Grief Journey: Perception and Response Based on Cultural Beliefs in Thai Women Experiencing Perinatal Death

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Abstract: Studying perinatal death needs to involve cultural beliefs influencing women's perceptions and responses to illuminate their grief journey following the loss of their baby. There is an urgent need to provide a deep understanding in this area that will be useful in meeting the unmet needs of women experiencing perinatal death. This qualitative study explored the grief journey set among cultural beliefs of Thai women experiencing perinatal death. Twenty-five participants who experienced perinatal death between six months and two years before participating in the study were recruited by purposive sampling through the medical history records of four community hospitals in a province of Thailand. Data were collected by in-depth interviews from September 2020 to March 2021 until data saturation. Content analysis was applied to analyze the data.

Findings revealed four themes: 1) bewildering in the dark (wondering what is wrong, anxiety and fear about the anticipated loss, flickering hope); 2) grief response (the world suddenly shuts down, overwhelming sorrow); 3) self-reflection (by talking to self, talking to others); and 4) self-healing (compliance with cultural beliefs, the forgiveness of self and others). In conclusion, healthcare providers should be equipped with essential knowledge for addressing issues holistically based on cultural sensitivity that will be useful in enhancing the utmost ability of women in moving through their grief.

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Introduction

Perinatal death is both devastating and enduring since death can occur without warning and is contrary to our life expectations. Many women who face this tragedy are overlooked because of societal attitudes that minimize the personal value of the baby's life in terms of societal views, which differ once the baby has died.[1-3] Accordingly, society anticipates a milder emotional response from women in this circumstance than it would in the case of the death of a child in almost any other circumstance. Meanwhile, women often maintain a strong desire to stay connected to their deceased children by commemorating anniversaries

and conversations within families and friends.[4-7] Such incongruent perspectives between what grieving women feel and what others think they should feel can intensify the severity of grief since women are made to feel that they have been devalued. They often feel left in stark isolation from their families and society, resulting in psychological impacts such as stigmatization, post-traumatic stress disorder (PTSD), self-blame, low self-esteem, depression, suicidal thoughts and suicide attempts.[5,8] Finally, there are spiritual impacts such as helplessness, loss of dreams, unrealized goals, reduced future expectations and lurking doubt in faith and religion.[3] Significantly, negative psychological impacts may continue through subsequent pregnancies and can affect maternal bonding relationships with subsequent children and siblings.[8-10]

In Thailand, where perinatal death can be considered the result of the past karma of a woman who did bad deeds in a past life, death is frequently perceived as punishment for women who previously violated social rules during pregnancy until the postpartum period.[11] Such social perceptions impact women in a way that makes them feel judged and evaluated negatively, with interpretations of perinatal death as women's sinfulness attached to the spirit of motherhood.[12] This causes women to suffer from feelings of self-blame and stigmatization, the most critical conditions of intense grief that disturb women in moving through their grief journey.[13-15]

Nevertheless, although grief is usually a human response that occurs after a perinatal death and helps women adjust through the grieving process, it does not mean that everyone can move through their grief journey well. This is particularly in the case of women who had abruptly terminated a pregnancy because their unborn children was diagnosed with a life-limiting condition or when the loss occurred at an early stage of pregnancy.[8,16] Thus, overcoming grief is an influential task that women need to accomplish,[6,17] because the grief causes negative consequences and conceals a magnificent power that resides within a woman.[18-19] According to previous cross-country studies, religious beliefs, spiritual beliefs, social perspectives, cognitions about life, the future, and the world of the bereaved women have been documented as having considerable effects on recovery from the tragic events caused by perinatal death.[3,6-8,16,18-21] In Iran, some women believe the solution is in God's hands, while others believe God helps those who help themselves.[20] In Taiwan, women reflected on their grief journey and struggled to spiritually connect with the deceased child, eventually seeking a personal pathway to emotional peace.[6] In the United Kingdom, religious beliefs are vital coping strategies women use to overcome their grief journey and are also associated with higher levels of post-traumatic growth (PTG).[19] In a study by Kain,[22] systematic reviews of Islam, Buddhism, Hinduism, Judaism, and Christianity indicated that rituals, culture, and spiritual care influence women's grief journey. Thus, cultural beliefs influence women's grief journey or how women encounter their grief and subsequently integrate the loss into their lives.

However, recent studies suggest that perinatal grief is not solely a Western phenomenon.[12] Since Thailand is a country with a culture different from other countries in the world, beliefs about perinatal death are regarded as an immense loss tied firmly to the sins of the mother. Perinatal death has also been judged based on the beliefs of the Northeastern Thai people, whose beliefs have been inherited from the past to the present and influenced by religious doctrines, ritual practices, and belief in ghosts. Extended families and beliefs about building nearby housing mean relatives can help and support one another in happy and sad times.[11-12] Importantly, beliefs about Norm (or Klong 14) are a practice guideline or way of life for Thai people that the ancestors of Thai people laid down for the guardians to guide governance, parents teaching children, grandparents teaching grandchildren, and monks teaching Buddhists and leading people to practice.

These beliefs illustrate the worldview of Thai people who are described as other-oriented and highly religious concerning their faith and spiritual lives. According to this worldview, the Thai community maintains its culture and traditions based on inherited

beliefs that continue to be commonly observed among Thai people because they believe that human destiny is primarily controlled by fate and karma.[11] Cultural beliefs, therefore, have dominated conceptions about the health and illnesses of Thai women that probably shape the way these women perceive and respond when they are suffering, particularly concerning vulnerable issues caused by perinatal death. However, there are no data available to explain women's grief journey in Thai women experiencing a perinatal death.

Study Aim

To understand culturally sensitive knowledge about women's perceptions, responses, and cultural beliefs valid to optimize the quality of care for women who experienced perinatal death

Methods

Study Design: A qualitative descriptive approach was employed as a research design in this study,[23] since this approach provides the researchers with theoretical approaches, sampling techniques, data gathering strategies, and assurance of the rigor of results. Furthermore, this methodology offers summary data, factual language, rich information investigation, and understanding of a selected phenomenon. A qualitative descriptive approach is well suited to explore the grief journey according to cultural beliefs in Thai women experiencing perinatal death. In our article, Standards for Reporting Qualitative Research (SRQR) were used as the guideline for reporting this study.[24]

Settings: Public community hospitals in a province in Northeastern Thailand were chosen as the study setting since this context has its own culture and is different from other contexts in the world. This setting was a specific setting that had witnessed a particular phenomenon involving perinatal death that had just happened. The setting enabled the researcher to obtain sufficient and direct information.

Participants and Sampling: Purposive sampling[25] was employed to recruit the participants based on the cultural beliefs women held to perceive and respond to their grief following perinatal death. Thai women who had experienced the loss of children from perinatal death in the labor room, neonatal or pediatric intensive-care units, or emergency room at public community hospitals were purposefully selected according to the following inclusion criteria: (1) age >18 years; (2) duration between six months and two years after experiencing perinatal death, and (3) ability to understand and communicate in Thai. The exclusion criteria were as follows: (1) diagnosis with the psychiatric disorder(s) or major depressive disorder or other psychological symptoms, and (2) in current receipt of mental healthcare services. Finally, 25 women agreed to participate in the in-depth interviews.

Ethical Considerations: Ethical clearance was obtained from the Ethical Review Sub-Committee Board of Human Research Involving Sciences, Thammasat University (COA No. 100/2563). The participants were informed about the research objectives and details with an opportunity to ask questions until a clear understanding was gained. Written and verbal informed consent from participants was obtained at the beginning of the study and again before starting the interviews. To achieve confidentiality, the consent form was coded, and all other documents, such as the transcripts and demographic form, bore only the code number. The researcher eliminated identification information from transcribed data, and field notes and keep them secure. Aliases were used to protect participants' identities, quotes, and profiles. Audio recordings were done by asking permission from the participants and stored in password-protected flash drives that were destroyed at the end of the study. The participants had the option of withdrawing from the study at any time without any consequence.

Data Collection: After ethical approval, the letters requesting permission to collect data were sent to the relevant organizations. Then the process of recruitment was done in cooperation with healthcare personnel through participants' medical history. The local nurse who was the gatekeeper introduced the researcher to the participants. The primary researcher

collected the data using an in-depth interview method and an interview guideline. For the convenience of the participants, all interviews were conducted at the participants' residences and lasted 45-60 minutes each until the data were saturated. Field notes, observation, and audio recordings were also conducted. The total study duration in the setting was 7 months from September to March 2021.

An interview guideline was used to ensure the consistency of topics covered and to allow for the experiences of the women who had experienced perinatal death to be captured. The interview guideline was approved by three qualitative research design experts. Examples of questions included "Please tell me about your experience of losing your child to perinatal death," "How has life been since you lost your child to perinatal death?" and "How did you move yourself to return to normal life?"

Data Analysis: Data collection and analysis were conducted simultaneously by the authors of this study. Content analysis was employed to analyze all data in the interview transcriptions.[26] First, full transcription was classified according to perceptions and responses based on cultural beliefs in women experiencing perinatal death. Second, the lists of categories were grouped under higher-order headings. Finally, the researcher selectively coded a list of verbatim quotations based on the participants' reflections on the perceptions and responses involved in the emerging concept of the journey through the grief caused by perinatal death.

Trustworthiness: Trustworthiness was obtained through credibility, dependability, confirmability, and transferability.[27] Credibility was determined through member checking by asking five participants about their interview transcripts to allow them to correct any factual misconceptions and recheck what they perceived to have been erroneous interpretations. Multiple methods were conducted to ensure dependability and credibility in different data sources.[28] Auditing all research processes and documents also ensured dependability and confirmability. Regarding confirmability, the authors kept raw data, personal notes, field notes, and existing interrelated literature to confirm the research findings. Additionally, the researcher's feelings and reflections on those feelings were recorded during the phase of data collection and analysis. Lastly, a thick description of the findings was used to obtain transferability.

Findings

Description of Participants

The participants were between 18 and 42 years, with most (68%) aged between 20 and 35 years old. Most participants (52%) were secondary education holders and came from extended families (80%). Most (64%) had lost their children at 28 to less than 37 weeks gestation, and most (48%) had suffered the loss for between 19 and 24 months. Nearly all the participants (92%) were married at the time of their loss; notably, two participants (8%) were divorced following perinatal death at the time of the interviews. The characteristics of the participants in this study are summarized in **Table 1**.

Table 1 Participant characteristics (n = 25)

Characteristic of the participants	Frequency	Percent
Age (years) (Mean=27.56, SD=6.79, Min=18, Max=42)		
Less than 20	3	12
20-35	17	68
Exceeding 35	5	20
Education		
Primary school	5	20
Secondary school	13	52
Bachelor's degree	7	28

Table 1 Participant characteristics (n = 25) (Cont.)

Characteristic of the participants	Frequency	Percent
Occupation		
Agriculture	6	24
Employee / Company employee	10	40
Trading or personal business	4	16
Government officer	1	4
Housewife	3	12
No occupation	1	4
Household income (baht/month) (Mean=15,120 SD=7,986.01, Min=8,000, Max=36,000; 1 USD=33 baht)		
Less than 10,000	13	52
10,000-20,000	7	28
20,001-30,000	3	12
Exceeding 30,000	2	8
Religion		
Buddhism	25	100
Family type		
Nuclear family	5	20
Extended family	20	80
Time since loss (Mean=16.44, SD=6.84, Min=6, Max=24)		
6-12 months	9	36
13-18 months	4	16
19-24 months	12	48
Gestational age at time of perinatal death		
28- less than 37 wks. of gestation	16	64
37-40 wks. of gestation	3	12
1-7 days after birth	6	24
Cause of perinatal death		
Congenital heart disease	5	20
Congenital malformations	2	8
Umbilical cord complications	3	12
No quickening	8	32
Hydrops fetalis	2	8
Anemia	2	8
Unknown cause	3	12
Marital status at the time of loss		
Single	2	8
Married	23	92
Current marital status		
Single	1	4
Married	22	88
Divorced	2	8
Have living children at the time of loss		
Yes	14	56
No	11	44

The grief journey according to cultural beliefs in Thai women experiencing perinatal death was revealed in the following four superordinate themes: (1) bewildering in the dark; (2) grief response, (3) self-reflection, and (4) self-healing, and its following subthemes below.

Theme 1: Bewildering in the Dark

Most participants noticed abnormal signs in fetuses/neonates that triggered the women's suspicious thinking leading to anxiety and fear about anticipated, impending loss. Bewildering in the dark involved the sudden shift in emotion from expectancy to the devastating events following the death of their fetuses/neonates created inner emotional and stress-related conflict, which can be defined as three subthemes detailed below.

Subtheme 1.1: Wondering What is Wrong?

Most participants perceived there might be something wrong with their child. However, they were not sure whether the symptom was abnormal or not because some women had been pregnant and given birth many years ago. Some women did not remember how to count the child's quickening. Additionally, in the case of women who had had their children diagnosed with severe illnesses and little chance to survive, the women usually suspected the reasons for the devastating situation with their children and the cause of the abnormality, as in the following examples:

> *"I felt my child did not move, but I was not sure whether the symptom was abnormal or not, because I did not remember how to count the child's quickening."* (Woman 04, 25 years old)

> *"I did not think that my child would be diagnosed with a severe illness. I did not understand the cause of the disease or why it happened to my child, even though I had carefully provided the best care for my child in the womb."* (Woman 01, 26 years old)

Subtheme 1.2: Anxiety and Fear about the Anticipated Loss

After the women perceived the noticeable signs, all the participants immersed themselves in anxiety and fear about the child's health or the anticipated loss. This led to the women urgently seeking the truth for something they suspected by going to the doctor immediately. Some women also took some advice from talking to their neighbors on this matter.

> *"I noticed that my child still had not moved since the last time after dinner. I suspected that something might be wrong with my child. So, I did not hesitate to go to the doctor immediately."* (Woman 10, 24 years old)

> *"I consulted my neighbors to answer my suspicious thinking on the matter. They told me it might have happened as a came near to giving birth; the baby in the womb might be less active."* (Woman 02, 26 years old)

Subtheme 1.3: Flickering Hope

Some women wished for a miracle to save their child's life. Even when they were informed about the death of their baby in their uterus they hoped to hear crying noise once their child was born. And in the case of women who gave birth to an infant with an abnormality with a low chance of survival, they still put a lot of energy into maintaining hope by strictly following the biomedical treatment and sought alternative treatment by adopting their belief in supernatural powers.

> *"I could not accept such a fact at that time. So, I hoped to hear a crying noise once my child was born."* (Woman 06, 34 years old)

> *"Even though my child would have little chance to live, I will keep doing my best to follow both biomedical treatment and beliefs or practices based on my contexts. So, I went to a moh-mor* (Isaan language: a representative communicating with ghosts or supernatural powers to predict illness and explain how to recover from illness). *In this regard, the moh-mor gave me the sacred threads for tying my child's wrist. I hoped that there would be a miracle and helped my child to get better"* (Woman 05, 19 years old)

Theme 2: Grief Response

Grief response was the painful experience that occurred when the women had been informed of the unexpected death of their children. However, it was the necessary response that would allow the women enough time until they were eventually completely ready to accept the loss. This theme comprised the following two subthemes:

Subtheme 2.1: The World Suddenly Shuts Down

Once the women had been informed of the deaths of their children, the women were numb and felt like they were living in a dream world. "The world suddenly shuts down" was the theme emerging in this study. It referred to women who could not perceive any information anymore and had faces filled with many tears that flowed automatically. The women wanted to stay with the silent grief, repeatedly think about their deceased child and not talk to anyone.

> *"Once the doctor stopped talking, I did not hear other words anymore. It looked like my screen to receive the information had shut off. I sat there quietly, without talking to anyone almost all day."* (Woman 18, 28 years old)

> *"I was numb and shocked after I heard the devastating news about the death of my child. My face filled with many tears, and I felt like my heart had disintegrated into dust. I could not accept the terrible loss that had happened so suddenly. Thinking about my deceased child usually happened repeatedly in my mind all the time in a way that I could not control."* (Woman 17, 38 years old)

Subtheme 2.2: Overwhelming Sorrow

Most of the women revealed that a good mother had given birth to a healthy child and raised the child to be a healthy person, which is essential according to social expectations in the area studied. This social perception led the women to respond to the tremendous tragedy with feelings of guilt, self-blame, and stigmatization that stuck in their hearts. This was particularly the case of women who perceived themselves as the causes of the death of their child.

> *"This was the second time I had lost an unborn child. People in the village probably thought I was a woman who had sinned and, therefore, caused my child to die. The reoccurrences of perinatal death hurt me with the feeling of guilt stuck in my heart that destroyed the self-worth in my life as a mother."* (Woman 19, 30 years old)

> *"I was pregnant without being married. In the end, my child died. My boyfriend and I broke up shortly after my child died, so people in the community probably blamed me for being a bad person and causing my child to die."* (Woman 10, 24 years old)

Theme 3: Self-reflection

Self-reflection was the women's realization of the grief impact in their lives. It reminded the women to reflect on their losses and painful feelings of grief. This theme comprised the following two subthemes as below.

Subtheme 3.1: By Talking to Self

All of the women scrutinized themselves through the grief impact that occurred in their lives. The women realized that the grief impact affected themselves and other loved ones. Self-reflection by talking to themselves promoted the women to realize their self-worth and the worth of those around them, which resulted in understanding the meaning of living for themselves and loved ones. This reflected the unconditional love women perceived from those who loved them. They perceived that true love facilitated them to recognize the good things in life, even during bad times.

> *"At first, I had suicidal ideas after my child died. Fortunately, I was lucky to have a living child who made me realize true love that should not be selfish and did not focus on self-interest. So, right now, I place importance on the task of keeping my role as a mother and taking care*

of my living child based on social expectation in the context where I live." (Woman 16, 37 years old)

"Even I had to face the bad time caused by my child being dead. However, I was not alone at all. I still had my family, especially my living child who was the only reason that empowered me and the hope in my life." (Woman 19, 30 years old)

Subtheme 3.2: By Talking to Others

Talking to others such as spouses, parents, neighbors, friends, or folk philosophers was the way women used to reflect on themselves in terms of reminding them to live in the present moment because the death of their children was a past situation no one who could go back to resolve. So, it was useless to think about the past event too much.

"I had the opportunity to chat with an old woman who was respected by our community. She taught me a lot about helpful religious doctrines that could be applied in daily life for healing myself. I felt comfortable, and I could learn to let go of the suffering." (Woman 13, 25 years old)

"Many people told me that it was a past event. I could not go back to fix anything. I had to let it go and live in the present. It's not only me who lost my child. There are many people who have lost children like me; no one can escape from birth and death according to the laws of karma or the laws of nature." (Woman 23, 22 years old)

Theme 4: Self-healing

Once the women realized the grief impact on their lives, it hugely impacted both the grieving women and other loved ones. They also realized good things, even in bad times. This perception led the women to try and heal themselves, which was the strategy the women used to explain how they transcended their grief. This theme comprised the following three subthemes:

Subtheme 4.1: Compliance with Cultural Beliefs

Cultural beliefs were the social rules influencing the women's lives from birth to death that have been established in this area from past to present. The women preferred to go to the temple to make merit, offered food to the monks, made sacrificial offerings to their deceased children, and prayed to God based on their faith in religion to release their suffering and seek strength in their journey through the suffering they faced. In addition, following traditional ceremonies was a helpful way to deal with their grief.

"I frequently went to the temple to make merit for my deceased child. It helped me feel happy. Even I did not know whether he would receive it or not, it made me comfortable. I would also go to the temple to pray to God to share my heartache and ask for strength in my heart so that I could get through my grief." (Woman 22, 25 years old)

"Making merit for the lost child was like compensating to him for something I did wrong during pregnancy. It made the guilt in my heart lessen." (Woman 14, 18 years old)

"Many relatives, including people from the same village, attended the Bai-Si-Su-Kwan ceremony (in the Isaan language or the Thai blessing ceremony). *They would tie my wrists and bless me with happiness and healing from all sorrows. It was like giving me more encouragement."* (Woman 25, 27 years old)

Subtheme 4.2: Forgiveness of Self and Others

Once the women accepted the reality of perinatal death, they realized that it was useless to live with such negative feelings as grief because it only brought

more suffering. In this regard, the women no longer blamed themselves and others. Consequently, their minds felt lighter and more comfortable, and they felt they could get back to being themselves again.

> *"The more I blamed myself, the more I suffered. People around me, like my parents, husband, and living children, were also suffering. So, I thought that, no matter how much I blamed myself, it could not change the fact that my child had died. So, I adapted myself and stopped blaming myself and others. Then, I felt like I was freed from the shackles of sadness and guilt." (Woman 05, 19 years old)*

> *"After I stopped blaming myself and others, I felt like my heart was light and clear. It was almost one year ago that I was so unhappy. I felt like I was back to being myself again."* (Woman 17, 38 years old)

Discussion

The women's grief journey began when they perceived signs of something happening with their children. It triggered the women with feelings of confusion and suspicion that led to anxiety and fear about the anticipated loss that might be coming soon. This finding corresponded with Javadifar et al.,[29] who stated that the birth of a baby is considered a happy event for women and their families. Unfortunately, once a pregnancy ends in loss, it will give women a sense of bewildering in the dark that refers to the sudden shift in emotion from expectancy to the devastating loss.[30] Our study found that the women tried to seek the truth for something they suspected by talking to their neighbors, which can be explained in that the worldview of the women in the area studied, the northeastern region of Thailand, was described as other-oriented with mutually helpful community values.[7] Furthermore, most participants in this study came from extended families, and the participants and their relatives' houses were built in nearby areas. This promoted them to help and support one another in happy and sad times. In this regard, when the women suffered perinatal death, they sought helpful advice by finding a support person such as a parent, grandparent, or folk philosopher with the hope of being able to sustain their minds through grief.[7,16] In the study by Testoni et al.,[31] the social environment of the griever was identified as a significant factor in grief outcomes, and the role of social support in parental grief has been well-documented.

Unfortunately, the women could not protect their child's life due to the severity of the life-limiting condition resulting in their child eventually dying. Once the women were informed of the deaths of their children, they usually faced a myriad of emotions that referred to grief response, such as feelings of deep sadness, frustration, powerlessness, worthlessness, and guilt. This intense grief occurred following perinatal death because the women loved intensely and had a strong emotional attachment to their children. These responses were present in several previous studies.[14-15,30,32-33] In this regard, a consistent feeling of guilt is commonly experienced after perinatal death and is associated with pathological grief. In particular, the women in this study had cultivated specific social values and feminine roles based on mothering, whereby they were responsible for nurturing their children, while beliefs about patriarchy continue to be commonly practiced in this area.[34] In addition, perinatal death in the area studied, is traditionally and firmly tied to the mother's sins. This belief system makes women feel that their bodies have failed and that their femininity has been undermined with a traumatic life event involving the loss of the spirit of motherhood that can often cause pathological grief and increase the risk of post-traumatic stress disorders.[8]

In self-reflection, once time had passed, the overwhelming sorrow caused by the perinatal death the women faced allowed them to look back on their

loss and painful feeling of grief, which facilitated them to realize the true love from those around them. In this regard, the women realized that the intense grief they faced did not occur just to themselves but also caused suffering for those around them who loved them. This perception reminded the women to express loving themselves and others, which became their reason for figuring out ways to move through their grief. As stated in a study by Kejkornkaew et al.,[35] the feeling of love could explain the reason to be a caregiver that influenced the decision of taking on the caregiver role. This reflects the magnificent power of love hidden behind grief. Therefore, self-reflection facilitated the women in staying in the present and considering all aspects of loss that had negative consequences and allowed them to perceive good things, even in bad times.

As for self-healing, although some beliefs about perinatal death in the context studied may be similar to beliefs found in other contexts in terms of the death of unborn children, or death shortly after birth, or the death of a child that was too young and seen as a non-person,[4-5] this perception resulted in no culturally sanctioned rituals or traditions to help the bereaved women say good-bye.[3] In some contexts, this resulted in those women being forced to cope in isolation, thwarting their capacity to mourn and subsequently achieve psychological adjustment.[3-5,9] Nevertheless, in the area studied, it was found that many rituals based on cultural beliefs were applied as effective ways to promote the women's ability to deal with their grief. In this regard, following a religion and making merit to purify the mind has been believed to bring merit to both women and their deceased children. It also brings women happiness and peace of mind as they believed that the children who had died would receive the merits and necessities that the women had dedicated to them.[36] This meant that the deceased children enjoyed well-being after death. Significantly, making merit could lessen the guilt or stigma of those women who thought they might have caused the deaths of their children.[36] As for praying to God, it is a necessary way to reduce the emotional pressure by facilitating the women in expressing their feelings of sorrow while further allowing the women to maintain hope through religious blessings such as praying for their children to be reborn in a good realm or for themselves and their children to be reborn as a mother and child again. This finding concurs with the study by Lin and Yen,[37] who found that the belief in reincarnation made it easier for grieving women to accept perinatal death as it followed the natural cycle of life.

This finding was consistent with previous studies that discussed the strategies women used to deal with their grief by turning to spirituality and religion, which have a significant role in coping with parental grief. This includes going to church; praying; maintaining, renewing, or developing a relationship with God; and attributing the death to God's will,[22,38] reflecting that woman cite their faith as a source of strength in their deep sorrow to help them through the worst part of the grief. Wright[18] found that perinatally bereaved women relied on spiritual, religious, and sacred things that allowed them to feel that, amidst their suffering, there was a higher power who knew their pain and could be petitioned for support through prayer. Prayers and rituals brought comfort and healing to the women as individuals. Religious beliefs also allowed the women to metaphysically relocate the deceased child to another place, such as in God's arms or heaven surrounded by angels.[6,18] Such beliefs brought comfort to the women because they believed that their deceased child not only still existed in another way but was also being cared for in the spiritual world. Some women prayed to deceased ancestors, asking them to care for the deceased child in the afterlife, and burned ghost money to help ensure that the baby would have good things in the afterlife.[6] This reflected the spiritual anchor that provided the women with the strength to overcome the suffering they faced caused by perinatal death.

Once the women transcended their grief, they no longer blamed themselves and others, which made

their minds feel lighter and more comfortable as they gradually improved and eventually found a sense of meaning in life. This indicated that forgiveness of self and others were useful strategies for transcending grief.[17] Finally, our study revealed strong evidence that the grief journey of women who experienced perinatal death relates to beliefs in religious doctrines, supernatural power, and local cultural links.[11,19-21,39]

Limitations

The participants were women in the Thai cultural context. Women in other regions with different backgrounds may have different perspectives and experiences. Therefore, the application of the research findings should be utilized with careful consideration in a similar context.

Conclusions and Implications for Nursing Practice

This study presented an evolution of the perception and response of Thai women experiencing perinatal death. Although some results have been found in previous studies related to perinatal death, few have pointed out the role of the Thai cultural context and its influence on women's grief journey following perinatal death, particularly beliefs in religious doctrines and supernatural powers. These cultural beliefs stem from the fears of natural phenomena that harm human lives, such as earthquakes, flooding, and drought. Cultural beliefs were applied as a way for dealing with the grief journey. Ultimately, the women could fully realize and accept the truth of the loss forced upon them as permanent and incorporate the loss into their lives, eventually leading to self-growth. The study, therefore, has the potential to inform nursing practice.

According to our findings, healthcare providers should promote health literacy for women, families, and neighbors concerning basic knowledge about self-care during pregnancy and unwanted symptoms requiring a visit to the doctor. In particular, healthcare providers who work under these circumstances need to be equipped with essential knowledge for addressing issues holistically, based on cultural sensitivity. The current scientific knowledge and common lay beliefs in religious doctrines and supernatural powers such as making merit, praying to God, performing the Bai-Si-Su-Kwan ceremony, and spiritual counseling should be considered to optimize women's ability to move through their grief journey by promoting resilience beliefs and eliminating constraining beliefs. Further research is recommended to explore perception and response from husbands' and siblings' perspectives. Notably, the findings can be used for nurses to develop effective interventions promoting women to accept their losses and work through their grief. Finally, the findings can be used to suggest applicable health policies and integrate these policies with the healthcare system to provide appropriate guidelines for taking proper care of women who have experienced perinatal death, including hospital care, as well as a follow-up when the women are discharged from the hospital.

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References

1. Camacho-Ávila M, Fernández-Sola C, Jiménez-López FR, Granero-Molin J, Fernández-Medina IM, Martínez-Artero L, et al. Experience of parents who have suffered a perinatal death in two Spanish hospitals: a qualitative study. BMC Pregnancy Childbirth. 2019;19:512. doi:10.1186/s12884-019-2666-z.
2. Ridaura I, Penelo E, Raich RM. Depressive symptomatology and grief in Spanish women who have suffered a perinatal loss. Psicothema. 2017;29(1):43-8. doi:10.7334/psicothema2016.151.

3. Markin RD, Zilcha-Mano S. Cultural processes in psychotherapy for perinatal loss: breaking the cultural taboo against perinatal grief. Psychotherapy (Chic). 2018;55(1):20-6. doi:10.1037/pst0000122.
4. Salenius P. Sociological and psychological effects of stillbirth: theory, research, and midwifery. Br J Midwifery. 2019;27(10):616-9. doi:10.12968/bjom.2019.27.10.616.
5. Faro L. Monuments for stillborn children and disenfranchised grief in the Netherlands recognition, protest and solace. Mortality (Abingdon). 2021;26(3):264-83. doi:10.1080/13576275.2020.1779202.
6. Tseng YF, Chen CH, Wang HH. Taiwanese women's process of recovery from stillbirth: a qualitative descriptive study. Res Nurs Health. 2014;37(3):219-28. doi:10.1002/nur.21594.
7. Sriarporn P, Turale S, Lordee N, Liamtrirat S, Hanpra W, Kanthino A. Support program for women suffering grief after termination of pregnancy: a pilot study. Nurs Health Sci. 2017;19(1):75-80. doi:10.1111/nhs.12307.
8. Fernández-Ordoñez E, González-Cano-Caballero M, Guerra-Marmolejo C, Fernández-Fernández E, García-Gámez M. Perinatal grief and post-traumatic stress disorder in pregnancy after perinatal loss: a longitudinal study protocol. Int J Environ Res Public Health. 2021;18(6):2874. doi:10.3390/ ijerph18062874.
9. Könes MÖ, Yıldız H. The level of grief in women with pregnancy loss: a prospective evaluation of the first three months of perinatal loss. J Psychosom Obstet Gynaecol. 2021;42(4):346-55. doi:10.1080/0167482X.2020.1759543.
10. Kokou-Kpolou K, Menick DM, Moukouta CS, Baugnet L, Kpelly DE. A cross-cultural approach to complicated grief reactions among Togo–Western African immigrants in Europe. J Cross Cult Psychol. 2017;48(8):1247-62. doi:10.1177/0022022117721972.
11. Tanglakmankhong K, Thongphao P, Srisuwan J, Phuwongkrai O. The study of local wisdom of maternal and childcare using community classroom and research-based learning. J Prapokklao Hosp Clin Med Educat Center. 2016;33(4):288-99 (in Thai).
12. Wattanagun K. The phenomenology of supernatural belief: the ravenous spirit (Phii Pob) belief tradition in contemporary Northeast Thailand. Asian Ethnol. 2018;77(1):79-97 (in Thai).
13. deMontigny F, Verdon C, Meunier S, Dubeau D. Women's persistent depressive and perinatal grief symptoms following a miscarriage: the role of childlessness and satisfaction with healthcare services. Arch Womens Ment Health. 2017;20(5):655-62. doi:10.1007/s00737-017-0742-9.
14. Gopichandran V, Subramaniam S, Kalsingh MJ. Psycho-social impact of stillbirths on women and their families in Tamil Nadu, India – a qualitative study. BMC Pregnancy Childbirth. 2018;18:109. doi:10.1186/s12884-018-1742-0.
15. Hill PW, Cacciatore J, Shreffler KM, Pritchard KM. The loss of self: the effect of miscarriage, stillbirth, and child death on maternal self-esteem. Death Stud. 2017;41(4):226-35. doi:10.1080/07481187.2016.1261204.
16. Wiriya K, Ketkaewmanee O. Experience of mental suffering in mothers who faced with dead fetus in utero: DFIU. Srinakharinwirot University (Journal of Science and Technology). 2014;6(12):1-12 (in Thai).
17. Rashid S, Jehan N, Khan NA, Gul S, Khan HM. Relationship between self-compassion and compassion for others. Ilkogretim Online. 2021;20(6):440-7. doi:10.17051/ilkonline.2021.06.046.
18. Wright PM. Perinatal loss and spirituality: a metasynthesis of qualitative research. Illn Crisis Loss. 2020;28(2):99-118. doi:10.1177/1054137317698660.
19. Lafarge C, Mitchell K, Fox P. Posttraumatic growth following pregnancy termination for fetal abnormality: the predictive role of coping strategies and perinatal grief. Anxiety Stress Coping. 2017;30(5):536-50. doi:10.1080/10615806.2016.1278433.
20. Allahdadian M, Irajpour A. The role of religious beliefs in pregnancy loss. J Educ Health Promot. 2015;4:99. doi:10.4103/2277-9531.171813.
21. Kokou-Kpolou K, Megalakaki O, Nieuviarts N. Persistent depressive and grief symptoms for up to 10 years following perinatal loss: involvement of negative cognitions. J Affect Disord. 2018;241:360-6. doi:10.1016/j.jad.2018.08.063.

22. Kain VJ. Perinatal palliative care: cultural, spiritual, and religious considerations for parents—what clinicians need to know. Front Pediatr. 2021;9:597519. doi:10.3389/fped.2021.597519.
23. Turale S. A brief introduction to qualitative description: a research design worth using. Pacific Rim Int J Nurs Res. 2020;24(3):289-91.
24. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245-51. doi:10.1097/ACM.0000000000000388.
25. Higginbottom GM. Sampling issues in qualitative research. Nurse Res. 2004;12(1):7-19. doi:10.7748/nr2004.07.12.1.7.c5927.
26. Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs. 2008;62(1):107-15. doi:10.1111/j.1365-2648.2007.04569.
27. Lincoln YS, Guba EG. Naturalistic inquiry. Thousand Oaks: Sage; 1985.
28. Jentoft N, Olsen TS. Against the flow in data collection: how data triangulation combined with a 'slow' interview technique enriches data. Qual Soc Work. 2019;18(2)179-93. doi:10.1177/1473325017712581.
29. Javadifar N, Majlesi F, Nikbakht A, Nedjat S, Montazeri A. Journey to motherhood in the first year after childbirth. J Family Reprod Health. 2016;10(3):146-53.
30. Nuzum D, Meaney S, O' Donoghue K. The impact of stillbirth on bereaved parents: a qualitative study. PLoS One. 2018;13(1):e0191635. doi:10.1371/journal.pone.0191635.
31. Testoni I, Bregoli J, Pompele S, Maccarini A. Social support in perinatal grief and mothers' continuing bonds: a qualitative study with Italian mourners. Affil - J Women Soc Work. 2020;35(4):485-502.doi:10.1177/0886109920906784.
32. Watson J, Simmonds A, La Fontaine M, Fockler ME. Pregnancy and infant loss: a survey of families' experiences in Ontario Canada. BMC Pregnancy Childbirth. 2019;19:129. doi:10.1186/s12884-019-2270-2.
33. Youngblut JM, Brooten D, Glaze J, Promise T, Yoo C. Parent grief 1-13 months after death in neonatal and pediatric intensive care units. J Loss Trauma. 2017;22(1):77-96. doi:10.1080/15325024.2016.1187049.
34. Rodsub N. Patriarchy: the reflection of the inequality between male and female in Asian society. Academic Journal of Humanities and Social Sciences Buriram Rajabhat University. 2012;4(2):30-46 (in Thai).
35. Kejkornkaew S, Sirapo-ngam Y, Monkong S, Junda T, Wallhagen MI. A grounded theory study of the quality relationships between family caregivers and persons with head and neck cancer. Pacific Rim Int J Nurs Res. 2016;20(2):161-73. Available from: https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/39281
36. Phra Promkhunaporn (Prayut Payutto). Buddhadham. Bangkok: Phli-Dharma Publishing; 2014 (in Thai).
37. Lin CT, Yen WH. On the naturalization of karma and rebirth. Int J Dharma Stud. 2015;3:6. doi:10.1186/s40613-015-0016-2.
38. Cheng FK. Buddhist insights into life and death: overcoming death anxiety. Athens J Soc Sci (online). 2017;4(1):67-88. doi:10.30958/ajss.4-1-4.
39. Ayebare E, Lavender T, Mweteise J, Nabisere A, Nendela A, Mukhwana R, et al. The impact of cultural beliefs and practices on parents' experiences of bereavement following stillbirth: a qualitative study in Uganda and Kenya. BMC Pregnancy Childbirth. 2021;21:443. doi:10.1186/s12884-021-03912-4.

วิถีแห่งความเศร้าโศก: การรับรู้และการตอบสนองตามความเชื่อทางวัฒนธรรมของสตรีไทยที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิด

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บทคัดย่อ: การตายปริกำเนิดเกี่ยวข้องกับความเชื่อทางวัฒนธรรมที่มีอิทธิพลต่อการรับรู้และการตอบสนองของผู้หญิงซึ่งสะท้อนวิถีแห่งความเศร้าโศกของผู้หญิงภายหลังสูญเสียบุตรจากการตายปริกำเนิด ความเข้าใจอย่างถ่องแท้ในประเด็นนี้จะเป็นประโยชน์ในการตอบสนองความต้องการที่ยังไม่ได้รับการตอบสนองของสตรีที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิด การวิจัยแบบพรรณนาเชิงคุณภาพนี้มีวัตถุประสงค์เพื่ออธิบายวิถีแห่งความเศร้าโศกตามความเชื่อทางวัฒนธรรมของสตรีไทยที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิด คัดเลือกผู้ให้ข้อมูลแบบเจาะจงผ่านบันทึกประวัติทางการแพทย์ของโรงพยาบาลชุมชน 4 แห่งที่ตั้งอยู่ในจังหวัดหนึ่งในภาคตะวันออกเฉียงเหนือของประเทศไทย เก็บข้อมูลระหว่างเดือนกันยายน 2563 ถึงเดือนมีนาคม 2564 ด้วยการสัมภาษณ์เชิงลึกผู้ให้ข้อมูลจำนวน 25 คน กระทั่งข้อมูลมีความอิ่มตัว โดยเป็นผู้หญิงที่มีประสบการณ์ภายหลังสูญเสียบุตรจากการตายปริกำเนิดก่อนถึงวันเข้าร่วมการศึกษาอยู่ในช่วง 6 เดือน ถึง 2 ปี วิเคราะห์ข้อมูลด้วยการวิเคราะห์เนื้อหา ผลการวิจัยเผยให้เห็นประเด็นสำคัญสี่ประเด็น คือ (1) งุนงงในความมืดมิด (งงว่าเกิดอะไรขึ้น วิตกกังวลและกลัวการสูญเสียที่คาดการณ์ไว้ ความหวังที่ริบหรี่) (2) สนองตอบความเศร้าโศก (โลกหยุดหมุนในทันใด ความเศร้าโศกอย่างท่วมท้น) (3) สะท้อนคิด (ฟังเสียงตนเอง พูดคุยกับผู้อื่น) และ (4) เยียวยาตนเอง (การปฏิบัติตามความเชื่อทางวัฒนธรรม การให้อภัยตนเองและผู้อื่น)

โดยสรุป ผู้ให้บริการด้านสุขภาพควรมีความรู้ที่จำเป็นในการแก้ไขปัญหาแบบองค์รวมโดยคำนึงถึงความอ่อนไหวทางวัฒนธรรมซึ่งจะเป็นประโยชน์ในการเสริมสร้างความสามารถสูงสุดของสตรีในการก้าวผ่านความเศร้าโศก

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คำสำคัญ: วิถีแห่งความเศร้าโศก ความเชื่อทางวัฒนธรรม การรับรู้ การตายปริกำเนิด วิจัยเชิงคุณภาพ ประสบการณ์ผู้หญิง

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