table 3.** Participant identification is coded, for example, P9L36 refers to participant number 9, line 36 of their transcription.

**Table 1.** Demographic data of participants (n=12)

| Demographic Characteristics | n (Person) |
|---|---|
| Age (years) | |
| 20-30 | 1 |
| 30-40 | 5 |
| 41-44 | 6 |
| Nationality | |
| Thai | 12 |

**Table 1.** Demographic data of participants (n=12) (Cont.)

| **Demographic Characteristics** | **n (Person)** |
|---|---|
| Religion | |
| Buddhism | 11 |
| Catholicism | 1 |
| Education | |
| Primary school | 4 |
| Junior high school | 2 |
| Senior high or vocational school | 3 |
| Bachelor degree | 3 |
| Employment | |
| Tailor | 1 |
| Employee | 4 |
| Merchant | 5 |
| Government officer | 2 |
| Adequacy of incomes | |
| Inadequate and having debt | 8 |
| Adequate but no spare income | 4 |
| Marital status | |
| Single | 1 |
| Couple | 10 |
| Divorce | 1 |
| Number of marriages | |
| 0 | 1 |
| 1 | 6 |
| 2-3 | 5 |
| Number of family members, including participants | |
| 3 | 5 |
| 4 | 5 |
| 6 | 2 |
| Number of children | |
| 0 | 1 |
| 1 | 2 |
| 2 | 7 |
| 3 | 1 |
| 5 | 1 |

**Table 2** Data of 12 individual participants

| Code[a] | Age (years) | Rel[b] | Ed[c] | Emp[d] | Income (baht/ month) | MS[e] | Number of children | Number of pregnancy termination | GA at pregnancy termination (weeks) | Methods of pregnancy termination | Years of last pregnancy termination | Complications | Reasons of pregnancy termination |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| P1 | 39 | B | BD | M | 7,000 | M | 5 | 1 | 6 | Intravenous oxytocin | 13 | - | Having many children and financial problem |
| P2 | 44 | C | PS | M | 6,000 | D | 3 | 1 | 20 | RU 486 & curettage | 26 | Severe vomiting & severe abdominal pain | Lesser wife |
| P3 | 44 | B | PS | T | 5,000 | M | 2 | 1 | 10 | RU 486 | 10 | Severe abdominal pain | Irresponsible husband |
| P4 | 28 | B | BD | Gov | 12,000 | M | 1 | 1 | 4 | Vaginal suppository | 10 | Hypermenorrhea and infertility | Studying |
| 5 | 37 | B | SH | E | 9,000 | M | 2 | 1 | 8 | Curettage | 10 | - | Severe morning sickness |
| P6 | 31 | B | JH | E | 5,000 | M | 2 | 4 | 18, 8, 6, 18 | Vaginal suppository, Internal irrigation | 13, 11, 10, 10 | Severe abdominal pain, hemorrhage | Irresponsible husband and financial problem |
| P7 | 43 | B | PS | M | 18,000 | M | 2 | 1 | 8 | Curettage | 24 | - | Divorce |
| P8 | 43 | B | SV | M | 30,000 | M | 2 | 1 | 4 | RU 486 | 20 | - | Having enough children |
| P9 | 44 | B | SV | M | 12,000 | M | 2 | 1 | 8 | RU 486 | 10 | - | Having enough children |
| P10 | 44 | B | PS | E | 10,000 | M | 2 | 1 | 8 | Curettage | 17 | - | Irresponsible husband |
| P11 | 38 | B | BD | Gov | 20,000 | M | 1 | 1 | 20 | RU 486 & Curettage | 18 | - | Studying |
| P12 | 38 | B | SV | E | 11,000 | S | - | 1 | 8 | RU 486 | 10 | - | Studying, lesser wife |

Note. aP = Participant; bRel=Religion; B=Buddhism, C=Catholicism

cEd = Education, PS=Primary school, JH=Junior high school, SH=Senior high school, SV=Senior vocational school, BD=Bachelor degree

dEmp =Employment; M= Merchant, T= Tailor, Gov=Government officer, E= Employee

eMS=Marital status; M= Married, S= Single, D=Divorce

**Table 3** Findings of coping with pregnancy termination among Thai women

| Themes | Sub-themes |
|---|---|
| Suffering from wrongdoing | Feelings of being wrong: sad, guilty, sinful, stigmatized, shameful, and anxious |
| | Feelings of being haunted: sensing of illusive pictures, sound, or touches |
| | Feelings of having failed in life: difficulties, obstacles, and no progress |
| Making amends for wrongdoing | Accepting one's wrongdoing |
| | Protecting self-values: keeping secrets |
| | Seeking forgiveness: emancipation from sins and bad karma, obtaining peace of mind, and praying for baby's rebirth to a new better life, through various religious rituals |
| | Empowering oneself: learning from mistakes, not being stuck in the past, becoming stronger, and improving one's life in a better way |
| Expecting support | Just understanding: empathy, no condemnation, or disapproval |
| | Men's sharing of responsibility: both men and women need to take responsibility together for their mistakes |
| | Restoration of body and mind: suggestions from women toward health services for caring their body and mind well-being |

**Theme 1: Suffering from wrongdoing**

Although ten years or longer had passed since their experience of pregnancy termination, the women still suffered. This suffering developed from the perception about pregnancy termination as destroying or killing their baby or stopping a baby from being born, and was expressed through various feelings:

> *It's like I killed a person, stopping it from being born. This is a sin.* (P9L36)

*Sub-theme 1: The feelings of being wrong*

Feelings of guilt and sadness developed when they believed they cruelly hurt their baby, especially when their unborn baby was already formed as a person. One expressed:

> *I felt hurt and sad. The baby was still moving in front of me and I felt really sad.* (P6L29)

Feelings of sinfulness, stigmatization, shame or anxiety could develop and not be erased:

> *I don't believe that it can be erased. At least the stigma remains in my mind until I die.* (P2L83)

> *I don't want people to know. I feel ashamed that I did something terrible.* (P9L261)

> *I just want to lie still, not seeing anybody. It's like this when I'm worried too much. I don't want to go to bed because morning will come after I go to bed.* (P10L355-7)

*Sub-theme 2: The feelings of being haunted*

These feelings were of 'craziness,' confusion, fear, or unhappiness that developed from having sensed illusive pictures, sounds or the touch of their dead baby. Their feelings came from their belief that the dead baby would get even with the mother who harmed them, and then kept following them and made them have hallucinations:

> *It's like the baby is following you all the time. I am not happy. The baby haunted me all the time and asked why I harmed him or her. It is a deceptive picture in my head all the time.* (P1L117-8)

> *Sometimes I hear a baby crying. It doesn't matter* (whether it is) *night or day. It happens. Maybe I was just crazy.* (P6L199-20)

*Sub-theme 3: The feelings of having failed in life*

The participants felt that they were living with difficulties, confronting various obstacles, and having

no progress in their life due to their wrongdoing. This wrongdoing caused bad things to return in their life, as evidenced by these statements:

> *I start to feel better, for a short while, but then I feel stuck again. I totally believe that it (abortion) affects everything in my life.* (P12L69-70)

**Theme 2: Making amends for wrongdoing**

In attempting to make amends for their wrongdoing of pregnancy termination, they accepted their wrongdoing and tried to do the right things:

> *It's like, yeah, I know I have made a mistake and I will try to do the right thing.* (P7L188)

*Sub-theme 1: Accepting one's wrongdoing*

The participants accepted their wrongdoing rather than denying it or blaming someone else, leading them to feel guilty. Some participants accepted it as the law of karma to detach from their own mistakes and regret. They could not undo what they had done but let go of their mistakes. This detachment is called Plong (ปลง or not thinking about it (abortion) and let it be as usual) and made them felt better and through this, they obtained peace of mind. In the case that they could not undo what they had done, they detached from and let go of their mistakes, as stated by this participant: "I kind of 'plong.' I let it go with karma." (P1L113).

> *I realize that I have made a mistake about the baby. I feel guilty all the time. I shouldn't have done it or been in that situation.* (P1L202-3)

*Sub-theme2: Protecting self-values*

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

> *I keep it as a secret because having an abortion is wrong in Buddhism. I don't want people to know. I feel ashamed that I did something terrible.* (P14L252-3)

*Sub-theme 3: Seeking forgiveness*

Making a mistake about their baby led the participants to attempt to amend their wrongdoing, by making an apology to the dead baby, and asking for forgiveness from them. They wished their baby would not seek revenge on them so they would have a peaceful mind:

> *It the peace of mind, right? Today, as I offered food to a Buddhist monk, I prayed and wanted the baby to get that merit and seek no revenge on me.* (P10L331-2)

Various rituals were performed, including making merits, offering food or religious essentials to monks, pouring dedication water, praying, chanting, meditating, confessing, swearing, giving alms by setting birds and fish free, and getting sprinkled with holy water. One Buddhist participant mentioned kae-karma (แก้กรรม) or setting oneself free from bad karma by chanting the particular mantra called Panyak (ภาณยักษ์: praying aimed to drive away evil). (P5L354-6). The one Catholic participant in this study used confession to reduce her sense of sin (P2L409-11). Their wishes were also about liberating themselves from sins or bad karma and having the baby reborn with a better life.

> *I think I am free from my sin. I was in a really bad state. Then I went to ordain, so my life has become better. I pray and meditate a lot.* (P7L69)

*Sub-theme 4: Empowering oneself*

Although their wrongdoing brought trouble and difficulties in their lives, the women were not passive and never surrendered to their suffering. Instead, they learned from their painful experiences

as a life lesson, were not stuck in the past, but rather, improved their life in a better way.

> *It's like I killed a person. So, it's bad. If I could turn back time, I wouldn't have done it.* (P9L151)

> *My life must go on. I don't want to be stuck in the past. I need to work to make money and to think about my family. This will pass. I need to stand up and fight for my family.* (P12L353-4)

**Theme 3: Expecting support**

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

> *Feel like the merit has been reached. I feel he has forgiven me and doesn't want revenge. He will be reborn, something like that.* (P5L68-9)

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

> *It was the only one remaining channel at those moments in lessening my feelings of guilt. It helped reduce sins I had committed. And it was easy to reach because it is our culture. We think about it at first. It is easier than going to the hospitals. We don't need to wait for a long queue. We can go anytime we want to.* (P2L184-7)

In terms of family support, some participants disclosed their secret to the close ones to obtain support from them. Most supporters were primarily their mothers, and secondarily their sisters or aunts, who provided mental and physical support, advice, good caring, and protection.

> *Mom and aunt often bought food to nurture me.* (P6L104)

The participants did not initiate their requests for help because they were the ones who chose to make terrible mistakes and disclosure might bring them the problems, as one participant expressed:

> *You wouldn't need any help if you were in my situation. It's my personal matter. Nobody forced me to do it. I did it myself. The doctor would help with bleeding, of course. He/She knows what I had done. You don't want to tell the doctor, but of course, they know. This thing is illegal. If you tell the doctors, they will report to the police.* (P4L224-7)

The participants were invited to respond to the question: If their loved ones were in the same situations as them, what forms of support they would suggest and help them go through with it? The following subthemes were their suggestions:

*Subtheme 1: Just understanding*

They just needed to be understood with empathy and compassion, not to be blamed or condemned. They just needed someone to understand that they did not intend to make mistakes. They terminated their pregnancy because it was necessary. They wanted to solve their problems. Each of them had their reasons; those who were not in the same situation understand. They did not want anyone to use their past mistakes to further judge them for everything. What they asked for was to stop blaming them repeatedly.

> *I wish people would understand me. I wish they understand my reasons and my action,*

*not just blaming me. But please just look at the reasons and give me some advice. We can't undo the past, but we can prevent the problem.* (P1L82-4)

*I don't want help from anybody. Just don't blame me. Just wait and see whether my behavior would change or not; whether I am really a bad person or not; whether I'm not a responsible person or not. But just don't blame me.* (P3L274-6)

*Subtheme 2: Men's sharing of responsibility*

The participants felt unfairly treated. It was only them that had to take responsibility for their wrongdoing whereas men were free. If it were possible, they needed society to have men share their responsibility as evidenced in these statements:

*Social values have been giving the wrong definition of being a mom and a woman 'being aware.' As a woman, you have to love your child, you shouldn't kill your own child. Men don't have a uterus. What would happen if they have one? What if men had an abortion, would they be blamed? Society condemns a woman because she is the one who is pregnant. Everybody just put the blame on women. Both are actually wrong, but women are the ones who take the sin.* (P2L209-16)

*Subtheme 3: Restoration of body and mind*

The participants attempted to manage their suffering independently and by actively seeking plenty of religious support and obtaining some family support. However, they still needed more professional support to help them recover from both body and mind wounds.

*There should be a psychologist to give support and strengthen our mind to get over this. Psychiatrists, psychologist, they have good words. For health, there should be a care clinic, located in a secure area. This kind of thing is embarrassing. Skilled obstetric practitioners and equipment are available. All personnel should have ethical codes and leave everything inside the clinic or they should be suspended from work. There should be regulations for all the staff. That's how things should be because there are some women who feel ashamed to go to the hospital.* (P2L265-72)

In conclusion, all findings, the experiences of pregnancy termination, led the participants to feel suffering from their wrongdoing, to further develop their feelings of being wrong, being haunted, and having failed in their life. To manage their suffering, the participants took responsibility for their mistakes, initially by accepting their mistakes and then sought forgiveness to liberate themselves from sins and bad karma, mostly through religious rituals. In taking responsibility for self-values, they attempted to keep their stories secret. The women also took responsibility for empowering themselves through learning from their mistakes, not being stuck in the past, becoming stronger, and living their lives in a better way. To go through their suffering, they sought plenty of religious support and some support from their family. If it could be made available, they suggested the following: empathetic understanding, men's sharing of responsibility, and mental and obstetric care services based on gender-sensitive approaches.

## Discussion

The Thai women in this study internalized the legal, social, religious, moral, and ethical norms and regulation mentioned above, as evidenced by their beliefs in destroying or killing their baby. It is controversial as to the ethical issues in such situations, for example, as to whether the woman's rights or the fetus' rights needs greater protection. The results of this study have supported this attitude as shown in the

strong feelings of wrongdoing even though they performed the termination out of necessity.

In terms of coping, the issue of women's responsibility is discussed. Society places a heavy burden of reproductive responsibility on women. This gender bias stems from biological functions of women in bearing a child and women's roles as mothers. An ideology of motherhood as all-loving, kind, gentle, and selfless,[35] and womanhood as polite, gentle, religious, and aware of other feelings,[29] also shapes women to behave in a good manner and to be the responsible person. Therefore, in this study, the women took personal instead of social responsibility. They dealt with their suffering by themselves rather than be targeted at societal levels by social institutions. Their responsibility was likely ethically oriented since their wrongdoing was killing or hurting someone, which was considered morally wrong. Consequently, they carried out their moral responsibility mostly by seeking forgiveness. In healing their suffering, women started with accepting their wrongdoing rather than denying it or blaming someone else. Taking moral responsibility for their wrongdoing led the women to voluntarily accept the consequences and feel better.

More importantly, the women tried to correct their mistakes. The women tried to protect their self-values by keeping their stories secret and did not seek help to avoid blame or legal repercussions. Having their reasons for pregnancy termination was also another means to relieve the devaluing of themselves. These methods were used for coping with their feeling of stigmatization and shame. With regards to the self-stigma, this perhaps similar to the study of bipolar disorders patients where they were more likely to endorse the use of secrecy and withdrawal in coping with stigma. Therefore, stigma-reduction interventions should be arranged during the early stage of their sentiment and targeted at various dysfunctional stigma coping mechanisms.[36] However, avoidant stigma coping likely has harmful effects, potentially exacerbating pre-existing psychological distress and undermining social networks.[37] Additionally, avoidant coping strategies are predominantly associated with shame through mental disengagement, resignation, and blaming others.[30]

In this study, blaming others was not usually mentioned. However, after reflexive questions were raised, many women considered men should take responsibility and also be blamed. Empowerment represents the culmination of two components: 1) agency as the ability to define and act upon goals, and 2) resources, such as education and household circumstances, to enable women to exercise agency.[38] Women in this study empowered themselves by learning from their mistakes. The lessons from their experiences stopped them from repeating the pregnancy termination. Furthermore, they tried to live their lives in better ways, for example, taking good care of their children and family, because their lives were valuable, especially for them as a mother. These coping methods were similar to those of young parents of ethnic minorities from low-income communities who experienced stigma and discrimination.[39] Their coping methods included developing a positive self-concept as a person and worth, finding the benefits or lessons learned from early parenthood, and viewing parenthood as a major motivator for actively initiating life changes.

In this study, the women obtained plenty of psycho-emotional support from their religious beliefs and practices. They also obtained support from their family, mostly their mother and female relatives. Unfortunately, from their perception, they were never been given support by healthcare providers. Previous studies indicated that the support of a spouse or partner was very helpful for their mental adaptation.[40] However, the women did not ask for their partners' support until they were encouraged to reconsider the contributions of their partners. They then requested men to share responsibility in this issue, which was similar to one study.[27] They both had to take responsibility when there was something wrong so that it was not just the women who took the blame. As previously mentioned women expected their partner providing them with mental and financial support,

and caring them during the pregnancy termination procedure.[26,27] If help was available, they suggested just understanding them without condemning, men's sharing of responsibility, and health services for their body and mind recovery to go through this prolonged suffering, and help them live better lives.

## Limitation

Most of the participants were Buddhists who lived in Nakhon Nayok province. The results might be quite different for women from other religions and settings. According to the privacy and confidentiality of the studied phenomenon, consciousness-raising through reflexive questioning was elicited only from individuals' critical analysis rather than through group process analysis. For further studies on this sensitive topic, researchers are warned that more time might be needed to recruit participants.

## Conclusion and Implication for Nursing Practice

The women are responsible for their pregnancy terminations and willing to amend their wrongdoing. The ways for their coping employed by individual women should be assessed and facilitated. They are not viewed as passive nor incapable. Their capacity and existing resources should be assessed and strengthened and incorporated into their coping. Family support should be enhanced as the sources of coping. Importantly, women with pregnancy termination have the right to obtain post-termination counseling services. Their rights should be respected through the delivery of gender-sensitive services with appropriately trained health personnel. Moreover, the accessibility of the services can be attained through various routes of anonymous services in all general hospitals, and psychological care immediately after pregnancy termination and in the long-term should be provided for these women.

The understandings gained from this study make an important contribution to nursing knowledge in terms of gaining empirical evidence to supporting women's capacity in coping with pregnancy termination and unavailability of healthcare services for these women. We also have some recommendation for further research. Importantly, the gained knowledge can be applied in designing the studies on gender-based counseling services, emphasizing on sympathetic understanding, avoiding condemnation and stereotyping, enhancing women's coping for empowerment, capacity and existing resources.

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# การแก้ไขความผิดพลาด: การเผชิญกับการยุติการตั้งครรภ์ของสตรีไทย

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**บทคัดย่อ:** การยุติการตั้งครรภ์พบได้ในหลายประเทศ แต่กรณีที่ขาดข้อบ่งชี้ทางการแพทย์นั้นยังไม่เป็นที่ยอมรับในสังคมไทยทั้งด้านศีลธรรม สังคม และกฎหมาย นำมาซึ่งปัญหาทางด้านจิตใจมากมายในสตรี การวิจัยแบบพรรณนาเชิงคุณภาพนี้มีวัตถุประสงค์เพื่ออธิบายการเผชิญของสตรีที่ยุติการตั้งครรภ์โดยไม่มีข้อบ่งชี้ทางการแพทย์ ผู้เข้าร่วมวิจัยมี 12 คน พำนักอยู่ในจังหวัดนครนายก ซึ่งถูกคัดเลือกแบบเฉพาะเจาะจง เก็บข้อมูลโดยการสัมภาษณ์เชิงลึก ระหว่างเดือนมกราคม พ.ศ 2560 ถึง เดือนมกราคม พ.ศ 2562 และใช้การวิเคราะห์เชิงเรื่องเล่า สร้างความเชื่อถือได้ของการวิจัยด้วยการให้ผู้ให้ข้อมูลตรวจสอบข้อมูล การตรวจสอบโดยผู้เชี่ยวชาญ และการบันทึกสะท้อนคิด ผลการวิจัยสรุปได้เป็น 3 ประเด็นหลัก คือ ความทุกข์จากการทำผิด การแก้ไขความผิดพลาด และความช่วยเหลือที่ต้องการ ความทุกข์จากการทำผิดประกอบด้วยความรู้สึกว่าผิด ความรู้สึกว่าถูกหลอกหลอน และความรู้สึกว่าชีวิตล้มเหลว การแก้ไขความผิดพลาดประกอบด้วยการยอมรับความผิดพลาดของตนเอง การปกป้องคุณค่าของตนเอง การแสวงหาการให้อภัยจากบุตรที่เสียชีวิต และการเสริมพลังอำนาจให้ตนเองด้วยการเรียนรู้จากความผิดพลาด การไม่ยึดติดอยู่กับอดีต การเข้มแข็งขึ้น และการดำเนินชีวิตไปในทางที่ดีขึ้น ความช่วยเหลือที่ต้องการได้แก่ ขอเพียงความเข้าใจ การมีส่วนร่วมรับผิดชอบของบุรุษ และการฟื้นฟูร่างกายและจิตใจ

สตรีที่ผ่านการยุติการตั้งครรภ์ทนทุกข์มากมายเป็นเวลายาวนาน และได้อุทิศเวลาและความพยายามอย่างมากในการจัดการกับสิ่งท้าทายทางจิตใจ เพื่อให้สตรีผ่านเหตุการณ์ไปด้วยดี จึงควรส่งเสริมสตรีในการเผชิญด้วยการแก้ไขความผิดพลาด และจัดบริการสุขภาพที่ให้ความช่วยเหลือตามที่สตรีตั้งการ ประเด็นการวิจัยต่อไปควรเป็นเรื่องบริการสุขภาพที่เข้าถึงได้และมีความไวต่อเพศสภาวะ

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