Overcoming Grief in Thai Women Experiencing Perinatal Death: A Grounded Theory Study

Nedruetai Punaglom, Puangpaka Kongvattananon, Bih-Ching Shu*

Abstract: Thai women grieving over perinatal death are usually judged and evaluated negatively due to a belief that sinfulness is attached to the spirit of mothering. Women suffer self-blame and stigmatization that disturbs the grieving process. This grounded theory study aimed to construct a descriptive theory to explain the process of overcoming grief in Thai women experiencing perinatal death. Twenty-five north-eastern Thai women experiencing perinatal death were recruited by purposive sampling to provide the initial data, then the researcher undertook theoretical sampling to develop codes, categories, and additional information. Each in-depth interview lasted 45-60 minutes and was conducted at the participants' homes between September 2020 and March 2021 until data saturation. Constant comparative analysis with open, axial, and selective coding was applied. The results revealed four major processes: perception of loss and grief, cultural cognitive adaptation, acceptance, and overcoming grief. Importantly, cultural cognitive adaptation was the core category existing in the process of overcoming grief in Thai women experiencing perinatal death.

In conclusion, the results were conceptualized to explain the culture and context influencing women's grieving process. This substantive theory emerged gradually through the passage of time in which women honed themselves through painful events caused by perinatal death resulting in women's ability to reach their capacity to move through their grief. Based on the results, particular beliefs in religious doctrines, and supernatural powers can be applied to develop effective nursing and health interventions for women to work through grief smoothly and successfully.

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Introduction

Globally, approximately 6,700 neonatal deaths occur daily, and nearly three-quarters occur within the first week of life.[1] Sudden perinatal death

is a catastrophic event for women and families due to its wide impact on women's lives within the physical, social, psychological, and spiritual dimensions which can destroy women's quality of life.[2-3] The problem is also prevalent in Thailand, particularly in northeastern Thailand where three regions report the highest perinatal death rates in the country.[4] Perinatal death is the death of a fetus or neonate from 28 completed weeks (196 days) of gestation to seven completed days after birth.[5] Perinatal death differs from pediatric deaths under other circumstances as it is generally seen as non-persons resulting in no culturally sanctioned rituals or traditions to help the women say goodbye in some contexts.[6-8]

Grief following perinatal death is a typically unexpected and highly devastating event for women that can be complicated due to the additional loss of hope for raising a child, an immensely important role in women's lives.[2-3,6-8] Perinatal death is perceived as disenfranchised grief,[9] which refers to a loss that is not openly acknowledged, publicly mourned, or socially supported due to a lack of social recognition.[10] Thus, perinatal death is seen as the death of a non-person with an absence of cultural norms and understanding about how to mourn the death of a child.[11] As a result, women are forced to cope in isolation, thwarting their capacity to mourn and subsequently achieve psychological adjustment.[2] Importantly, women feel their bodies have failed and their mothering has been undermined, which impacts women within the wide range of feminine ideologies, particularly in emotional and spiritual dimensions.[2] Perinatal death, therefore, is the loss of the spirit of mothering and a mother's sense of femininity.[2]

Particularly, the important roles of Thai women have been socially constructed in a way that is inseparably linked with issues of feminine sexual identity. This means that women attempt to exercise their maternal roles in accordance with the social expectations of a good mother, ultimately giving birth to healthy children and raising them to become healthy people.[12] This reflects the myth of Thai society imposed that if a woman who nursed a child deviated from a determined and expected society, that woman would be punished by having an unhappy life. However, when a woman accepted and acted well in her mothering role, she will receive the award of social acceptance.[13] Once perinatal death has occurred, a woman might be judged and evaluated negatively by her society, because she may have violated one of those traditions and cultures and is thereby thought to have caused the death of her child.[7,14] All of these elements indicate social values and female roles based on mothering with responsibility for nurturing children,[12-13] while beliefs about patriarchy continue to be commonly practiced in the area studied.[15] This kind of belief system, embedded within the culture of the Thai people, intensifies the severity of grief and causes the women to suffer from self-blame, low self-esteem and self-confidence, and stigmatization caused by perinatal death in complicated grief and post-traumatic stress disorders.[2]

A deep and comprehensive understanding of norms regarding grief can allow healthcare professionals to identify people at risk for exhibiting abnormal grief and establish nursing care. Psychological models for grief recovery include well-known theories categorized into two groups: traditional models[16-20] and the current model.[21] In this regard, traditional models focus on disengaging from the deceased is necessary for successfully resolving grief. Also, in keeping with the emphasis of Western culture on autonomy and individuality as signposts of psychological health, such models may not appropriately explain the process of overcoming grief in Thailand where women desire to maintain a relationship with the deceased due to belief in rebirth as mother and child again.[22-23] Likewise, in the current model, even the withdrawing energy from the relationship with the deceased is not necessary, however, it has been developed in the Western context with potential limitations in the extent to which the process of overcoming grief is explained in Thai contexts because perinatal death is not only a Western phenomenon.[7] The process of overcoming grief thus is a socio-cultural process associated with coping

with loss and integrating that loss into life. Unfortunately, previous models fail to provide a comprehensive explanation of culture and context, which are important factors influencing the ability to go through the grief process.

Although grief is normally a human response that occurs after the loss to help women can adjust through the grieving process, it does not mean that everyone can achieve the process of overcoming grief well, particularly in the case of women who lose their child from perinatal death. Perinatal death is a catastrophic event leading to deep pain and distress with immense grief amidst a large silence.[2,7,14] Northeastern Thailand is a region with unique cultures compared to other countries. Perinatal death can be perceived as the *karma* of a woman committing bad deeds in her past life and punishment for violating social rules during pregnancy and the postpartum period.[14] Thai perspectives of perinatal death are closely linked to sinfulness attached to the spirit of mothering, resulting in women being usually judged and evaluated negatively. Consequently, women suffer self-blame and stigmatization, the most important conditions of intense grief in women that disturb the grief process.[2] However, there are no data available to explain the process of overcoming grief in this context. Hence, grounded theory (GT) was employed as an appropriate methodology in this study when little is known about a phenomenon being studied.[24] This study aimed to construct a descriptive theory to explain the process of overcoming grief over perinatal death in Thai women. The researcher was interested in studying a specific culture of the northeastern region to understand how grieving women respond to perinatal death in their interpersonal relationships and how they react to supernatural powers, gods, and the natural environment in their efforts to overcome grief within beliefs bound up in religious doctrines. The findings will promote an understanding of how cultural cognition is related to women's overcoming grief and help develop effective interventions to work through these women's adaptation smoothly and successfully.

Methods

Study Design: GT was employed in the format of a rigorous methodology in this study,[24] because we sought to understand human behavior in social interactions and the social process of symbolic interactionism.[24] Finally, the Standards for Reporting Qualitative Research (SRQR) were used as the guideline for reporting our study.[25]

Settings: Northeastern Thailand was selected as the setting for conducting the study based on the real phenomena occurring in this setting. Importantly, the setting has its own cultures that obviously differ from other countries. Particularly, beliefs in the region about perinatal death have been tied firmly to the mother's sins based on the prevailing religious doctrines inculcating the presence of ghosts of Thai people inherited from the distant past and continue to embrace to the present day.

Participants and Sampling: Purposive sampling[26] was used at the first step to select participants meeting the inclusion criteria who were identified as having the knowledge and/or experience that would be needed to provide the initial data for the inquiry. The inclusion criteria were (1) Thai women, aged >18 years, (2) experience with perinatal death (6 months to 2 years ago), and (3) ability to understand and communicate in Thai. The exclusion criteria were a diagnosis with psychiatric disorder(s) such major depression or psychological symptoms. Once the information data emerged from the initial analysis, the women experiencing perinatal death and participants who were likely to assist in developing these categories were sought. Thus, the researcher purposively sought women with different grief responses, different lengths of time since their perinatal deaths occurred, different gestational ages, and different socioeconomic statuses when experiencing perinatal death, as well as grieving women who exhibited different personal factors. Participants in this study, therefore, were sought by theoretical sampling and were guided based on the constant comparative analysis performed simultaneously with data collection.[24]

Ethical Considerations: After IRB (COA No 100/2563) approval by the Ethical Review Sub-Committee Board of Human Research Involving Sciences, Thammasat University, the researcher informed the participants about the research objectives, the process of data collection, benefits and risks, information confidentiality, voluntary participation, and the researcher's contact details. Verbal and written informed consent were obtained at the beginning of the study and before starting the interviews. To achieve confidentiality, the only document containing the participant's names was the consent form; other documents, such as the transcripts and the demographic form, bore only the code number. The completed consent forms were stored separately from other documents in the researcher's locked cabinet. Audio recordings were conducted after requesting permission from the participants and kept in password-protected flash drives that were destroyed at the end of this study. The researcher provided the participants with the right to discontinue participation at any time without consequence.

Data Collection: The first author conducted the interviews at the participants' homes. Each interview lasted 45-60 minutes until the data were saturated. The participants were asked to review their journey through the grief process: "How did you heal yourself through the grief process to return to normal life?" "What feelings/behaviors helped you overcome grief?" "How did those feelings/behaviors help you overcome grief?" "What are the characteristics of overcoming grief?" Additional probing questions were asked to clarify topics and ensure that the interview accurately captured each participant's experience: "Could you describe in detail each characteristic of overcoming grief?" The interview guideline for the next interview was reviewed and modified based on suggestions from the previous interview and data analysis.

Data Analysis: The data were analyzed by constant comparative analysis with open, axial, and selective coding.[24] In open coding, the researcher conducted data gathering and coding simultaneously in a timely and synchronous manner to facilitate the illumination of emerging themes and explore potential areas of inquiry. Open coding resulted in emerging themes, sub-categories, and full categories. The results of open coding guided the subsequent sampling of the participants through theoretical sampling. An example participant in the preliminary work and coding of names is presented here. One participant stated, "After dinner, I felt severe contractions in my belly; at that time, I didn't think something wrong might have happened. That night, I still went to bed normally without any suspicions. The time passed until midnight; I woke up and noticed that my child had not moved since after dinner." This statement clearly indicated noticing abnormal signs.

The next stage, axial coding, was reflected in the concept of clustering open codes around specific axes or points of intersection. The coding paradigm was used to create a connection between categories and subcategories, focusing on such cases as casual conditions of phenomena, intervening conditions, actions/interactions, and consequences, which were used for connecting categories. The previous example, "perception of loss and grief" was a form of axial coding that had been clustered from the open coding performed in the previous step. In this regard, "perception of loss and grief" was the causal condition in this evolving theory.

Finally, selective coding meant that the researcher selectively treated the various code clusters, decided how they were interrelated and what stories they told the researcher. Thus, the researchers constructed a set of relational statements that could be used to explain, in a general sense, what was going on. As an example from our preliminary work, after redefining all categories, the researchers did have a tentative core category, i.e. "perception of loss and grief, adaptation, acceptance, and overcoming of grief." In this step, we challenged ourselves to explore, "What was the strategy that the Thai women experiencing perinatal death used to overcome their grief?" These four categories were related to the core category of "cultural cognitive adaptation," which pertains to the consequences of actions.

Trustworthiness: The criteria of trustworthiness for the qualitative research consisted of credibility, transferability, dependability, and confirmability.[27] Credibility was achieved by member checking, which

was conducted by asking the participants about their interview transcripts to give them an opportunity to correct any factual misconceptions and recheck what they perceived to have been erroneous interpretations.[27] Additionally, alternative data-collection methods were used, such as triangulation to ensure validity, in-depth interviews, constant comparative methods, observation, field notes, and memos to verify the data. Transferability was obtained through the extensive description to explain the process of overcoming grief in Thai women experiencing perinatal death. To achieve dependability, a detailed step-by-step description was conducted to allow other researchers to track the process if they should need to conduct a similar study. For confirmability, the researchers kept memos, raw data, personal notes, and field notes, as well as existing interrelated literature as a means of confirming the research findings. These notes were meant to remind the researchers of the need to remain aware of any potential prejudice inadvertently developing during the analysis process.

Findings

Description of Participants

All of the participants were Buddhists (100%). For most participants (48%), the time since loss was between 19 months and 2 years; 80% were from extended families and nearly all (92%) had experienced their first perinatal death. Most (56%) had one living child at the time of perinatal death and 28 % subsequently had a live birth. Nearly all of the participants (92%) were married at the time of their first loss, while two participants (8%) divorced following perinatal death. The characteristics of the participants are shown in **Table 1**.

Table 1. Participant characteristics (n = 25)

Characteristic of 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
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 the time of loss		
28-less than 37 wks of gestation	16	64
37-40 wks of gestation	3	12
1-7 days after birth	6	24
Number of pregnancy loss		
First	23	92
Second	2	8
Marital status at the time of Loss		
Single	2	8
Married	23	92
Living children at the time of loss		
Yes	14	56
No	11	44
Subsequently experienced a live birth		
Yes	7	28
No	18	72

The process of overcoming grief in Thai women encompassed four major processes: perception of loss and grief, cultural cognitive adaptation, acceptance, and overcoming grief. The findings of this study are illustrated in **Figure 1**. The core category of the four processes was 'cultural cognitive adaptation,' a process used by the women to overcome grief.

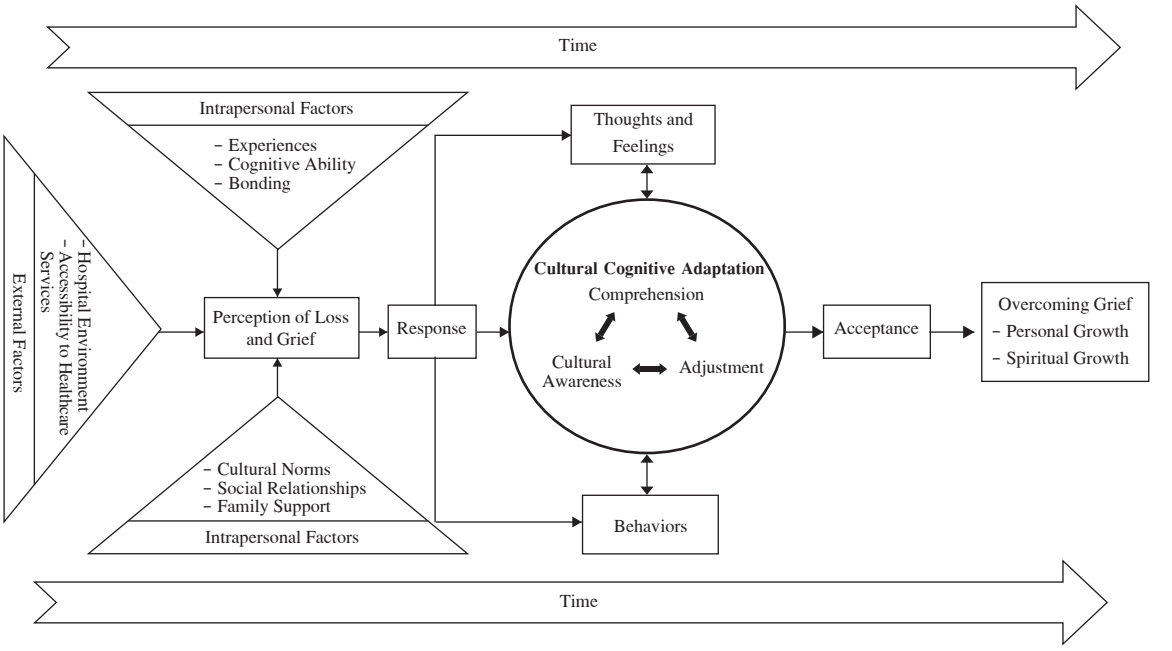

Figure 1. The substantive theory of the process of overcoming grief in Thai women experiencing perinatal death

Core Category: Cultural Cognitive Adaptation

Cultural cognitive adaptation was the core category explaining how the women conquered the grief caused by perinatal death and how the women found a magnificent power that was hidden by overwhelming feelings of grief, thereby reflecting personal strength that emerged from the process of cultural cognitive adaptation and could drive the women beyond the pain of the death. In this study, cultural beliefs were applied as the appropriate way to overcome grief, because the cognitive processes the women used to understand and explain perinatal death were influenced by beliefs in religious doctrines and supernatural powers inherited from past to present. These beliefs greatly influenced the women's thinking in dealing with any situation in their lives that reflected conceptions about the health and illness of Thai women. Cultural cognitive adaptation resulted from women learning from the pain of grief, which led to the women adjusting their cognitions to find a way to move through their grief, for example,

> *"It is the belief of the Thai people, whether in suffering or happiness. We often go to temples to pay respect, pray for goodwill, make life restful, and free ourselves from all sorrows."* (W23)

> *"Many relatives, including people from the same village, attended the Bai-Si-Su-Kwan ceremony (Thai blessing ceremony). They tied my wrists and blessed me with happiness and healing from all sorrows. It was like giving me more encouragement."* (W12)

Stage 1: Perception of Loss and Grief

Perception of loss and grief was a causal condition as a set of events that influenced the central phenomenon and created a need for the core social process to occur. In the process of overcoming grief, the women illustrated the perception of loss and grief, which was a vital process resulting from the interactive action between two sub-processes in this stage, namely perception and response.

Perception was awareness of any abnormal sign happening in fetuses/neonates that triggered the women's suspicious thinking and caused them to wonder how such abnormal symptoms had occurred with their child, because they perceived that they had provided the best care for their child throughout the whole pregnancy. This perception reflected the unexpected loss that produced the feelings of fear and anxiety about the anticipated loss, for example,

> *"I suspected that there might something wrong with my unborn baby. From midnight until the morning, I could not sleep anymore and tried to keep an eye on my child's movements. Unfortunately, my child did not move even once. So, I did not hesitate to see a doctor immediately."* (W10)

> *"I wondered why this pregnancy was not normal, even though I had provided my child with a good intrauterine life."* (W08)

Response: This sub-process was an important component of the theory that emerged following the perception of perinatal death. The response was the women's reactions once they perceived perinatal death and involved two characteristics: thought-feeling responses and behavioral responses. The responses in blaming others and themselves were part of the cognitive process that was very important to healing in the initial phase. This reflected that the women had not yet accepted perinatal death at that time, for example,

> *"Although I told the doctor that I had obviously noticed that my belly was so hard, the doctor at the antenatal clinic still told me that my child was okay. So, I went to the hospital and found that my child no longer had a fetal heartbeat. I thought the late diagnosis made my child eventually die."* (W04)

> *"It was absolutely my fault, because I could not save my child's life. I had an important role in a woman's life to give a healthy birth and raise my child, but I could not do it."* (W18)

Additionally, the women also expressed behavioral responses after perinatal death by avoiding places, people, or memories associated with their deceased children, lacking the motivation to take care of personal health and hiding from others due to fear of social criticism, for example,

> *"I normally stayed inside my house, not talking to others, and avoiding some places triggering thoughts of my child."* (W20)

> *"I lacked the motivation to take care of myself after the stillbirth. I did not follow the Yoo-Fai ritual* ("stay on fire"), *or postpartum confinement based on my cultural belief. So, I was no longer a healthy person, could not tolerate hard work as before, and became prone to illness."* (W06)

> *"I did not allow people to know too much about the death of my child, because I was not sure what they would think about the matter. People in the village probably thought that I was a woman who had sinned and, therefore, caused my child to die."* (W19)

In this regard, how the women perceived and responded to perinatal death varied based on influences from many ways in the context where the women lived and interacted with other people in their contexts

comprising intrapersonal, interpersonal, external, and timing factors. For example two participants explained:

> *"It was the second time that I had faced the death of a child. It seemed like an old memory of the time I lost my first child that popped up in my head like a movie that was being re-played over and over again. The same feelings burst up again. The reoccurrence of perinatal death hurt me with the feelings of guilt that stuck in my heart."* (W06)

> *"Life or death depends on merit or good deeds done in the past and carried from birth. Maybe he made only so much merit, so he could only live this way."* (W07)

Stage 2: Cultural Cognitive Adaptation

Cultural cognitive adaptation refers to the process in which the women tried to control or deal with their grief through cognitive adaptation based on their culture as the process connected with recognizing and understanding the grief occurring in their lives comprising comprehension, adjustment, and cultural awareness.

Comprehension was the women's ability to understand perinatal grief as a whole, which directed the women's thinking in terms of perception and determination of appropriate strategies for overcoming grief, for example,

> *"Many people have lost children like me, so I think no one can escape birth and death according to the laws of nature."* (W16)

> *"Thai people believe that babies without birthmarks are not human children. My child did not have a birthmark, so he died to return to his former mother." (W05)*

Adjustment was the women's decision to change to something better, more accurate, or more effective. Thus, the women changed their attitudes, physical conditions, behaviors, social activity, self-concepts, and roles to promote successful overcoming of grief such as in the following examples:

> *"As time passed, I realized that my child had multiple anomalies, since he was an unborn child. I felt like he did not have much quality of life. So, I felt like it was better that he died at the time. If he were still alive now, it would be so difficult to provide care for him to meet complex needs based on his condition."* (W25)

> *"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 my role as a mother taking care of my living child."* (W16)

> *"At first, I did not talk to others about the death of my child. Now, I feel like the more I was alone, the more intensely I grieved. So, I tried to talk to my husband. Fortunately, he tried to comfort and understand me. I felt like he tried to grieve together with me, which allowed us to share and express our feelings about grief, so we could support each other."* (W05)

Cultural awareness was conceptualized by the participants in this study, as referring to their realization the ideas, customs, religion, and social behavior in the contexts where they lived. In this study, the women's cultural awareness involved the beliefs in their religion, supernatural powers, and the traditional ways they followed as the ways for dealing with their grief, for example,

> *"Making merit for the lost child was like paying him back for something wrong I had done during pregnancy. It eased the guilt in my heart."* (W14)

"After the child died, I was so overwhelmed with sadness. So, my family held the Bai-Si-Su-Kwan ceremony for me. It was believed that the ceremony could drive the bad luck away and bring my soul back to live with me again. My relatives bound my wrists with a sacred twine along with wishing me happiness without suffering. It made me feel more encouraged and stronger." (W25)

Stage 3: Acceptance

At this stage, the women began to talk and paid attention to their normal lives, considering all aspects of loss that were not only negative consequences, but still allowed them to perceive the positive aspects of harsh situations. This led the women to find a life balance that emerged amid the difficult event, for example,

"Not everything was bad, even though I was facing the death of my child. However, I did not do it alone at all. I still had my family, especially my living child." (W19)

"It was a past event. I could not go back to fix anything. I had to let it go and live in the present." (W23)

Stage 4: Overcoming Grief

At this stage, the women unconditionally acknowledged and understood the truth of perinatal death, which enabled the women to gain personal and spiritual growth.

Personal growth was an ultimately positive outcome that gradually emerged through the continual process of overcoming grief until the women were eventually able to transcend their grief. In this study, the women did not just fix themselves or recognize personal weaknesses. They also loved and accepted themselves wholly and unconditionally while recognizing and appreciating personal strengths, for example,

"The death of my child pushed me down into a feeling of depression that was hard to overcome. However, I was eventually able to do it. I could overcome distressing events. After that, I perceived myself as a stronger person. I was not so anxious about whatever might come into my life anymore." (W10)

Spiritual growth was the women's awareness of natural truths, insight into the truth of perinatal death, not adhering to ego, unselfishness, a strong will, and powerful spiritual anchors to overcome many problems and obstacles in life. In this study, the women reflected on spiritual growth through light and comfortable feelings, true love, hope, a sense of meaning in life, and reliance on spiritual, religious, and sacred ideologies or beliefs, for example,

"Before, I blamed myself for the death of my child. The more I blamed myself, the more I suffered, and this included the people around me. So, I adapted myself and stopped blaming myself and others. When I thought like this, I felt like I was free from the shackles of sadness and guilt." (W02)

"After I had faced the death of my child, it made me stronger. I perceived love around me that touched my heart. It seemed likely that the miraculous powers could support me to heal myself. It made me feel that my life had a lot of meaning. The suffering I faced taught me to give compassion to others." (W10)

"My deceased child stays in my heart. So, what I can do as a mother is go to the temple to make merit for my deceased child, because I believe that my deceased child will have abundant food and utensils and not be in need. Doing this makes me happy." (W21)

Discussion

Cultural cognitive adaptation emerged as the core category in this theory that explained how women overcome grief, because bereavement is a cognitive process in which they reacted and dealt with the difficult event they faced. Cultural beliefs are central to many people's global meaning systems, and death is a central arena for the enactment of cultural beliefs likely to be a central part of coping and adjustment following grief caused by the death of a loved one and including beliefs in continued attachment to the deceased.[6,17,22] This concept corresponds with Worden,[20] who revealed that grieving people need to accept the reality of the loss, adapt, and move on with life. Similarly, Marrone[28] revealed that cognitive restructuring is essential to the grief process in terms of how the bereaved reorganize and restructure thoughts and concepts to assimilate a loss. Cultural cognitive adaptation, therefore, is powerful in driving women to adaptation in the transformative work of grief.

Perception of loss and grief is consistent with vulnerability in the theory of self-transcendence,[29] and symptom experience in the theory of symptom management,[30] which refers to distressing events interfering with life and resulting in seeking help and more effective strategies to eliminate or minimize symptoms. So, the perception of loss and grief caused by perinatal death is widely mentioned as a devastating event and reflects that no loss in the world could cause more intense grief than the death of a child.[2,7,14]

When there is no grief reaction, a loss will impact grieving women in the form of preventing them from expressing their feelings of grief or getting stuck in any step of the grieving process, thereby resulting in having prolonged or pathologic grief.[2] Hence, the findings emerging in this evolving theory contain important concepts that needed to occur in the dynamic process of overcoming grief to drive the women toward moving on from the first phase to the next until they finally conquered their grief. Hence, women's perceptions in this study led to the responses manifested in various aspects of women's lives, such as thoughts, feelings, and behaviors that corresponded with previous studies.[2-3,7,9-10]

However, how women respond to perinatal death might depend on how women perceive this type of situation. This was reflected in the ways women encountered their grief, depending on related factors influencing the women's perceptions of perinatal grief comprising interpersonal, intrapersonal, external, and time factors. As Boyden et al.[31] revealed, bereaved African-American parents were less likely to discuss loss in professional and personal contexts leading to greater grief intensity and pathological grief symptoms. This relative silence might have been related to the cultural value of strength.[32] Fortunately, some women in this study stated. "It was very good that we could talk together about the death of our child, because we could share feelings of love and empathy." This finding can be explained by Norm 14 (or the Klong 14 in the local dialect), a practice guideline or way of life for the Thai people handed down from their ancestors. For example, *heet pua klong mea* (in the local dialect, "*heet*" means tradition, "*pua*" means husband, "*klong*" means norm and "*mea*" means wife)[33] focuses on how husbands and wives need to treat each other well.

The tough time women faced triggered self-reflection that promoted the development of ways to cope with perinatal death through adjusting cognition to overcome grief in the stage of cultural cognitive adaptation. Thus, the women's cognitive process was greatly influenced by cultural beliefs. In this stage, the women sought ways to face their grief through the three cultural cognitive adaptation methods consisting of comprehension, adjustment, and cultural awareness, even though perinatal death in the Thai cultural context has been linked closely to women's sinfulness based on their beliefs.[7,14] Nevertheless, many rituals based on beliefs in religious doctrines and supernatural powers were applied as effective ways to promote the women's ability to conquer their grief. Examples

include making merit to purify the mind, praying to God to convey their suffering, and seeking strength in their journey through the suffering they faced by performing the *Bai-Si-Su-Kwan* ceremony to promote a sense of encouragement and relief from their grief and performing the *Tut-Phee Tut-Chui* ceremony (in the local dialect), which is a ritual for the severing of mother-child ties in order to release the souls of deceased children and enable rebirth. Therefore, with love and desire for the deceased children to be reborn into a good world, the women tried to accept and express their feelings of grief with a sense that they understood it well. Participants learn through a devastating situation when they have a belief that no one can control anything.[34] Thus, feelings should not be tied to anything that might be happiness or sorrow. Cultural awareness is a necessary topic to be combined in psychotherapy to help grieving parents.[8]

Once the women had accomplished the cultural cognitive adaptation stage, they were driven to the third stage, "acceptance." This concept corresponds with the acceptance concept in the five stages of the grief model,[18] and readjusting the concept in Rando's Six R processes of mourning.[35] Another study found a different phrase, adjusting to a new environment,[36] or recovery,[16,19,37] the stage where a person adjusts to normalcy and accepts the loss. In this study, the women began to talk and paid attention to normal life and could consider all aspects of loss, not only negative consequences. Thus, they perceived the positive aspects of harsh situations and found a life balance emerging amidst a difficult event. This finding can be explained by the religious doctrine in term of "Yonisomanasikarn,"[23] meaning to analytical thinking and critical reflection applied as a framework for determining ways of thinking to improve life and well-being. Beliefs in religious doctrine, therefore, place importance on cultivating the mind to think positively and find happiness.[23,38] This finding corresponds with Cheng,[34] who stated that thinking positively provides a positive worldview rather than a pessimistic one, because people can perceive an open phenomenal system. In this sense, beliefs in religious doctrine could help women obtain mindfulness and stay in the present, which facilitated the women in considering all aspects of loss.

Overcoming grief was the ultimate positive outcome once the women had transcended the grief process comprising personal and spiritual growth. Overcoming grief can be compared with the self-transcendence concept[29] referring to a characteristic of developmental maturity with an enhanced awareness of the environment and orientation toward broadened perspectives about life such as accepting death as a part of life, letting go of losses, and finding spiritual meaning in life. Wright's[39] concept of transcendence of suffering was the ultimate outcome after the women had pushed themselves to transcend their grief over perinatal death. Similarly, the women in this study described their feelings in terms of being more compassionate, more lovingly, and more appreciative of the people and relationships they had.

Personal growth is a widely accepted concept that has been identified through numerous studies as the positive outcome in which individuals are able to experience significant positive personal changes in the aftermath of a traumatic event.[40-42] Noticeably, those studies revealed that females can contribute more to personal growth than males. As in this study, after the women's journey to move through the grieving process, they perceived themselves as having more strength than ever, which they had not been aware of until that time. The women appreciated their relationships with others around them, particularly living children who seemed likely to be a great power that was a motivation for women to move on and shift their priorities to focus on their family obligations instead of feelings of grief. This was a unique finding in the Thai cultural context where women have been cultivated from past to present regarding role identity as females with the main role of raising and taking care of their children in the best way they can.

Spiritual growth enabled the women to perceive their life's preciousness and the value of other things they had. This enabled the women to free themselves from the tremendous sorrow caused by perinatal death. This finding can be explained by the religious doctrine about worldly conditions or in Thai , *Lok-Ka-Dharm*,[8] pointing out the principles of the natural world dominating the animal world, including all human beings, facilitating the women to accept and let go of sorrow.[23] Similarly, the Dalai Lama and Cutler[38] stated that suffering is the underlying nature of the human existence. If the bereaved accepts suffering as a natural part of existence, the bereaved will undoubtedly be more tolerant of life adversities.[22] In this study, the women sought spiritual anchoring through beliefs in religion and supernatural powers since they believed in the power of faith and its ability to empower the women to live with hope and perceive miraculous powers to combat threats firmly and confidently. This resulted in strengthening the women's minds and letting go of grief, fear, and anxiety about the future and death while continuing to promote the development of a continuing bond with the deceased who stayed with them forever in spirit with love. This reflects that religious and spiritual beliefs in an afterlife and continued bond with the deceased facilitate adaptation to the death of a loved one.

Limitations

These findings are specific to the Thai population and may not be generalizable to other populations.

Conclusions and Implications for Nursing Practice

This substantive theory was conceptualized through women's cognitive adaptation by focusing on cultural awareness. The findings suggest that various types of nursing interventions tailored to clients within different phases and processes must be developed for addressing issues holistically based on cultural sensitivity. The current scientific knowledge and common lay beliefs in religious doctrines and supernatural powers should be considered in promoting women to navigate the grief process due to influences on the cognitive process to perceive, evaluate, and decide how to overcome perinatal grief. Nursing care should focus on religion and traditions such as making merit, praying to God, and performing any rituals based on cultural beliefs in promoting women to overcome grief.

Further research could focus on developing the core category 'cultural cognitive adaptation' through comparative studies which could result in a substantive theory with wider applicability.

Conflict of Interest

The authors have no conflicts of interest to disclose.

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การก้าวข้ามความเศร้าโศกในสตรีไทยที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิด: การศึกษาทฤษฎีฐานราก

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บทคัดย่อ: สตรีไทยที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิดมักถูกตัดสินและประเมินในทางลบจากความเชื่อที่ว่าเป็นผลพวงจากบาปของสตรีซึ่งผูกติดกับจิตวิญญาณการเป็นแม่ เป็นเหตุให้สตรีไทยเผชิญกับความทุกข์ใจจากการตำหนิตนเองและการถูกตีตราจากสังคมในบริบทที่อาศัยอยู่ซึ่งส่งผลกระทบต่อกระบวนการก้าวข้ามความเศร้าโศก การศึกษาทฤษฎีฐานรากนี้มีวัตถุประสงค์เพื่อสร้างทฤษฎีเชิงพรรณนาอธิบายกระบวนการก้าวข้ามความเศร้าโศกในสตรีไทยที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิด ผู้ให้ข้อมูลเป็นสตรีไทย 25 คนที่อาศัยอยู่ในภาคตะวันออกเฉียงเหนือของประเทศไทยซึ่งได้รับการคัดเลือกโดยการสุ่มตัวอย่างแบบเจาะจงในขั้นแรก จากนั้นจึงทำการสุ่มตัวอย่างเชิงทฤษฎีเพื่อนำไปสู่การพัฒนารหัส ประเภทและข้อมูลจำเป็นเพิ่มเติม เก็บรวบรวมข้อมูลระหว่างเดือนกันยายน 2563 ถึงมีนาคม 2564 โดยการสัมภาษณ์เชิงลึกที่บ้านพักของผู้ให้ข้อมูล ระยะเวลาประมาณ 45-60 นาที/ครั้ง จนข้อมูลอิ่มตัว วิเคราะห์ข้อมูลด้วยวิธีการวิเคราะห์เปรียบเทียบแบบคงที่ การเข้ารหัสแบบเปิด แนวแกน และแบบเลือก ผลการวิจัยเผยให้เห็นกระบวนการก้าวข้ามความเศร้าโศกซึ่งประกอบด้วยกระบวนการสำคัญ 4 ประการ ได้แก่ การรับรู้การสูญเสียและความเศร้าโศก การปรับกระบวนการรู้คิดบนพื้นฐานทางวัฒนธรรม การยอมรับ และการก้าวข้ามความเศร้าโศก การปรับกระบวนการรู้คิดบนพื้นฐานทางวัฒนธรรม เป็นหมวดหมู่หลักที่สำคัญซึ่งปรากฏในกระบวนการก้าวข้ามความเศร้าโศกในสตรีไทยที่เผชิญการสูญเสียบุตรจากการตายปริกำเนิด

ทฤษฎีที่ศึกษานี้ค่อยๆ ปรากฏขึ้นในช่วงเวลาที่ผู้หญิงฝึกฝนตนเองผ่านเหตุการณ์อันเจ็บปวดจากการสูญเสียบุตรจากการตายปริกำเนิด ส่งผลให้ผู้หญิงบรรลุสมรรถนะแห่งตนในการก้าวข้ามความเศร้าโศก ผลการวิจัย โดยเฉพาะอย่างยิ่ง ความเชื่อในหลักคำสอนทางศาสนาและพลังเหนือธรรมชาติสามารถนำไปใช้พัฒนาแนวทางการดูแลที่มีประสิทธิภาพเพื่อส่งเสริมให้สตรีไทยที่สูญเสียบุตรจากการตายปริกำเนิด ประสบความสำเร็จในการก้าวข้ามความเศร้าโศกได้

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