Title
Unintended Thai Adolescent Pregnancy: A grounded Theory Study

Author
Neamsakul, Wanwadee

Publication Date
2008-08-14

Peer reviewed|Thesis/dissertation

UNINTENDED THAI ADOLESCENT PREGNANCY: A GROUNDED THEORY STUDY

by

Wanwadee Neamsakul

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

NURSING

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

DEDICATION

This dissertation is dedicated to my parents:

Wanchai and Ngamij Neamsakul

for their uncondition love and support

ACKNOWLEDGEMENTS

First of all, I would like to express my deep appreciation to the following organizations for giving me a scholarship and research awards to pursue my doctoral study in the United States: the Thai government, Sigma Theta Tau Alpha Eta Chapter, the Graduate Division, and the School of Nursing, University of California, San Francisco. Because of the financial support from these sources, it has been possible for me to reach my dream and achieve my goals. I also would like to thank the administrators of Praboromarajchanok Institute of Health Workforce Development and Boromarajonani Nursing College Uttaradit, Thailand as well as my colleagues who support my opportunity to study aboard. I gained new knowledge in nursing, exchanged cultures among countries, and had wonderful experiences. I recognize that the nursing instructors at my college have sacrificed themselves and worked for me during my four year absence.

Second, I would like to express my gratitude to the dissertation committee members, namely Associate Professor Holly Kennedy, my advisor and dissertation chair, Associate Professor Susan Kools, my qualifying examination chair, Professor Sally Rankin, and Professor Claire Brindis. Their kindness, understanding, support, and encouragement will be in my memory forever. Not only I have learned academics from them, I have learned how to be an excellent teacher from them. I am sure it was difficult to be a teacher of a person whose second language is English. However, they have patiently tried to understand my Thai-accented English as well as correcting my writing. They have helped expanding my horizons in language, knowledge, and self-confidence. Every time I met with them, they provided a supportive atmosphere which encouraged

me to find solutions to problems. They made the barriers and difficulties disappear with their guidance and useful suggestions. I am very lucky and feel privileged to have them as my committee.

Third, I am really grateful to my family; Wanchai and Ngamnij, my parents; Tanya, Aradee, and Yanee, my sisters; Archan and Supachok, my nephews, and Subhuniga and Anchisa, my nieces; as well as Yuthana and Adisak, my brother-in-law who provided me support and inspired me to pursue the doctoral degree. I can not mention all my family members' names but the fact is that my family is the foundation behind of all my success. Besides my family, I am lucky to have friends who help me complete my study and dissertation, for example, Bumnet Kunthasen, Pikulthong Klibthong, Anchaleerat Korkitsunthornsarn, Dr. Supatra Sirichotiyakul, Tasanee Sakajornbhop, Dutdern Kaewleaung, Hatairat Jiranuntiputti, and Chompunut Sriwichai, who always provide support in Thailand. Dr. Sangjan Rungreangkulkij, Dr. Pratima Bhuttarowas, Thomas Cary, and Ruth Cary devoted their time to help me edit the papers. I also would like to give special thanks to Dr. Somporn Rungreangkulkij who helped me with the data analysis and Dr. Supaporn Wannasuntad who provided me with a lot of support and guidance as a student in the United States. In addition, I will always remember Juhey Jin for her advice and help with the paper and computer skills during my studies. I am grateful also to Chanchai Kuphotiphan, Sirirat Leeyanukul, and Pensri Brunelle who provided a second home and extended family in San Francisco which helped relieve my homesickness.

Last but not least, I would never forget the 20 participants, director, and health care providers of Uttaradit hospital and the Health centers. Without their cooperation and

services I could not complete my study. Finally, I will always remember the friendship from my classmates, faculty members, and staff at the School of Nursing. I have made relationships with people from different countries and appreciated their kindness given to me. All wonderful experience gained from the University of California, San Francisco will always be remembered.

Wanwadee Neamsakul

August, 2008

Abstract

UNINTENDED THAI ADOLESCENT PREGNANCY:

A GROUNDED THEORY STUDY

Wanwadee Neamsakul

University of California, San Francisco, 2008

The purpose of this grounded theory was to discover the social processes used by Thai adolescents with unintended pregnancies throughout the childbearing year. Twenty Thai adolescents with an unintended pregnancy, between 14-19 years old, enrolled between 24-28 weeks while receiving prenatal care clinic at Uttaradit Hospital, Thailand. Semi-structured interviews were conducted at 3 different points during pregnancy through 8-12 weeks postpartum.

"*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood" was identified as the basic social psychological process for adolescents who decided to carry an unintended pregnancy. The process was shaped within the contexts of family, life styles and values, traditions, religion, education, gender roles, and law.

The life journey began with "surrender *(Yom jum non)* to an unintended pregnancy" and which reflected the causal conditions. It started in the chronological order of events during pregnancy. "Preparation to become a new mother" comprised the action/interaction strategies used to cope with changes during pregnancy. "Support from their close circle is like nourishment for their soul *(Yad nam tip chalom jai*) and which gets them through difficult time (*Tee peung yam yak*)," were the intervening conditions

that helped facilitate and balance the strategies used to cope with changes during pregnancy on the journey to motherhood. The journey ended with “Adolescent mom: I can do this mission.” which described the consequences of the use of different strategies and the support from people surrounding them.

Needs and sources of support during pregnancy and transition to motherhood were identified. Specific strategies for clinicians and research questions were also identified. These findings held potential to inform the health care community on how best to meet the adolescents’ needs during pregnancy and to foster them as new mothers.

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GLOSSARY

Thai phrase	English meaning
Arai ja gerd mun kor tong gerd	What ever will be, will be
Chinnabunchorn chant	One of the chants that Buddhists pray in order to be healthy, happy, and peaceful.
Gu naa	Saving faces
Kwa ja ru diang sa	A Thai expression used to describe the maturation process from innocent adolescence to motherhood.
Phi prai	A type of ghost who lives in the water.
Pratripidok	The Buddhist scriptures
Rak nuan sa-nguan tua	Take pride in being "untouched" and "sexually reserved
Sad lok yom pen pai tam karma	People are responsible for what they have done.
Sai yai rak nai krob kua	A web of family connection
Sati	Mindfulness
Sin sod tong mun	Monies and gold given by a groom's parents to a bride's parents as a pledge.

GLOSSARY (Continued)

Thai phrase	English meaning
Su khor	A Thai traditional activity that a male's family comes to see a female's parents as an honor for asking a female's parents to allow their daughter to marry its son. After female's parents agree with this, they then set date, month and time for an engagement and a wedding ceremony.
Tee peung yam yak	Someone who will always there for you through the difficulties in life.
Tum jai	Accept the truth of an unexpected situation
Wak sen Ceremony	An uncommon Thai traditional wedding organized in Uttaradit Province.
Yu fire	A Thai traditional postpartum practice that a postpartal woman would lie near the fire in order to be healthy.
Yu Fireshood	One of the practices during *Yu fire* period to keep the body warm to promote the involution of uterus and the flow of lochia. The processes include lighting 4 bars of herbal charcoal and putting them inside a box then wrapping it around postpartum women's belly twice or more a day.
Yad nam tip chalom jai	Nourishment for one's soul
Yom jum non	Surrender

CHAPTER ONE

THE STUDY PROBLEM AND SIGNIFICANCE

Introduction

Adolescent sexual activity and adolescent pregnancy continue to be a major health problem in Thailand, with the number of unplanned pregnancies among Thai adolescents dramatically increasing every year (Thailand Public Heath Statistics, 2004). Compared to adults, adolescent pregnancy occurs at a time of a greater challenge for women since they are still engaged in the developmental tasks of adolescence and are undergoing physical development. These individuals may not be prepared physically, psychologically, or economically for maternal role attainment, and complications rooted in familial and social expectations may compound these factors (May & Mahlmeister, 1994). In particular, adolescents in Thai culture who become pregnant can bring humiliation to the famliy and often experience societal rejection (Thongchompoo, 1999). Society-wide factors affecting pregnant adolescents include culture, religion, moral values and beliefs, law, education, and lack of support structures such as finding access to health care. This puts both pregnant adolescents and their children at high risk for poor health and social outcomes (Pongtadsirikul, 2006; Thongchompoo, 1999; Vongjinda, 2004). There has been minimal research about the experiences of being pregnant and becoming a mother among Thai adolescent women (Thonchompoo, 1999; Vongjinda, 2004). Their insights about the experience hold potential to inform the health care community on how best to meet their needs during their pregnancy and to support them as new mothers. The purpose of this grounded theory study was to discover the social processes that affect pregnant Thai adolescents with unintended pregnancies throughout

the childbearing year. Chapter one describes the nature of the study, which includes a statement of the problem, purpose and specific aims, and significance.

Statement of the Problem

In 2000, over one billion people (19%) in the world were 10-19 years old (United Nations, 2001). The Asian and Pacific region comprises 717 million people in this age group. The largest number of adolescents (45%) resided in South and Southwest Asia; whereas in Southeast Asia, adolescents comprised 16% of the population. According to United Nations projections, the world population in the age group 10-19 will continue to grow, while in the Asian and Pacific region this number will decline.

In Thailand the distribution of the population aged 15-19 declined from 9% in 2000 to 8% in 2006 (National Statistical Office, 2006). Of this distribution, 34% of adolescents live in the Northeast, 23% live in the Central region (excluding the Bangkok metropolitan area), 17% live in the Northern region, 16% live in the Southern region, and 10% live in Bangkok.

Most countries have multiple organizations placing great emphasis on the problems and needs of adolescents because of the crucial role adolescence plays in the future growth and development of individuals (United Nations, 2003). Adolescents have become a growing concern in every society, especially in terms of reproductive health. One of the major problems related to the reproductive health of adolescents is adolescent pregnancy. Worldwide reports for the years 1995-2000 estimate that 14 million women between the ages of 15 and19 gave birth each year during this period with 12.8 million births occurring among adolescents in the developing regions (United Nations, 2003). From 1995-2000, the adolescent fertility rate was 54 births per 1,000 women for the

world as with rates varying among different regions. The adolescent fertility rate between more developed and the less developed regions was 29 and 58 births per 1000 women aged 15-19, respectively. In the least developed countries, the average birth rate was 133 births per 1,000 women aged 15-19. On average, the highest rate of adolescent childbearing was found in Africa (115 births per 1,000 women); whereas the lowest rate was found in Europe (25 births per 1,000 women). In Asia and Northern America the average rate was 39 and 51 births per 1,000 women aged 15-19, respectively (United Nations, 2003). In a comparison of 10 countries in South-east Asia in the year 2000, Thailand ranked fourth (13%) in the number of births to adolescents as a percentage of all births; Cambodia ranked highest (16%) and Singapore ranked lowest (2%).

Since 1997, Thailand's National Health Plan goal is to reduce the prevalence of adolescent pregnancies to less than 10% of all pregnancies (Ministry of Public Health, 2002). Nonetheless, the Thai birth rate among pregnant adolescents per 1000 females increased sharply from 31.1 in 2000 followed by 33.7, 37.9, 39.2, and 47.3 in 2001, 2002, 2003, and 2004, respectively (Thailand Public Heath Statistics, 2004). In 2006, the Thai birth rate among pregnant adolescents per 1000 females was 90 ranking first for all of Asia, excluding Muslim countries (Reaungareerat, 2007). Over a similar period, the birth rate in the United States of America among 15-19 year old adolescents declined from 61.8 per 1000 in 1991 to 41.2 per 1000 in 2004 (Martin et al., 2006). Adolescent pregnancy continues to be a national health concern.

Although Thai society remains predominantly conservative, there are increasing numbers of Thai adolescents engaging in premarital sexual activity (Allen et al., 2003; Chaipak, 1987; Chanakok, 1993; Koetsawang, 1987; Nuchanart, 1988; Puthapuan, 1994;

Srisuphan, 1990; Thato, Charron-Prochownik, Dorn, Albrecht, & Stone, 2003; Thevadithep, 1992). Unintended pregnancy among adolescents is one negative consequence of premarital sex, leading to a major public health concern in Thailand. Adolescent pregnancy affects both physiological and psychosocial aspects of their lives. Pregnant Thai adolescents have greater risks than adults for sexually transmitted infections (STDs), especially HIV-1 infection (Taneepanichskul, Phuapradit, & Chaturachinda, 1995). They also experience more anemia, severe preeclampsia/eclampsia, placental abruption, intrauterine fetal death, and cesarean delivery (Pattaragan, Ruangvuthilert, Witoonchart, Seneewong, & Seneewong Na Ayuthaya, 2005; Suravongsin, 2003). Not only does pregnancy have maternal implications, it also affects their infants. Low birth weight (LBW) infants, premature delivery, and fetal distress have been found to be greater among adolescent than in adult pregnancies (Buhachat & Pinjareon, 1998; Dhamachat, Limsawat, & Sanjai, 2003). These complications represent a growing concern for the individual family and a burden to Thai society.

Pregnant adolescents are in transitional stages of their lives facing two developmental tasks. One is the transition from adolescence to adulthood and the other is from pregnancy to motherhood. As adolescents becoming mothers, these tasks become even more challenging if they do not have help from their families or enough resources from a community and society at large (Mercer & Walker, 2006). Individuals who are unsuccessful in each developmental task may be delayed in later developmental tasks, all of which can create struggles in their adult lives (Havighurst, 1972).

Pregnant adolescents who have low levels of self-esteem, self-efficacy, education, income, and social support also exhibit lower levels of health responsibility and self care behavior and practices (Puttapitukpol, 2001; Rattanapong, 2001; Sriumporn, 2000). Most Thai pregnant adolescents identify their mothers and husbands as their main source of support and report less support from nurses, physicians, and others (Nirattharadorn, Phancharoenworakul, Gennaro, Vorapongsathorn, & Sitthimongkol, 2005; Piyasil, 1998; Puttapitukpol, 2001; Rattanapong, 2001; Sriumporn, 2000). Many pregnant adolescents have boyfriends who do not accept the pregnancy and often refuse to take any responsibility to help the mother. Some boyfriends state that pregnancy occurred because of the foolishness of the girl (Pongtadsirikul,2006). These perceptions suggest reasons why Thai adolescent mothers may be more likely to be single parents (Isaranurug, Mo-Suwan, & Choprapawon, 2006; Varakamin, Chamwithilert, & Thavisith, 2004; Vongjinda, 2004).

Thai pregnant adolescents often have unstable jobs and work for low wages. Pregnant adolescents who are homemakers must depend on their families and husbands' income (Rattanapong, 2001; Thonchompoo, 1999; Vongjinda, 2004). Most adolescents who carried an unintended pregnancy also reported a delay attending prenatal care clinics and received inadequate prenatal care due to economic constraints (Buhachat and Pinjareon, 1998). Although research evidence demonstrates an increase in risk for psychological distress for this population, many do not avail themselves of care that might be of assistance to them. Lack of prenatal care for pregnant adolescents can lead to adverse effects to their health and the health of their infants.

Thai adolescent pregnancy has been researched using different foci over the past several decades. The majority of the studies carried out between 1989 and 2006 have focused on self-care and health promoting behaviors. Among those, several studies asked whether certain factors such as self-efficacy, self-esteem, social support, intention to have a baby, level of education, occupation, income, and health perception influenced healthy behavior patterns in pregnant adolescents (Puttapitukpol, 2001; Rattanapong, 2001; Sriumporn, 2000). Sriumporn (2000) found significant positive correlations between self-esteem ($p<.01$), social support ($p<.01$), level of education ($p<.05$), and intention to have a baby ($p<.01$) with self care behavior. Social support was the strongest predictor for self care behavior followed by self-esteem and intention to have a baby. Another study by Puttapitukpol (2001) showed that perceived self-efficacy ($p<.001$), social support ($p<.01$), age ($p<.05$), and education ($p<.05$) had a significantly direct positive effect on health responsibility. Rattanapong (2001) also found that there were significant associations among family characteristics, planned pregnancy, and self care practices ($p<.01$) for pregnant adolescents, in addition to a significant relationship between education and knowledge of self-care behavior ($p<.01$).

Several studies have focused more on psychological issues such as depression and anxiety. Piyasil (1998) reported that pregnant Thai adolescents had a higher prevalence rate of depression (23%) than adult pregnant women (12%). In addition, she reported a 15% prevalence of anxiety state during pregnancy for this population. Another study by Nirattharadorn and colleagues (2005) found that 47% of the participants experienced antepartum depression and 55% experienced postpartum depression. Antepartum depression had a significant positive influence on postpartum depression ($p<.001$); 89%

of adolescent mothers who experienced antepartum depression also experienced postpartum depression. Antepartum self-esteem and social support had significant direct and indirect influences on postpartum depression ($p<.01$). Mercer and Ferketich (1990) reported that mothers who had anxiety and depression had negative effects on their attachment to the infants. Similarly, Fowles (1998) reported that mothers who experienced postpartum depression had negative perceptions of their infants, their maternal roles, and perceptions of the ability to take care of their babies at 2 to 3 months after birth. These findings were congruent with Porter and Hsu (2003) who found that pregnant women who reported higher level of depression, anxiety, and marital ambivalence and conflict during pregnancy reported less efficacy in maternal role.

Research findings suggest that adolescent pregnancy leads to negative consequences for young women, their babies, and society. However, there have been few studies that have explored the experience from the perspective of the pregnant adolescents - to tell their experiences about pregnancy, to express their feelings, and to voice their own needs during this challenging time in their development as persons and new mothers (Thonchompoo, 1999; Vongjinda, 2004). Therefore health care providers need to take a step back to understand the young people they work in order to develop health interventions grounded in knowledge relevant to the population.

Purpose and Specific Aims

The goal of this grounded theory study was to understand experiences of pregnancy and becoming a new mother in Thai adolescents who decided to carry an unintended pregnancy. Understanding pregnancy from the perspective of Thai adolescents is important for health care providers in order to be adequately prepared to

deliver care that meets their needs, promotes healthy pregnancies, and works with them in their transition to motherhood. In addition, policymakers may use the findings as baseline data and a source of information to enact policies serving the needs of this group.

The specific aims were to understand and describe how the Thai pregnant adolescent:

1. perceives, assigns meaning, and appraises her pregnancy and postpartum period;
2. maintains, develops, and/or supports relationships with other people during her pregnancy and after birth;
3. identifies needs and sources of support during pregnancy and transition to motherhood;
4. develops strategies to cope with pregnancy and becoming a new mother.

Significance

Greater understanding is needed about how adolescent girls create their realities, either through social constructs, or by attaching meaning to situations. Likewise, how they manage their experiences and challenges during pregnancy and childbearing year must also be better understood. The social processes relating to phenomena that negatively and positively affect pregnant Thai adolescents may provide cues on how to promote healthy pregnancies, to provide care that meets the needs of the pregnant adolescent, and to foster her becoming a mother. Finally, enhanced understanding of these social processes could provide useful information for policymakers in the enactment of laws or development of programs to benefit this population.

Summary

There is a lack of knowledge about experiences of pregnant adolescents and what it is like to become a mother among these young people. The purpose and aim of this study was to describe and explain the transition of becoming a mother from the perspective of a Thai adolescent who decides to carry an unintended pregnancy. A better understanding of her experiences from pregnancy to a becoming mother provides a basis for promoting healthy pregnancy, serving her needs during pregnancy and fostering her becoming a new mother.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This review of literature provides background and concerns of adolescent pregnancy for the pre-understanding of the study participants. The review of literature is divided into eight sections: definitions of adolescence, health and social issues, and outcomes of adolescent pregnancy, developmental tasks of pregnancy, maternal tasks of early postpartum, conceptual and theoretical framework, assumptions, research questions, and definition of terms.

Definition of Adolescence

The World Health Organization (WHO) defines adolescence as "a particularly important phase in life; a critical time of rapid physical, mental, emotional, social, and spiritual development. The rate at which these changes occur, and the key events that mark them, vary considerably among individuals and among societies. There are differences in the place and quality of development among adolescents of the same age and sex, between the sexes, and among adolescents from different cultural, social, and economic backgrounds" (WHO, 2002, p.2). According to the United Nations (1997), adolescence is the transition period from puberty to maturity and the stage of life during which time individuals reach sexual maturity (United Nations, 2001). Konopka (1991) defines that "adolescents are growing, developing persons in a particular age group—not preadults, preparents, or preworkers—and human beings participating in the activities of the world around them. In brief, adolescence is not only a passage to somewhere but also an important stage in and of itself" (p.10).

In terms of numbered years, the age group 10-19 identifies the period of adolescence (WHO, 2002). Psychologists usually sub-divide adolescence into three periods: early adolescent ages between 11-14, middle adolescent ages between 15-17, and late adolescent ages between 18-20 (Fuller, 1986). Ingersoll (1992) identified that in early adolescence, the adolescents grow rapidly both physically and psychologically. Their thoughts become more mature and the physical changes in their bodies become noticeable, especially the beginning of their secondary sexual characteristics. During this period, they reassess who they are with all of the personal changes occurring and have a strong need to be accepted by peers. They do not want to be viewed as 'black sheep' within their group. Consequently, their growing social behaviors and social skills tend to follow the norms of the group. This is necessary in order for them to have a sense of belonging to that group. In middle adolescence, the development of secondary sexual characteristics is almost complete. They develop original thoughts, and begin to attain maturity as adults and to seek independence from their parents. They prepare, in late adolescence, to enact roles as adults. They begin to see futures for themselves, to set goals in their lives, and to determine their own values.

Health and Social Issues, and Outcomes of Adolescent Pregnancy

Adolescent pregnancy has profound effects not only on the health and well-being of adolescents, but also on their children, their families, and society. This section will critically review the literature about health issues, social issues, and outcomes of adolescent pregnancy in Thailand. The section will conclude with a synthesis of the theoretical and scientific knowledge of Thai adolescent pregnancy.

Health Issues Related to Adolescent Pregnancy

It is a situational crisis for adolescents who become pregnant since they are in the period of developmental transition to adulthood (Oxley & Weekes, 1997). Pregnant adolescents and their babies can suffer several adverse health effects, of both a physical and psychological nature.

Physiological Effects

Pregnant adolescents. Young adolescents, particularly those under age 15, experience a maternal death rate that is 2.5 times greater than that of mothers aged 20-24 (Morris, Warren, & Aral, 1993). Common medical problems among adolescent mothers include poor weight gain, pregnancy-induced hypertension, anemia, sexually transmitted diseases (STDs), premature labor, dystocia, operative delivery, and cephalopelvic disproportion (Grady & Punpuing, 1999; & Steven-Simon & White, 1991). It is also believed that teenagers are also at greater risk of prolonged labor because of cephalopelvic disproportion (American College of Obstetricians and Gynecologists, 1993; Wieland Ladewig, London, & Davidson, 2006).

Cephalopelvic disproportion can be related to immature pelvic structure in adolescent women (Kunawitikul & Sakulsutthiwong, 1987). During pregnancy, physical development of adolescents slows; the body grows less, especially in height. This is caused by the increased production of estrogen during pregnancy, causing the epiphysis of the bone to close more rapidly (WHO, 1998). Less is known about the long-term physiological sequelae. However, it is possible that women who undergo teenage pregnancy never overcome their developmental defects, and may face cephalopelvic disproportion at each later pregnancy. Adolescent mothers tend to be at greater risk for

obesity and hypertension in later life than older primiparas, but most studies have not clearly distinguished whether these conditions are related to early childbearing or early maturation (Steven-Simon & White, 1991).

Several studies in Thailand have shown that pregnant adolescents are at greater risk than adults for STDs and medical complications of pregnancy. A study carried out in Ramathibodi Hospital between 1991 and 1995 found that the prevalence of HIV-1 infection among pregnant adolescents was 1%, about 3 times higher than among the general pregnant population in the hospital (Taneepanichskul, Phuapradit, & Chaturachinda, 1995). In the HIV-1-positive pregnant adolescents, 23% were anemic, and 14% were Venereal Disease Research Laboratory (VDRL) reactive for syphilis. In 2005, the same hospital reported the case of a 13-year-old adolescent who was diagnosed with severe pre-eclampsia/eclampsia complicated by an abruption of the placenta and a dead fetus in utero (Pattaragan, Ruangvuthilert, Witoonchart, Seneewong, & Seneewong Na Ayuthaya, 2005). The eclampsia resulted in acute renal failure due to both pre-renal and renal causes. Another study found that pregnant adolescents contracted diseases, such as gonorrhea, chickenpox, pertussis, viral infection including urinary tract infection, and herpes simplex, more frequently than adults (Intaraprasert & Thaneepanichsakul, 1996). These studies suggest that in Thailand as in the US, the younger the mother, the more risk of exposure to complication and medical disease.

Infants. Although health risks to the adolescent mothers are great, the risks to their infants are even more concerning, including LBW and increased mortality and morbidity. Studies carried out both in the US and in Thailand show that infants born to teenage mothers have lower than average birth weight (Felice et al., 1999 ; Guyer et al.,

1999; & McAnarney & Hendee, 1989; Dhamachat, Limsawat, & Sanjai, 2003). For instance, a US study found that infants born to mothers less than 15 years of age were more than twice as likely to weigh less than 2,500 grams at birth and three times more likely to die in the first 28 days of life than infants born to older mothers (Guyer et al., 1999). Similarly, a study at Songklanagarind Hospital indicated that the rate of LBW in the pregnant adolescent group was higher than the adult group (12% and 9%, respectively) (Buhachat & Pinjareon, 1998). They also reported higher cesarean birth due to fetal distress in adolescent group (30% versus 14%). Another study supported these findings. Dhamachat, Limsawat, and Sanjai (2003) conducted a survey study to determine the characteristics of pregnant adolescents. Study participants were 1,122 pregnant adolescents whose ages were less than 20 years and gave birth to their first babies in Nakhornphanom Province. Data were collected by questionnaires constructed by the researchers. Most pregnant adolescents had an average age of 18.8 years old and were married (94%). Most of them had completed elementary school (83%) and were farmers or gardeners (87%). More than half resided in extended families with 5-9 family members (75%). Their average monthly family income was 2,608 Baht ($1=31.80 Baht). Most of them received the prenatal care at a health center (79%). Their average gestational age was 3.4 months when they first attended the prenatal care clinic. Pregnant adolescents experienced premature birth (6%) and 10% delivered a baby weighing less than 2,500 grams. There was a positive statistically significant relationship between health service utilization and fetal birth weight ($P<.05$).

Suravongsin (2003) conducted a retrospective study to compare the delivery outcomes between pregnant adolescents and pregnant adult women. Cohort study

participants were 227 pregnant adolescents and 227 pregnant adult women who attended the prenatal care clinic at Nopparat Rajathanee Hospital, Bangkok. Most of pregnant adolescents ranged from 17 to 19 years old (78%). More than half of them were housewives (67%) and lived with their husbands, but did not have a marriage registration (95%). The number of antenatal care visits, weight gain during pregnancy, gestational age at delivery, fetal birth weight of pregnant adolescents were significantly lower compared to the pregnant adult women (p=.000, .019, .030, and .001, respectively). This study also showed a significant increase in the incidence of preterm labor and birth of a LBW infant for teenagers relative to adults. Even after controlling for the number of antenatal care visits, gestational age at delivery, and fetal birth weight, LBW, and prenatal complication remained significantly higher in adolescents than in adults (p=.023, .000, .001, and .013, respectively).

Post-neonatal morbidity and mortality were also higher in infants born to adolescent mothers. Morris and colleagues (1993) found that after controlling for birth weight, the post-neonatal mortality rate was approximately twice as high for infants born to mothers under 17 than for infants born to older women. The incidence of sudden infant death syndrome was higher among infants of adolescents, and their infants also experienced higher rates of illness and injuries. A possible reason proposed was that adolescent mothers were more economically disadvantaged than adult mothers. Several studies have indicated that very young adolescent mothers are underweight and give birth to smaller babies because of poor diets and inadequate or no prenatal care (Steven-Simon & White, 1991). Similarly, the greater incidence of illness and injury in infants of adolescent mothers is more likely due to environmental factors such as poverty, poor

health habits, and insufficient supervision than to the age of the mother per se (Steven-Simon & White, 1991).

Psychosocial Effects

Most Thai adolescent pregnancies are unplanned and occur outside marriage (Manopaiboon et al., 2003). Adolescents who become pregnant before marriage confront many problems, and report feeling shocked, afraid, guilty, angry, ashamed, frustrated, depressed, upset, disappointed, stressed, anxious, confused, embarrassed, humiliated, dismayed, fretful, moody, and worried (Thongchompoo, 1999; Vongjinda, 2004). Changes in hormones, such as increasing estrogen and progesterone levels, during pregnancy are believed to enhance negative emotions, and these emotions may be more intense if the pregnancy is unplanned or premarital. Moreover, unplanned pregnancy in adolescents can increase the likelihood of depression (Orr & Miller, 1995). Adolescents may not be mature enough to appropriately solve problems. Some pregnant adolescents will consider and even attempt suicide (Gabrielson, Klerman, Currie, Tyler, & Jekel, 1970). Along with changes in their physical and mental states during pregnancy, adolescents may not adapt well to their new role, which has consequences for both themselves and their infants. Zuravin (1991) found that in severe situations of emotional deprivation, children born to adolescents with an unplanned pregnancy may be at higher risk of physical abuse or neglect. The following studies address these issues including self-esteem, self-efficacy, anxiety, and depression.

Piyasil (1998a) conducted a cross-sectional study at a non-private ward at Rajvithi Hospital, Bangkok to determine the prevalence of anxiety and depressive states in Thai teenage mothers compared with adult mothers. Mothers were divided into 2 groups

according to their ages, teenage mothers (age below 18 years, N=104) and adult mothers (age 21-35 years, N=98). Mothers were excluded if they were HIV positive. Anxiety and depression were categorized according to major depressive episode 4 criteria (Criteria from the Diagnostic and Statistical Manual of Mental Disorder: DSM 4 criteria, 1994). Mothers' moods over the past two weeks were evaluated by six questions on anxiety and six questions on depression. Anxiety and depression scores were summed and those with 9 or more were considered positive. Both groups of mothers were interviewed by a pediatrician. The mean age of the teenage mother was 16.8±0.97 years old. Most of the teenage mothers completed only elementary school (70%). Some of them had inadequate weight gain during pregnancy (21%). There was a significantly higher prevalence rate of depression in teenage mothers (23%) compared to adult control mothers (12%) ($p<.05$). However, there was no significant difference in the anxiety state of the two groups; 15% of teenage mothers and 12% of adult mothers scored positive for anxiety.

Another prospective study aimed to test the structural equation model of maternal depression and to determine how self-esteem, social support, and antepartum depression influence postpartum depression among Thai adolescent mothers (Nirattharadorn, Phancharoenworakul, Gennaro, Vorapongsathorn, & Sitthimongkol, 2005). Multi-stage random sampling was used to recruit 340 young mothers aged 14-19 from four hospitals in the Bangkok metropolis. Exclusion criteria were adolescent mothers who gave birth to premature infants or lost custody of the infant. Measurements included the Center for Epidemiologic Studies Depression (CES-D) Scale, the Rosenberg's self-esteem (RSE) Scale, and the Inventory of Social Support Behaviors (ISSB) Questionnaire. The participants completed the questionnaires two times: during the third trimester of

pregnancy and at the sixth week postpartum. A cut point of 19 of the CES-D scale was used to measure the current level of depression in adolescent mothers. The results revealed that at each time point, self-esteem and social support had a significantly negative direct influences on depression both in the antepartum and the postpartum periods. Positive screens for depressive symptoms were high; 47% of the participants experienced antepartum depression and 55% experienced postpartum depression. The antepartum depression had a significant positive influence on postpartum depression ($p<.001$); 89% of adolescent mothers who experienced antepartum depression also experienced postpartum depression. Antepartum self-esteem and social support had significantly direct and indirect influences on postpartum depression ($p<.01$).

Sriumporn (2000) conducted a descriptive study to determine the relationship between self-esteem, social support, selected factors, and self care behavior in pregnant adolescents and to determine whether these variables can predict self care behavior of pregnant adolescents. Selected factors included level of education, marital status, intention to have a baby, occupation, and family income. Orem's self-care theory was used as a theoretical framework. Study participants included 120 pregnant adolescents who received prenatal care at Rajavithi Hospital, Bangkok. Data were collected by self-administered questionnaires. Measurements included Rosenberg's Self- Esteem measurement (RSE), Support Behavior Inventory (SBI) of House conceptualization of social support, and Self Care Behavior during Pregnancy Questionnaire by Ruedee Pungbangkadee (1997).

The average age of pregnant adolescents in the sample was 18.07 years old with a gestational age range from 28 to 40 weeks. Most had a level of education in secondary

school (48%), were married (83%), intended to have a baby (61%), and were housewives or students with non-fixed hours (78%). An average family income was 8,193 Baht, which came from their husbands and families. Pregnant adolescents had overall rather high self-esteem scores. However, there were three items which had lower scores, for instance “I wish I could have more respect for myself,” “I am able to do things as well as most other people,” and “I feel that I have a number of good qualities.” Most were satisfied with support care they received. The main supporters were their husbands (66%), followed by their mothers (22%). Nurses and physicians were reported as the lowest percentage of supporters (0.8%). Most pregnant adolescents had overall good self care behavior scores. However, there were three items which had lower scores in the aspect of developmental self care. They included “I ask physicians and nurses about preparation for delivery,” “I ask physicians and nurses about the right practice,” and “I choose newborn clothes.” Three other items with lower scores in health-deviation self care included “I ask physicians and nurses about abnormality that might occur during pregnancy and with the fetus in uterus,” “If I have a fever, I go to see the doctor prior to an appointment,” and “If I have wrong symptoms such as weak quickening or bleeding per vagina, I go to see the doctor prior to appointment.” There were statistically significant positive correlations between self-esteem ($p<.01$), social support ($p<.01$), level of education ($p<.05$), and intention to have a baby ($p<.01$) with self care behavior. Social support, self-esteem, and intention to have a baby explained 26% of variance ($p<.01$) of self care behavior. Social support was the first predictor explaining 13% of variance of the pregnant adolescents’ self care behavior ($p<.001$), followed by self-esteem with 8%

of variance ($p<.001$), and intention to have a baby (4%) with variance ($p<.01$) (Sriumporn, 2000).

Puttapitukpol (2001) conducted a cross-sectional descriptive study to examine causal relationships among perceived self-efficacy, perceived barriers, social support, age, education, family income, and health responsibility using Pender's Health Promotion Model. Study participants included 607 adolescents who were admitted to the postpartum units of 9 public hospitals in the Bangkok Metropolitan area. Data were collected by using five sets of questionnaires including a personal data form, Perceived Self-Efficacy for Health Responsibility Scale, Perceived Barriers to Health Responsibility Scale, Personal Resource Questionnaire (PRQ85-Part II), and Health Responsibility Scale.

The average age was 17.77 years old, 45% had completed junior high school (grade 7-9) and 35% elementary school (grade 1-6), most (60%) were housekeepers, and lived with their husbands (90%). The average family income was 5,961 Baht. Most (66%) had an unplanned pregnancy. Most attended a prenatal care clinic (61%), but some of them never received prenatal care during pregnancy (12%). All started attending prenatal care clinic during the second trimester. Perceived barriers had a significantly direct negative effect on health responsibility ($p<.01$). Adolescents who had lower levels of perceived barriers to health responsibility had higher levels of health responsibility. In addition, perceived self-efficacy had a significantly direct positive effect on health responsibility ($p<.001$). Perceived self-efficacy also had a significantly direct negative effect on perceived barriers ($p<.001$). Social support had a significantly direct positive effect on health responsibility ($p<.01$). This demonstrated that adolescents who had higher levels of social support also had higher levels of health responsibility. Age and

education had a significantly direct positive effect on health responsibility ($p<.05$). In addition, education had a significantly indirect positive effect on health responsibility ($p<.001$) by affecting social support and perceived barriers. This means that adolescents who had high levels of education had increased levels of health responsibility and social support, and decreased levels of perceived barriers. Family income had a significantly indirect effect on health responsibility ($p<.01$) by affecting social support.

Rattanapong (2001) conducted a survey to determine knowledge of self care behavior and self care practices of pregnant adolescents and to examine the relationship among education, occupation, income, marital status, family characteristics, planned pregnancy, previous relationships with parents, with knowledge of self care behavior, and self care practices. Study participants included 300 pregnant adolescents who attended the prenatal care clinic at Rajavithi Hospital, Bangkok. Data were collected using two sets of questionnaires including Knowledge of Self Care Behavior of Pregnant Adolescent Inventory and Self Care Practices during Pregnancy Inventory.

The average age was 19 years old with gestational age ranging from 3 to 6 months at enrollment. Most had an unplanned pregnancy (53%), completed junior high school, and were housekeepers. Family income was 4,001-6,000 Baht. Nearly half of them lived with their husbands (48%) and others lived with parents or relatives. Most of them described good relationships with their mothers and fathers (93%, 82%, respectively) and had never gained information about how to take care of themselves during pregnancy (36%). Some of them gained this information from relatives and friends (35%). Knowledge of self care behaviors during pregnancy was moderate (59%). More than 50% of pregnant adolescents had an incorrect knowledge on aspects of weight gain, sexual

activity, and food intake during pregnancy. Most had an overall moderate self care practice score during pregnancy (66%). Inappropriate self care practice scores during pregnancy were reported in aspects of health and practices (17%), personal hygiene (16%), nutrition (20%), and mental health (19%). There was a statistically significant relationship between level of education and knowledge of self care behavior ($p<.01$). There were no significant relationships among occupation, family income, marital status, family characteristics, planned pregnancy, previous relationship with parents, and knowledge of self care behavior during pregnancy. There were statistically significant associations among family characteristics, planned pregnancy, and self care practices of pregnant adolescents ($p<.01$).

Visutthiwan (2000) conducted a quasi-experimental study to determine the effectiveness of a health education program designed to promote self care among pregnant adolescents using the Health Belief Model. The sample included 85 pregnant adolescents who attended the prenatal care clinic at Queen Sawangwattana Memorial Hospital, Cholburi Province. They were recruited by probability sampling method and then divided into experimental (N=41) and control groups (N=44). The program was divided into three sessions and delivered to the experimental group over a four week period. The program was composed of lectures, slide presentations, a demonstration session, group meetings, and skill development sessions. Data were collected twice in pretest and posttest by using a body weight measurement record and a questionnaire constructed by a researcher.

The average age of the experimental and control group was 18.59 and 18.55 years old, respectively. Most of the pregnant adolescents in the experiemental and control

groups had secondary education (66%, 64%) and were wage earners (85%, 59%). Most pregnant adolescents' monthly family income in the experimental group was above 10,000 Baht (34%), whereas the pregnant adolescents in the control group had monthly family income between 4,000-6,999 Baht (34%). Most of them lived with their husbands (85%, 68%). There was a statistical significance ($p<.05$) of the pregnant adolescents in the experimental group who perceived benefits and barriers in taking experts' advice in practice self care and had better self care practices than those in the control group. Pregnant adolescents in the experimental group had a proportionately higher weight gain than the control group ($p<.05$).

Two qualitative studies that explored pregnant Thai adolescents' experiences also supported the prevalence of psychosocial issues. Thongchompoo (1999) conducted a qualitative study to describe self care practices of pregnant adolescents with unwanted pregnancies and factors related to those practices. The concepts of self care practices, maternal role adaptation, and social support were used as a study framework. Study participants included 22 adolescents with unwanted pregnancies who were clients of the three crisis centers, situated in Bangkok and Samut Prakan province. All centers provided temporary residences, food, clothes, drugs, counselors, nurses, and vocational training. Data were collected by multiple methods including participants' life history and in-depth interviews. Life histories were collected by interviews about the history of childhood and adolescence, education background, relationship in the family, socioeconomic status, previous problems and solutions, sexual values in the community, health and health care behaviors, people who took care of them during childhood, and self care practices in

adolescence. Each participant was interviewed two or three times until the researchers reached saturation. Content analysis was used to analyze the data.

Most of the pregnant adolescents were from low socioeconomic status and finished secondary school (grade 9). Causes of having an unwanted pregnancy included lack of knowledge about pregnancy and family planning, misunderstanding and mistakes in using contraceptive methods, and being raped. Emotional responses to an unwanted pregnancy included unhappiness, anxiety, disappointment, hopelessness, loneliness, shame, fear, low self-esteem, low self-confidence, and guilt. Self care practices consisted of positive changes in their food habits, rest, exercise, and preventive health behaviors. Factors related to self care practices were maternal role adaptation, level and types of social support, meaning of pregnancy, income, and education level.

Another qualitative study conducted by Vongjinda (2004) aimed to understand the first pregnancy experience of female adolescents. Study participants included 20 pregnant adolescents who were less than 20 years of age, pregnant for the first time with a gestational age of 28 months or more, and attending prenatal clinic at Kamphaensan Hospital, a 60-bed-sized community hospital in Nakornprathom province. Data were collected by individual, in-depth interviews with an average of 2-4 interviews for each participant. Data were analyzed using the following steps: (1) all of the data were transcribed and recorded on the same day of each interview. They were, then, sorted out for each interviewee, carefully read and checked for the completeness. Missing data were identified and prepared for the next interview; (2) the data of each interviewee was filed in congruence with topics of interest such as socio-economic background, romantic relationships, being a mother etc.; (3) Filed data were then carefully analyzed. Reduction

of data aims to make important points was easily observable, processed, summarized, and reported.

Most of the girls were from socio-economically unstable families and did not finish compulsory education. The reasons why these young people left school included; their families could not afford it and needed their help; they had to stop their school life in order to give opportunities to younger brothers or sisters to study; and they were not successful at school. Factors related to the acceptance or denial of pregnancy were the meaning given to pregnancy, reactions of close relatives, degree of suffering caused by morning sickness, failure of abortion, and the extent of the affection while experiencing fetal movement. Their experiences of pregnancy involved various aspects, such as the managing of bodily, social, and economic changes, assuming new motherhood role, self care practices during pregnancy and preparing for the baby. Self care practices during pregnancy of the female teens involved many behavioral changes including diet alteration, avoidance of self-medication, exercise, general hygiene, body cleaning, safety care and regular visits to the prenatal clinic. All of these practices were found to be related to many factors such as the acceptance of pregnancy, age, the influence of parents, and economic status.

In short, it is clear that pregnant Thai adolescents experienced antepartum and postpartum depression as well as anxiety during their pregnancy. Self esteem and social support were related to depression. The studies indicated that high self-esteem and sufficient social support could decrease the level of depression in pregnant adolescents. In addition, self care behavior, self care practice and health responsibility of pregnant adolescents could be enhanced by high self-esteem, high self-efficacy, and sufficient

social support. Although many studies reported sufficient support these young people gained from their husbands and their mothers, it is still unclear who was the most helpful for them, who were other supporters during their pregnancy, and what kinds of support they received from these people. Furthermore, for the pregnant adolescents who experienced depression and anxiety, little is known about how they manage these experiences and strategies they used to cope with challenges during pregnancy. All of these deserve further study.

Socioeconomic Issues Related to Adolescent Pregnancy

Adolescent pregnancy has an impact on education both during and after pregnancy. Since Thai society does not approve of adolescent pregnancy, especially among students, most pregnant adolescents drop out of school. Some of them become unemployed because employers often lay off pregnant women. Overall, adolescents who have children are substantially less likely to complete high school and few adolescent mothers attend college (Moore, 1992). Since they tend to have a low level of education, live in extended families, and are single parents, they acquire less work skills, obtain low wages, and are more likely live in poverty. Their independence from parents can be delayed and they rely more on public assistance for financial difficulties, thereby becoming an economic burden to their families and the public at large (Brindis, 1991; Ladner & Gourdine, 1992 ; & Sherwen, Scoloveno, & Weingarten, 1999). A case-control study by Meng-Chih Lee (2001) supported this view. The study aimed to determine the risk factors for adolescent childbearing. Study participants included 324 adolescent mothers who delivered their first babies in Taichung City, Taiwan in 1997. They were divided equally into two groups; 162 cases and 162 controls. Data were collected by a

self-administered structured questionnaire developed by the researcher. The Family APGAR (10) questionnaire was used to assess family function. The average age for cases and controls was 18.7±1.1 and 18.4±2 respectively. Statistically significant risk factors significant for adolescent childbearing included adolescents living outside the home (95% CI 1.0-4.6), single-parent families (95% CI 1.4-16.1), family dysfunction (95% CI 1.1-3.1), mother's inadequate education (95% CI 1.0-2.2), and mother's childbearing in adolescence (95% CI 2.2-11.0). Almost one third (30%) of cases were reported as severe family dysfunction; 41% of cases reported that their relationships with parents were fair to poor, and 9% reported family violence.

Other studies have found that pregnancy during adolescence isolates them from their peers and the social activities. This can lead to increased experience of stress during pregnancy (De Mayo-Esteves, 1990; Ham & Larson, 1990 ; & Oxley & Weekes, 1997). Even if the unplanned pregnancy leads to marriage, it can place a great strain on the young parents. Adolescent mothers are at greater risk of experiencing domestic violence and their babies of experiencing child abuse (Thompson, Powell, Patterson, & Ellerbee, 1995; Wieland Ladewig, London, & Davidson, 2006). Overall, marriages that begin after an unplanned pregnancy have a higher chance of failure and the rate of divorce is high among Thai adolescent parents (Thonchompoo, 1999).

The Prospective Cohort Study in Thai Children (PCTC) by Isaranurug and colleagues (2006) illustrates these problems. This population-based prospective cohort study aimed to explore the relationship of socioeconomic status, service utilization, and pregnancy outcomes between teenage and adult mothers from four districts located in different geographical area of Thailand. All 3,501 pregnant women in the late trimester of

pregnancy with an expected delivery date within a 12-month period of recruitment were included and followed-up in the study. Information was collected from interviews and maternal health records. Women were classified as adolescent mothers if they were under 20 years of age at the time of their delivery and represented 13% of all pregnancies. There was a statistically significant difference in socioeconomic status and service utilization between teenage and adult mothers. Compared with adult mothers, teenage mothers had insufficient family income ($p<.001$), did not own their homes ($p<.001$), were single parents ($p<.001$), seldom consulted with health care providers ($p<.001$), and had an unplanned pregnancy ($p<.001$).

Buhachat and Pinjareon (1998) conducted a cross-sectional study to compare the LBW infant rate of teenage mothers with that of adult mothers. Study participants were divided into two groups. A study group consisted of 287 pregnant adolescents aged 13-19 years and a control group consisted of 2,009 pregnant women aged 20-29 years who gave birth at Songklanagarind Hospital, Thailand. Data were collected to compare the outcome of LBW rate between both groups. The study group was composed of more housewives (42%, and 29%, $p<.0001$), more high school or college students (2.4% and 0.2%, $p<.0001$), and more often received inadequate prenatal care (less than 4 times) than those in the control group significantly (19% and 7%, $p<.0001$). Fifteen pregnant adolescents (5%) never attended a prenatal visit. The findings reported that due to economic constraints and/or concealment of the pregnancy, the pregnant adolescents in this study never or delayed attending prenatal care clinics and received inadequate prenatal care leading to the health of their babies. It was found that the LBW infant rate in the study group was 12.2% significantly higher than that in the control group (8.6%, $p<.05$).

Pongtadsirikul (2006) revealed results of a survey study about pregnant Thai adolescents that received front page press in a Thai daily newspaper on August 31, 2006. Study participants were 121 pregnant adolescents between 14-20 years old with gestational age of 5 months and were living in Donmuang crisis shelters, the Rajathevi child and family residence, and other foundation organizations. Data were collected by in-depth interviews. A large percentage (43%) of the pregnant adolescents were unmarried and still students in elementary school (35%), vocational school (7%), higher education (7%), uneducated (3%), or other (5%). They reported various causes of becoming pregnant, such as unplanned pregnancy (43%), planned pregnancy (38%), and being deceived or raped (14%). These adolescents reported their decision to continue pregnancy because of being afraid of sin (55%), followed by fear of danger, abortion being refused by doctors, and could not afford abortion (23%). Some attempted to terminate their pregnancies (22%) by using many methods, such as hitting their bellies, falling from ladder, taking an oral drug, and being injected with a drug; however, they failed to abort and decided to continue the pregnancy. The most frequent places where they had sexual activity were rental houses (46%), followed by their own houses (21%), and others, such as dormitories or relatives' houses (16%). Most of the adolescents' boyfriends did not accept the pregnancy and 73% of Thai males cited that they were not the father of the baby, were not sure, or thought the baby belonged to another man. They did not take any responsibility for the pregnancy; some of them stated that pregnancy occurred because of the foolishness of the girl. Such perceptions of boyfriends suggest reasons why Thai adolescent mothers are more likely to be single parents (Isaranurug,

Mo-Suwan, & Choprapawon, 2006; Varakamin, Chamwithilert, & Thavisith, 2004; & Vongjinda, 2004).

In brief, most of pregnant Thai adolescents had low levels of education and were unemployed. Many were housekeepers, had financial difficulties, and depended on their families and/or husbands' income. Some of them had unstable jobs with low wages. Most of them never or delayed to attend a prenatal care clinic. Their gestational age for the first visit at the prenatal care clinic was in the second and third trimester. Some of them were abandoned by their boyfriends, attempted having an abortion during their first trimester, and were single parents.

Discussion

Adolescent pregnancy has become a great national concern in Thailand. The studies discussed above provided a description of pregnant Thai adolescents. It is known that most of them were in late adolescent ages (18-20 years old), poor, and had low level of education. Most studies recruited pregnant adolescents who resided in the Bangkok metropolis, the largest city in Thailand. Overall, rural adolescents were overlooked by most researches. Most pregnant adolescents were unemployed or had unstable jobs and worked for lower wages. Pregnant adolescents who were housekeepers depended on their families and/or husbands' income. Most of them carried unplanned pregnancy and stayed with their husbands. Many delayed or never attended prenatal care clinics and also had the incorrect knowledge of self behavior and self practices about pregnancy.

Adolescent pregnancy affected both physiological and psychosocial aspects of their lives. Pregnant Thai adolescents had greater risks than adults for STDs, especially HIV-1 infection. They also experienced more anemia, severe preeclampsia/eclampsia,

abruption of placenta, dead fetus in utero, and cesarean section. Not only did pregnancy affect the adolescents themselves, but it also had an impact on their infants. LBW, premature delivery, and fetal distress were found in higher rates among adolescent than adult pregnancies. These complications carry a large burden for Thailand. In terms of psychosocial issues, adolescents had antepartum and postpartum depression, as well as anxiety during pregnancy. Pregnant adolescents who had high levels of self-esteem, self-efficacy, education, income, and sufficient social support had higher levels of health responsibility and self care behavior and practices. The main supporters for them were their mothers and husbands. Most of them reported less support from nurses and physicians, and others.

The studies reviewed in this review of literature are lacking in several significant areas of adolescent pregnancy. These include the experiences of pregnant adolescents; (a) who are in the periods of early adolescent ages (11-14) and middle adolescent ages (15-17), (b) who reside in a rural area and in other settings, such as the village or community, (c) who are abandoned by their boyfriends, and (d) specific experiences during the three trimesters of pregnancy. Many delayed pregnancy care until later in gestation and the reasons for this are important to discover. In addition, there is little knowledge about specific aspects of social support; For instance, who was the most helpful for the pregnant adolescents? Besides their mothers and husbands, who are the other sources of support to them? What do these people do to support them? Although more pregnant adolescents are unmarried than married, little is known about how supportive husbands are in marriages that are arranged because of pregnancy. The reasons why they reported less support from nurses and physicians were also unclear and need to be clarified. For

adolescents who experienced depression and anxiety, little is known about how they manage these experiences and strategies they use to cope with challenges during pregnancy. Furthermore, how other people respond to their pregnancy is questionable. There is a lack of information about the relationships among pregnant adolescents, family, friends, and other people surrounding them. Last, but not least, there have been few studies that allow pregnant adolescents to tell their experiences about pregnancy, to express their feelings, and to voice their own needs during this challenging time in their development as persons and new mothers.

Developmental Tasks of Pregnancy

Wieland Ladewig, London, & Davidson (2006) identified developmental tasks of pregnancy and the early adolescents' responses to the tasks of each trimester. There are three stages of developmental tasks varying from the first, second, and third trimester. In the first trimester, the main developmental task for women is that they seek to see assurance if they are pregnant by either using a home pregnancy test or going to the hospital or clinic. When they are certain that they are pregnant, they may experience an ambivalent feeling whether the pregnancy is wanted or unwanted. It is a common feeling that can occur for every woman. This feeling refers to the feelings of uncertainty about whether they should become pregnant or not and such a feeling will happen only in the early period of the first trimester. After accepting the reality of being pregnant, the women then take good care of their food intake and activities in order to have a healthy pregnancy.

During the first trimester, the pregnant adolescents respond to the developmental tasks in different ways depending on each circumstance. Pregnancy for these young girls

is mostly unplanned and responses to the pregnancy are negative. As a result, most of them ignore seeking assurance of being pregnant. There are many reasons for them to postpone an acknowledgement of the pregnancy. For example, they may lack knowledge about signs and symptoms of pregnancy such as enlarged breasts because they think that physical changes in their bodies are occurring because of the development of adolescence; subsequently they may delay seeking confirmation of the pregnancy. In addition, for those who did not want to reveal the pregnancy also refused to believe that they became pregnant despite the noticeable changes they experienced. Some were afraid that the revelation of pregnancy to their families or others might upset everybody and then their lives would be chaotic. Their ambivalent feelings may last longer than other pregnant women. Consequently, it is not surprising that these young people may overlook or delay to taking care of themselves during pregnancy; as can be seen in the delay of prenatal visits during this period.

In the second trimester, pregnant women will experience noticeable physical changes and fetal movements. They finally accept the truth of being pregnant. During this trimester, they begin to wear a maternity dress to fit to the bigger belly. They perceive that the fetus is a person who is growing inside their bodies and they prepare themselves to become a mother as well as building relationships with other people, especially their family members. However, for the pregnant adolescents, they may still conceal the pregnancy until the second trimester by wearing a tightened outfit or do activities as usual that may affect their health and the fetus's well-being. They may view themselves as having a negative body image when their belly is getting bigger or they experience

changes in skin pigmentations. Furthermore, they become more dependent on their families and cannot develop a maternal role because of the egocentric reaction.

In the third trimester, pregnant women realize that a fetus is separated from themselves and they plan to welcome a new coming family member by providing baby stuff, places, a name, and other things. Additionally, they prepare themselves to give birth. During this period, they are anxious about the labor and birth processes and worry about their babies' health, therefore they seek knowledge and advice from many sources. On the other hand, some pregnant adolescents want to finalize the pregnancy by counting the days to delivering the baby and never preparing themselves for the labor and birth processes. Consequently, they may get more stressed than other pregnant women about labor and delivery. Some have nightmares and some may not prepare anything for the birth. They may think that the baby is an enemy who brings about discomfort during pregnancy, subsequently, it is difficult for them to take a maternal role.

Developmental tasks of pregnancy are very important to every woman since the accomplishments at each stage can predict how well they are enacting the maternal role for the maternal tasks of postpartum that is described as follows.

Maternal Tasks of Early Postpartum

Mercer (1981) identified seven steps for women to accomplish the maternal tasks of early postpartum. These include the following;

1. Reconcile the actual childbirth experience with her prenatal fantasies of birth (p. 343). In this step, the mothers viewed their experiences about the labor and birth processes by comparing their real experiences with other experiences such as mothers,

neighbors, or friends. When an evaluation of their experiences is not like their anticipation before giving birth, they may have a negative attitude to the birth experience.

2. Reconcile pre-birth fantasies of the baby with actual infant characteristics (p. 343). During this step, the mothers will compare the baby's characteristics with those that were fantasized about during pregnancy. This step is very important for every mother to respond to the baby's needs as they feel the baby belongs to them. Particularly, this can be important if the baby's gender is wanted and their characteristics were desired. They can pass these tasks easily and promptly move to other tasks.

3. Reconcile her body image after birth with her expectations (p. 343). All mothers want to recover from the physical discomfort after the labor and birth processes as soon as possible and become as normal as they used to be. During this step, it is common for them to worry about their shape and body image as may be viewed by themselves or others.

4. Observe the baby's normal bodily functions (p. 344). This step is the beginning of the attachment process between the mother and the baby. The mothers want to assure that their babies are healthy by observing the babies' bodily functions through feeding, sucking, burping, crying, excreting, etc.

5. Perform mothering tasks (p. 344). For a new brand mother, this step includes learning and practicing taking care of the baby, for example, they learn how to bathe, to breastfeed, to cleanse an umbilical cord stump, to change diapers, and to hold a baby to burp, etc. For those mothers who have personal experiences taking care of a baby, they may worry about how to build a relationship between the new baby and other family

members. During this step, all mothers want to be reassured of their ability to take care of the baby.

6. Redefine partner roles (p. 344). During this step, the new mother and father develop their parental roles to serve the needs of the new family member. They take responsibility as parents and adapt to the changes because of the birth of the baby. Their new roles are composed of caring and nurturing the demands of the new baby who needs to be taken care of 24 hours a day.

7. Resume other responsibilities (p. 344). After recovering from the delivery process, the mothers plan for other responsibilities, for example how to take care of other family members like older children, or how to handle the role changes as a wife and a mother after the birth of the baby.

In sum, women cannot accomplish each maternal task without support from the people surrounding them. Not only do health care providers understand the maternal tasks of early postpartum, they also want to better understand the development of adolescence. This can help them work with these young people effectively.

Conceptual and Theoretical Framework

Symbolic interaction theory was used as a theoretical framework for this study. This theory emphasizes the social processes that present within human interactions. Individuals create their realities by attaching meaning to situations and social constructs (Blumer, 1969). Based on this fundamental notion, three principles of symbolic interaction theory including meaning, language, and thought can be applied to the experiences of adolescent pregnancy (Blumer, 1969). First, the principle of meaning states that humans act toward people and things based on the meaning that they have

given to them. For example, a pregnant Thai adolescent may conceal her pregnancy or delay or never attend a prenatal care clinic because she gives a negative meaning to pregnancy because of the humiliation it represents to herself and her family in Thai society. Second, is the principle of language. People use language as symbols to convey their feelings, needs, information, or voices. Naming assigns meaning. Pregnant adolescents tell their experiences through communication with other people. The last principle is thought. Thought modifies each individual's interpretation of symbols and is based on language. Pregnant adolescents tell their stories through their thought processes (Blumer, 1969).

Two concepts of symbolic interaction theory, including a) the looking glass self as developed by Charles Horton Cooley (Perdue, 1986), and b) role (Mead, 1934) can be applied to study adolescent pregnancy. The concept of "the looking glass self" is presented in three phases. First, individuals think about themselves when they interact with people. Second, they consider how these people think about them. Finally, they create their own ideas and feelings by using the former phases as a mirror or a reflection. Based on this, the pregnant adolescent reflects about being pregnant and a mother who interacts with people in the society. In this study, the processes of roles, which are composed of role taking and role making will be clarified by the adolescents during their pregnancy and postpartum.

Four concepts of family life course development theory were also used as a conceptual framework of this study including positions, norms, transitions, and developmental tasks. First, the concept of positions refers to location or class of individual in a system (Gross and colleagues, 1958). Thai society is hierarchal and values

respect for elders and authority. This can be seen through the pregnant Thai adolescent's adherence to her family's wishes and instructions, or conversely if she does not. Second, the concept of norms refers to patterns of expected behavior held by the society (Bates, 1956). In Thai society, talking about sex is a cultural taboo and abortion is immoral and illegal. It is unacceptable for girls to loose their virginity before marriage. To do so is considered immoral, dishonorable, and disrespectful. Hence, an adolescent who becomes pregnant is considered a disgrace to the family as well as society. In addition, Thai society expects adolescent mothers to nurture their babies as well as adult mothers. This can lead to increased stress for adolescent girls, who may not be mature enough to enact the maternal role. Understanding these perspectives from her point of view will expand our understanding of her perceptions and enactment of her role in Thai society.

Third, the concept of transitions refers to "a passage or movement from one state, condition or place to another" (Webster's Third New International Dictionary, 1986, p. 2428). Adolescent pregnancy is an example of an "off time" which refers to any unexpected events that occur at the wrong time of some people's lives. Such event can lead to crisis in the family. Such events or transitions impact the developmental tasks for a family and alter the normative movement of the family (Klein and White, 2002). Finally, the concept of developmental tasks is defined as growth responsibilities that a family and an individual must accomplish at each stage of its developments. When an adolescent becomes pregnant, not only do she and her family face the usual developmental tasks of her stage of adolescence, but she also faces the developmental tasks of pregnancy and motherhood. The transformation of an adolescent into a mother is a developmental transition.

In summary, this study was framed using concepts from two theories, the concepts of looking glass self and role of symbolic interaction theory and the concepts of the family life course developmental theory, including positions, norms, transitions, and developmental tasks. These provided a foundation for the study of experiences of pregnant Thai adolescents who decide to carry an unintended pregnancy throughout the childbearing year.

Assumptions

The assumptions for this study are:

1. It is unacceptable in Thai society for adolescent females to engage in premarital sex or to become pregnant and bear children.
2. Pregnant Thai adolescents live in a society which assigns a set of expected roles and values to its members. A Thai adolescent who chooses to carry an unintended pregnancy steps outside these normative roles and values and is likely to experience certain levels of chaos and stress.
3. Adolescent pregnancy in Thailand is a time of stress and increased challenges for the mother and her family. She may create her realities by attaching either negative or positive meaning to her own situations, therefore, her responses to pregnancy and postpartum as a mother may be both experienced positively and negatively.
4. Pregnant Thai adolescents will experience role strain and role conflict during pregnancy and childbearing year. To maintain well being, they have to adapt themselves to survive. Understanding these adaptive strategies may inform health care providers and policymakers on how best to serve their needs during the childbearing year.

5. Pregnant Thai adolescents belong to groups. They build relationships with people surrounding them during the childbearing year as they enact a new role in society.

Research Questions

The research questions for this study are:

1. What is the experience of being pregnant and becoming a mother for Thai adolescents?
2. What are the positive and negative influences on pregnancy and becoming a mother for Thai adolescents?
3. How do Thai adolescents manage their experiences and challenges during pregnancy and childbearing year?

Definition of Terms

Adolescent pregnancy refers to a pregnant Thai adolescent whose age is between 14 to 19 years old and is pregnant with her first child.

Unintended pregnancy refers to pregnancy that occurs without intention – it was not planned.

Becoming a mother means pregnant Thai adolescents who decide to carry an unintended pregnancy until after birth and assume a maternal role.

The childbearing year refers to conception through 8-12 weeks postpartum.

Delayed prenatal care refers to pregnant adolescents who enroll for a prenatal care clinic late than other pregnant women when they are in the second or third trimester of pregnancy (after 14 weeks gestation).

Strategies used to cope with challenges are the ways pregnant adolescents adapt or adjust to changes and try to accomplish the developmental tasks happening during pregnancy and motherhood. The strategies may be found both positive and negative

ways, for example they may change to be more responsible and mature persons or they may replace their confusion by engaging in risk taking behavior like drinking, smoking, or drug abuse.

Summary

This chapter provided an overview of adolescent pregnancy. The literature documented the adverse effects of adolescent pregnancy on themselves, their babies, their families, and society. However, little is known about the experiences of being pregnant and becoming a mother among Thai adolescent girls. Health care providers need more understanding about these experiences in order to provide appropriate services that fit their needs during pregnancy and for a becoming mother. This study was conducted to discover the social processes that affect pregnant Thai adolescents with unintended pregnancies throughout the childbearing year.

CHAPTER THREE

METHODOLOGY

Introduction

This chapter covers grounded theory used as research method for this study including the research setting, sample, human subject assurance, data collection methods, procedure, and data analysis. The following section provides an overview of grounded theory and symbolic interaction as the theoretical underpinning for grounded theory. This is followed by a description of the characteristics of grounded theory, including theoretical sensitivity, theoretical sampling, constant comparative analysis, coding and categorizing the data, theoretical memo and diagrams, literature as a source of data, and integration of theory. The subsequent section describes the research setting, followed by human subject assurance, data collection methods, and procedures and data analysis.

Overview

Grounded theory is a leading qualitative method that has its roots in sociology. Sociologists, Glaser and Strauss, originally developed grounded theory in the 1960s (1965, 1967). They were interested in the study of dying in the hospitals in the United States because they noticed that the health care providers rarely talked about dying and death with patients who had severe illness or those who were near death. The research team observed how dying happened in various hospital settings. The team members asked the people who were involved in dying about their feelings or how they dealt with these critical events. Field notes were written during data collection. This was followed by team member data analysis through communications with each other and by exchanging notes about social interactions, processes, and contexts. Consequently, Glaser

and Strauss generated the theory of social organization and temporal order of dying. In addition, discovering analytic ideas from the study contributed to the development of systematic methodological strategies that other researchers could apply to their studies. Glaser and Strauss's book, *The Discovery of Grounded Theory* (1967) offered the basic strategies and encouraged researchers to develop new theories instead of testing hypotheses in the previous theories (Charmaz, 2006). It contributed to the development of many middle-range theories of phenomena.

Grounded theory was introduced to graduate nurse students at the University of California, San Francisco by its originators in the early 1970s (Stern & Covan, 2001). Most of the qualitative studies conducted by nurses that followed mentioned how grounded theory was used as an approach to their studies. Two examples of this include the nursing care of patients at risk for suicide (Sun, Long, Boore, & Tsao, 2006) and pregnant adolescent reflections of parental communication (Lloyd, 2004). Subsequently, nurses wrote several articles and books. These materials more clearly explained the method and were easy to understand when compared to original textbooks. Thus, they can be used as guides for researchers interested in generating theories (Munhall, 2007). Furthermore, in the forty years since its development, grounded theory also made a significant impact on social scientists to create several social science theories (Stern & Covan, 2001). For example, grounded theory was used to study the role of music in adolescents' mood regulation (Saarikallio & Erkkilä, 2007) and how religiosity helps couples in preventing, resolving, and overcoming marital conflict (Lambert & Dollahite, 2006).

Grounded theory has progressively changed since its introduction. Strauss's approach to grounded theory has been developed over time and this development can be seen in his book written with Corbin, entitled *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* (Strauss & Corbin, 1990, 1998). The original book introduced new procedures and concepts and demonstrated the process of data analysis systematically and thoroughly by describing it in detail. Several examples and many exercises provided readers with opportunities to practice scenarios in analytic processes. Glaser (1992) strongly criticized the work of Strauss and Corbin. He charged that their approach of analysis destroyed the fundamental process of grounded theory. From his perspective, in data analysis, Strauss and Corbin were forcing data rather than allowing them to emerge. Glaser writes about returning analysis methods to the place of meeting their original intentions. Munhall (2007) countered that alterations of methods over time are unavoidable and their changes and developments must be revealed. Since the 1990s, when the differences between the two originators were revealed as Straussian or Glaserian, grounded theory is still being used widely among researchers who aim to generate middle-range substantive theories. Their decisions whether to use the Strauussian or Glaserian approach depend upon the researchers' perspectives within an inquiry paradigm. For example, if the researchers have the perspective within the post-positivist inquiry paradigm, they will select the Glaserian approach to grounded theory. On the other hand, if their perspective exists within a constructivist paradigm, they will use the Straussian approach.

Researchers employ grounded theory across traditions. Traditions, such as constructivism and objectivism, which are common to grounded theory influence the

relationship between researchers and participants. The broad goals of the study, such as explanation, understanding, or transformation are also affected by two traditions. Constructivism and objectivism are different in many aspects. Constructivism claims that how people construct knowledge or realities dependent on their perceptions, previous experiences, values, and beliefs. They use these characteristics to interpret or create meaning of humans and situations. Constructivism is not taken for granted of the external reality, it only believes in that each person constructs his or her own reality by his or her own interpretation (Jonassen, 1991).

Charmaz (2000, 2005, 2006) has written extensively about constructivist grounded theory and called for applying principles of the Chicago school to grounded theory. When conducting a study, constructivists emphasize the study phenomena and multiple subjective realities. They encourage participants to share experiences, view their situations, and build relationships between them. The participants create their meanings and use language as a way to tell their stories. Constructivists and participants have interactions with each other. Data and analysis are created from this social process. Constructivists interpret shared experiences and commonalities and try to find differences and distinctions among people. Constructivists employ a reflexive process during their interactions with participants. They should be aware of their roles as researchers who have experiences, values, and beliefs that may affect the studies. Hence, when using constructivism as an approach, reflexivity should be used to enhance rigor of the study (Charmaz, 2006).

On the contrary, objectivism focuses on the objects of people's knowing. It has its roots in realism, which believes in the existence of a real world. Essentialism also

underpins objectivism. It holds that the existence of essential properties can produce appropriate knowledge (Jonassen, 1991). Unlike the constructivists, objectivists maintain a distance with participants. They believe in a single reality and that this reality can be discovered through research. They try to be as neutral as they can. They also derive conceptual sense from data and discover meanings inherent in the data (Glaser & Strauss, 1990). Data in their views are already existent in the world. Their roles as researchers are to find and discover theory from them. As a result, they have to be more careful while generating a theory; for example, they need not to put their own values into the process of analysis (Charmaz, 2006). Whether a researcher decide a constructivist or objectivist approach depends on the tradition she or he comes from as well as the particular circumstances of the study.

Grounded Theory and Symbolic Interaction

Milliken and Schreiber (2001) noted that grounded theory and symbolic interactionism are connected. They view that "the epistemology of grounded theory is steeped in symbolic interactionism" (Milliken & Schreiber, 2001, p.180). Many other researchers also agree that symbolic interaction is the theoretical underpinning of grounded theory (Charmaz, 2006; Munhall, 2007; Glaser &Strauss, 1967; Strauss, 1987). The history of the construction of grounded theory can explain these ideas.

Strauss brought to the development of grounded theory the knowledge of pragmatism that he gained from his doctoral studies at the University of Chicago, and through adaptations of Blumer's (1969) and Mead's (1934) ideas of pragmatism. Pragmatism is a theoretical perspective which depends on language and communication. It presumes that interactions between individuals and other people construct self, reality,

and society (Charmaz, 2006). Strauss brought the notions of human agency, emergent processes, social and subjective meanings, problem-solving practices, and the open-ended study of actions to grounded theory (Strauss, 1987). Meanwhile, as an expert in the area of quantitative methodology and qualitative math from Columbia University, Glaser (1978) added that symbolic interaction influences how people shape the worlds in which they reside. He discussed that the characteristics of life are variable, complex, alterable, and processual. When their strong backgrounds were combined to construct grounded theory, logical and rigorous quantitative methods were gradually mixed with interpretive processes from the tradition of symbolic interactionism (Dey, 1999).

Symbolic interaction theory focuses on communication as the processes of expressing feelings, desires, needs, opinions, and information exchanges (Strauss, 1987). Hence, it can be said that symbolic interactionism is informed by pragmatism. Therefore, pragmatism and symbolic interactionism are the primary foundations of grounded theory. Researchers who select grounded theory as their methodology in their studies should remember to use the concepts of symbolic interactionism to aid in their analyses.

Adele Clarke, a sociologist at the University of California, San Francisco, noticed that individuals in the postmodern era employed qualitative approaches as methodologies to obtain several people's narratives (Clarke, 2005). However, they ignored social context. Although social context is considered as complexity, it should be taken into consideration when conducting a study. For this reason, Clarke's inspiration was to integrate grounded theory with the postmodern turn and the methods are called "theory/methods package" (Clarke, 2005). She proposed six approaches for a researcher to accomplish this, which is called situational analysis. First, one should be able to

assume and acknowledge the embodiment and situatedness of all knowledge producers. He or she should be able to assume the simultaneous truth that comes from various knowledge. Second, one should employ the situation of the study phenomenon during analytic process. Third, one needs to shift from simple, normal, and homogeneous assumptions and representational strategies to complex, different, and heterogeneous. Fourth, one needs to assert sufficient analysis for sensitizing concepts and theoretically integrated analysis instead of following the formal theory. Fifth, one has to do situational maps, social world/arenas maps, and positional maps. Finally, one needs to turn to discourse-narrative, visual, and historical since they help expand the domain of social life that is found in a grounded theory study (Clarke, 2005).

The powerful strategies in situational analysis include situational maps, social worlds/arenas maps, and positional maps. Clarke used Glaser's saying "All is data" as a way to build structural properties directly into her maps and locate them in social worlds and arenas (Clarke, 2005).

Characteristics of Grounded Theory

Clark and McCann (2003) propose seven key characteristics of grounded theory. They include (1) theoretical sensitivity, (2) theoretical sampling, (3) constant comparative analysis, (4) coding and categorizing the data, (5) theoretical memos and diagrams, (6) literature as source of data, and (7) integration of theory. All of these characteristics are thoroughly described below.

Theoretical sensitivity

Theoretical sensitivity refers to a researchers' ability to "render theoretically their discovered substantive, grounded categories" (Glaser, 1978, p.1). It can help researchers

to generate actual theory that is grounded in data. Theoretical sensitivity demands researchers who are qualified in many different ways. For example, researchers must actively examine data as soon as data are collected. In this process, they use personal or professional experiences to conceptualize data and relate concepts to each other (Glaser, 1978). Having broad knowledge in various disciplines enhances the researchers' capability to test data. In addition, they should have a vivid imagination to interpret meanings of a given population. Inductive perspective is an example of this qualification. The researchers must have this perspective in order to construct a new theory because it can move the researchers from concrete to abstract levels of knowledge. Researchers who seek challenges are required to accomplish theoretical insights. They may welcome challenges by testing their own theories or prejudices against data in a process known as constant comparison. Theories emerge from these actions (Schreiber, 2001).

Theoretical sampling

Based on their own decisions and before collecting data, researchers determine the inclusion criteria for the participants, along with the setting and the methods. These processes are known as purposive sampling. As soon as the first collected data are in hand and analyzed, the researchers make other decisions and have a new direction to obtain data from selecting new participants from whom they believe to gain relevant experiences. Furthermore, they may change a setting or adjust the data collection method. All adapted procedures are called theoretical sampling (Glaser, 1978: Schreiber, 2001). In these ways, the activities of the researchers may include answering questions, interviewing new participants, going back to the setting, doing a participant observation, asking for procedural help, testing hypotheses, and reading the literature (Munhall, 2007).

In a grounded theory study, recommended sample sizes are varied and depend upon the characteristics of a domain of inquiry. A narrow domain requires interviews with fewer participants than does a broad domain of inquiry. Morse (1994) stated that 30-50 interviews should be conducted in a grounded theory study. Although it is helpful in guiding researchers in the planning phases, determining the sample size is not an important process of theoretical sampling. More important is the assurance that theoretical saturation is reached. Saturation refers to the practice by which researchers continue data collection until no new data are found. Moreover, researchers must be able to explain variations in categories or subcategories and be sure that the relations among categories, subcategories, and concepts are clearly explicated and validated. In theoretical saturation, the quality of data is considered more important than data that are found frequently in the interview (Strauss & Corbin, 1990, 1998).

Researchers' abilities to clearly define the selected participants and the explicit research questions may enhance theoretical saturation (Morse, 1995). The amount of time it takes to reach saturation depends on the breadth and diversity of the study domain. In narrower and the less diverse study domains, saturation is reached more rapidly (Glaser, 1978). To build a qualitative theory, novice researchers should be prepared and guided by experts to determine the demands of data (Munhall, 2007).

Constant Comparative Analysis

In the development of grounded theory, constant comparative analysis is the central approach to data analysis. The approach occurs when data collection and data analysis take place simultaneously (Strauss & Corbin, 1990, 1998). Following are the four stages in the constant comparative method (Glaser & Strauss, 1967): (1) comparing

incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory. A theory is a product of the process of constant comparison. During data collection, data sources come from individual interviews, focus group interviews, and/or participant observations. The three types of qualitative interviews are informal conversation interviews, semi-structured interviews, and standardized, open-ended interviews (Patton, 1990). Typically, grounded theory interviews are semi-structured. An interview guide is developed to give a direction for researchers conducting interviews. Like other researchers, students develop interview guides from research questions. However, they require supervision from their advisors or experts. The interview guide is composed of a list of questions that range from general to specific topics (Stewart & Shamdasani, 1990). No strict criteria are set for the total number of questions, however 10-12 questions are appropriate for each interview guide in order to limit interview time. Open-ended questions allow participants to share various experiences, while probe questions encourage participants to divulge more detailed information resulting in variation and richness of data. Additionally, the interview guide can be adjusted over time, and researchers may add or delete questions in order to obtain relevant data.

Interviews are more productive when participants feel safe and comfortable. Additionally, minimizing interruptions enhances the richness of data. Researchers may record data using either electronic devices or by compiling fieldnotes. Both methods have pros and cons. In the case of fieldnotes, instead of paying attention to participants during interviews, researchers may become distracted when recording important points. The amount of relevant data available through fieldnotes is, however, often worth the effort.

Likewise, transcripts derived from electronically recorded interviews include every word spoken by participants, yet it is time consuming to process the transcripts (Glaser, 2005; Munhall, 2007).

Observation is another form of data collection. Sole reliance on interviews may lead to data insufficiency. Observations enhance research through improved understanding about settings, incidents, activities, and people, and can more thoroughly describe situations and accurately capture contextual information. Because each strategy has advantages and disadvantages however, researchers must carefully select observation strategies by determining whether to actively engage in situations or assume the role of the outsider. For example, when researchers choose to play an active role, participants' awareness of being observed can lead to changes in their behaviors, thus invalidating the collected data. Conversely, when researchers choose to observe situations as outsiders, they cannot get involved and may consequently obtain incomplete data. In either case, observations are more likely to be effective if observers are well-trained (Strauss & Corbin, 1990, 1998).

Coding and Categorizing Data

In grounded theory, an analytic process aims to generate a theoretical description from given patterns of behaviors in study phenomena. The first step of data analysis is developing qualitative codes to characterize the data. Coding is the process by which researchers simultaneously categorize and summarize many pieces of data to determine and establish a short name for the segments of data. Data coding activities include selection, differentiation, and classification (Charmaz, 2000). Three steps or levels of coding, known as open, axial, and selective, are discussed below.

Open coding. Open coding, also known as Level I or substantive coding, is the process of data expansion. During this process, data are broken into separate parts to be conceptualized and categorized (Clark & McCann, 2003), and researchers create as many codes as needed to reach the goal of open coding (Strauss & Corbin, 1998). The goal of open coding is the identification of data concepts and the discovery of properties and dimensions of each concept. Several strategies are offered for code building. These include staying close to data, choosing words to reflect data, creating short codes, remaining open to building new codes, comparing data with other data, and moving quickly through data (Charmaz, 2000; Munhall, 2007; Strauss & Corbin, 1990, 1998). Typically, researchers analyze raw data by coding line-by-line. Once accustomed to the data when concepts and categories have been identified, researchers can code by sentence or by paragraph (Strauss & Corbin, 1990, 1998).

Two types of open coding can be used in this process. The first type is *in vivo codes* whereby codes are named using the participants' exact words. Researchers benefit from using *in vivo codes* by protecting themselves from using preconceived notions to establish codes. The other type of coding is the sociological construct, a process by which collected data are combined with professional, knowledge and expertise to create code. Building academic conceptualization of the analysis is a prominent point of sociological construct (Strauss & Corbin, 1998). Although *in vivo codes* may lack scholarly conceptualization, they contribute to high degrees of imagery (Strauss & Glaser, 1967). During this step, researchers compare data to data and find that some codes occur frequently, while other rarely occurring ones may be discarded from the analysis. Generally, researchers cannot grasp particular codes at the beginning of data collection

until they have more time to become familiar with the data. As part of an important process, theoretical sampling leads researchers to compare old and new codes, to recode, and to subsequently start constructing new categories. Ongoing, properties and dimensions of each concept will continue being discovered. (Strauss & Corbin, 1998).

Axial coding. Strauss (1987) introduced axial coding as a process of relating categories to their subcategories. This process is also known as theoretical or Level II coding. Its purpose is to limit data that were expanded during open coding. Several basic tasks in axial coding are (1) laying out the properties of categories and their dimensions, a task that begins during open coding, (2) identifying the variety of conditions, actions/interactions, and consequences associated with a phenomenon, (3) relating categories to their subcategories through statements denoting how they are related to each other, and (4) looking for cues in the data that denote how major categories might relate to each other (Strauss & Corbin, 1998, p.126)

During axial coding, researchers always answer questions beginning with why or how come, where, when, and how. Seeking answers to such kinds of questions leads to the discovery of relationships among categories. This analytical tool is called a paradigm (Strauss & Corbin, 1998). Strauss and Corbin (1998) proposed that “a category is considered saturated when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in data.” (p.136)

Selective coding. Selective coding or Level III coding is the process of integrating and refining the theory (Strauss & Corbin, 1998). The goal is to identify a central category and to establish links among categories (Charmaz, 1990). Researchers employ inductive and deductive perspectives during constant comparative analysis to set and test

hypotheses or create hunches about the central or core categories and its relationships (Schreiber, 2001). Strauss (1987) provided six criteria used to select a central or core category. First, a core category needs to be central and all categories are related to it. Second, it needs to be frequently found in the data and can be used to indicate each concept. Third, it must be ensured that the data have not been forced to create a core category. The core category can be used to explain the relationship among categories logically and consistently. Fourth, a core category should be named abstractly in order to be used to conduct other research in several areas and to be used to develop more general theory. Fifth, when the concepts are integrated with other concepts, the theory will be generated strongly and has a powerful background explanation. Finally, the concept has an ability to explain the variety and importance of the data. The central idea can still be used to explain a phenomenon although conditions may be found to be different under different circumstances.

The process and technique of integrating the theory will be thoroughly discussed in the seventh characteristic of grounded theory "Integration of theory." During this process, researchers refine the theory after identifying the overarching central category. The process of refining the theory includes reviewing the scheme for internal consistency and for gaps in logic, filling in poorly developed categories, trimming the theory, and validating the theoretical scheme (Strauss & Corbin, 1998).

Theoretical Memo and Diagram

Theoretical memos and diagrams are very useful tools for building theories in the analytical process. Researchers write memos as reflections of their ideas and thoughts throughout the course of analysis. They may raise questions in memos during data

collection and analysis. A record in memos helps remind the researcher of important information (Strauss & Corbin, 1990, 1998). When writing a memo, the researcher uses both inductive and deductive reasoning (Hutchinson, 1993). Conceptualizing data requires inductive reasoning, whereas deductive reasoning helps researchers evaluate linkages among concepts, categories, or subcategories. Memos can be in the form of questions and anecdotes. Strauss and Corbin (1998) proposed three types of memos; code notes, theoretical notes, and operational notes. Open, axial, and selective coding are found in code notes. Theoretical notes consist of researchers' thoughts and ideas about theoretical conceptualizations. Operational notes determine the direction of further analytic processes, including theoretical sampling, or remind researchers not to overlook important information. Furthermore, memos can help determine the scope of a study (Schreiber, 2001).

Diagramming is a tool to help researchers understand and anticipate the relationships among concepts, categories, or subcategories (Schreiber, 2001; Strauss & Corbin, 1990, 1998). Diagrams can be developed in various types of visual representations. The visual diagrams can describe initial relationships between categories or their subcategories. Initially, researchers may develop a simple diagram, and then progressively develop more complex data-based diagrams over time. Creating diagrams can enhance researchers' abilities to create new categories or to cluster them rapidly. Diagrams can also illustrate properties and dimensions of categories. Furthermore, researchers recognize how a powerful diagram can provide an explanation for the relationships among categories, how broad or narrow categories are, or what in directions categories should be (Strauss & Corbin, 1998).

Literature as a Source of Data

There are two schools of thought about review of literature when using grounded theory as a methodology. Some grounded theorists propose having researchers initially conduct literature reviews. Researchers will gain many benefits from reading or exploring various literature, for instance, enhancing their theoretical sensitivity, demonstrating strengths and weaknesses of previous studies, helping develop more effective theories, and providing important information for theoretical sampling (Munhall, 2007; Morse & Richard, 2002; Strauss & Corbin, 1990, 1998). On the other hand, many grounded theorists are concerned that researchers will begin their studies with preconceived ideas from literature reviews (Glaser, 1978). Researchers may be contaminated by this process and are therefore advised to limit their readings. This helps them avoid preconceived ideas while developing a theory. However, all researchers have their educational background, personal experiences, professional experiences, and previous knowledge gained from reading. When conducting a study, most researchers may unavoidably integrate much of that knowledge in the study. It is a false notion to imagine a researcher conducting a study without previous experiences. Although a literature review is not required in grounded theory, it is necessary for every researcher to conduct one as a means of establishing baseline data for use by committees and funders in the proposal approval and funding processes (Munhall, 2007; Morse & Richard, 2002; Strauss & Corbin, 1990, 1998).

Integration of Theory

Strauss and Corbin (1998) proposed several techniques to facilitate the integration process. These techniques include writing the storyline, making use of diagrams, and

reviewing and sorting memos. Writing the storyline helps researchers to articulate their thoughts and ideas about the integrated theory. A storyline memo identifies concepts and their relationships through a narrative process. When using this technique, researchers should question themselves frequently and seek answers. Examples of appropriate questions include “What seems to be going on here?”, and “What keeps grabbing my attention again and again?” (Strauss & Corbin, 1998, p.148).

Making use of diagrams is a second technique. A diagram is a valuable tool for integrating theory as was discussed thoroughly above in the fifth characteristic of grounded theory, entitled “Theoretical memo and diagram.” Furthermore, diagrams assist researchers by facilitating work with concepts instead of data details. Researchers should avoid complexity by creating diagrams that contain minimal numbers of words, lines, and arrows.

The third and final technique is reviewing and sorting memos. Memos include all conceptualizations written during data collection and analysis. They can be sorted by categories or specific themes. Integration of theory occurs when researchers carefully review them and look for cross-relationships among categories (Strauss & Corbin, 1998).

Research Design

This study employed grounded theory to developed knowledge about experiences of pregnancy and experiences of becoming a mother for Thai adolescents who decided to carry an unintended pregnancy. Grounded theory was an appropriate method for this study for several reasons. First, grounded theory explores social processes and this is helpful when the goal is developing theory that explains human behaviors during their interactions with other people in a society (Glaser & Strauss, 1967). Second, pregnant

adolescents and their families were in transition, and nursing research has shown that grounded theory is suitable for the study of individual behaviors related to developmental transitions and challenging situations (Wuest, 2007). Finally, grounded theory is beneficial when less is known about the area of study, as is the case for adolescent pregnancy in Thailand. “The goal of grounded theory is to generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved” (Glaser, 1978, p.93). Constructivist grounded theory was used as an approach in this study since it focuses on the study phenomena and multiple, subjective realities (Charmaz, 2006). Participants were encouraged to share experiences, view their situations, and build relationships with the researcher. During interviews, the researcher and participants had interactions with each other and data and analysis were partially created through this social process. A reflexive process was used during the interactions with participants in order to enhance the rigor of the study (Charmaz, 2006). The researcher’s prior roles, experiences, values, and beliefs could influence the process of data collection and analysis. Reflexive processes provided a way to help the researcher critically examine her personal interface with the data. As a result of using the grounded theory approach, a researcher could arrive at a very solid and useful theory. The flexible analytic tools provided by grounded theory help policymakers and researchers establish the scope of usefulness of their middle-range theory building (Strauss & Glaser, 1965; Strauss and Corbin, 1990, 1998). The study generated a theoretical framework to help health care providers and policymakers better understand adolescent pregnancy in Thailand and potentially develop interventions to assist these young people during the childbearing year and transition to motherhood.

Research Setting

This study took place at the Uttaradit Province, a rural area, located in the lower North region of Thailand. A plain, a plateau, and a river form the geographical features of this area located on the right bank of the Nan River and 491 kilometers (~ 305 miles) from the capital city of Bangkok. Covering an area of 7,838 square kilometers, Uttaradit Province has a rich history dating back to prehistoric times. A governor is the leading political authority of the nine districts, 67 sub districts, and 613 villages that comprise the province. In 2006 Uttaradit had a total population of 467,482 (230,838 males and 236,644 females). Meaung districts had the most number of populations (153,165). The average population density of the province was 60 people per 1 square kilometer and Meaung district had the highest population density (200). The population in 2006 from registration records by age group 10-19 years was 62,755. In 2005, the average monthly income per household per year was 47, 705 Baht ($ 1= 33 Baht). The economic condition of the province was ranked the 9^{th} of the northern region and the 50^{th} of all provinces in the country. The climatic condition is influenced by the northeast and south west monsoon. The weather is hot and humid, with an average temperature of 35 degrees Celsius from March to June. It is comfortably cool in the winter (November-February) with heavy rain in the rainy season (July-October) (Provincial Statistical Report, 2007). Most of the people are Buddhist and agriculture is the primary economic base, followed by fishing and commerce. Langsad, a famous fruit in Uttaradit, is the province's major cash crop and the cost of living is moderate. Well-established transportation links allow people access to other provinces by car, bus, and train (Boonked, 2006).

A total of twelve hospitals provide 890 inpatient beds in Uttaradit, and nine of these are under the jurisdiction of the Ministry of Public Health. This study took place at Uttaradit Hospital, a 47 year old regional hospital situated in the Meaung District. Providing 580 inpatient beds, 24 hour services, and covering an area of 35 square kilometers, Uttaradit Hospital is the largest hospital in the province. The hospital's prenatal care clinic is supervised by the Department of Obstetrics, Gynecology, and Family Planning, and provides daily services between the hours of 8.00 a.m. and 4.00 p.m. from Monday to Friday. Two registered nurses and a technical nurse provide services in the prenatal care clinic. In 2006, 1,729 pregnant women attended the prenatal care clinic. On average, 91 pregnant adolescents whose ages are below 17 years old attended the clinic every month and the average number of all of pregnant women attending the clinic was 764 cases per month (Statistic Report of pregnant women in Uttaradit Hospital, 2007).

Sample

Human Subjects Assurance

This study was reviewed by the Committee on Human Research at the University of California, San Francisco and the Research Ethics Committee, Faculty of Medicine, Chiang Mai University, Thailand before it was conducted (Appendix A). Participants were recruited under strict criteria to protect client confidentiality, prevent coercion, and avoid interference with ongoing prenatal care services. All consent forms were written in simple Thai language and the researcher had explained them orally to the participants and to their parent(s) or guardian(s) before having them sign the consent.

Nature and Size of Sample

Pregnant Thai adolescents whose age were between 14 to 19 years old, were pregnant with their first child, carried an unintended pregnancy, and attended the prenatal care clinic at Uttaradit Hospital, Thailand were the focus of this study. In a grounded theory study, recommended sample sizes are varied and depend upon the characteristics of a domain inquiry (Strauss & Corbin, 1990, 1998). Sample size was only part of the sampling process in grounded theory, although it was helpful in guiding researchers during the planning phase. More important was the assurance that theoretical saturation was reached. Saturation referred to the practice by which the researcher continues data collection until no new data were found. A sampling of 20-30 pregnant adolescents was set for this study or until the saturation was reached.

Criteria for Sample Selection

Inclusion Criteria

The following were the criteria for selecting pregnant adolescents.

1. Pregnant adolescents between the ages of 14 to 19 years old;
2. Carry an unintended pregnancy;
3. Pregnant with their first child and gestational age between 24-28 weeks;
4. Attend the prenatal care clinic at Uttaradit Hospital.

Exclusion Criteria

The following were the criteria to exclude pregnant adolescents.

1. The adolescents aged below 14 years were excluded from the study because they were too young and not considered mature enough for assent.

2. Pregnant Thai adolescents with known complications requiring medical intervention (e.g., pregnancy induced hypertension, cardiac complications, HIV-1 positive, and fetal death in utero) were excluded from the study because of the potential for these conditions to confound the stress related to non-medically complicated pregnancies.

3. Those adolescents who were not cognitively or psychologically able to engage in an interview.

4. Thai pregnant adolescents who were unwilling to participate in all three interviews.

There were 35 pregnant adolescents at the prenatal care clinic, Uttaradit Hospital, who met these inclusion criteria as of May, 2007. There were three pregnant adolescents asked to be in the study but chose not to participate. A total of 20 pregnant adolescents were recruited from the 35 who were eligible.

Data Collection Methods

Techniques

Data were collected from the same participants at three different points during the pregnancy through 8-12 weeks postpartum. Since pregnancy is a transition period to motherhood, the developmental tasks of pregnant adolescents vary depending on the particular trimester of pregnancy. This prolonged engagement enhanced the understanding of the full experiences. Since many adolescents in Thailand delay prenatal care clinic until the second trimester, enrollment in the first interview was between 24-28 weeks. The second interview was conducted around 36 weeks, and the third at 8-12 weeks postpartum. In addition, the investigator made a visit at the hospital when the participants gave birth in all cases. This was a strategy to build rapport with pregnant

adolescents because the more frequently the researcher met the pregnant adolescents, the higher level of trust they gained from them.

Semi-structured interviews were conducted with an interview guide. The interview guide was developed from the researcher's pilot study. The pilot study was conducted in December, 2005 at Uttaradit Hospital, Thailand. Data were collected through a semi-structured interview with a total of four participants who were recruited for the study and lasted 60-90 minutes. The results from the pilot study helped guide the researcher to gain more richness of data by adding some questions into the previous interview guide. For example, general questions about support, besides support from their boyfriends and mothers, questions about support from other people like friends, teachers, boyfriends' families or health care providers were asked in this study to gain more in depth data. Consequently, participants were encouraged to give more examples or details about each type of support by asking appropriate probing questions such as "What type of support do you want and need?", "Who provide you support?", "What kind of information/support do you need from the doctor/nurse?", "When you have a financial problem, who helps you?", and "Have you ever asked for help from friends during pregnancy?"

This interview guide was composed of eight open-ended questions regarding experiences of being pregnant, negative and positive effects of pregnancy, decision about pregnancy, types of support and supporters, strategies used to cope with changes during pregnancy, and needs during pregnancy. Probes were used as needed to gain more details. This interview guide was revised after a review of the current literature and to fully reflect the childbearing years. The researcher wrote field notes after each interview about

her observations during each interview. The systematic method used in the field notes was the additional questions for asking the participants in the next interview .

Demographic Data

Prior to interviewing about experiences during pregnancy, demographic data were collected from the participants. These included age, marital status, gestational age, occupation, income, number of attending prenatal care clinic, number and relationships of family members, and level of education. For adolescent mothers with a newborn aged 8-12 weeks, additional questions were asked including date of delivery, type of delivery, fetal birth weight, length of hospitalization after delivery, and infant feeding. A first draft of the demographic questionnaire was supervised by the advisor for face validity.

Criteria to Establish Trustworthiness of the Study

Lincoln and Guba (1985) have suggested four criteria to establish trustworthiness that enhance the rigor of the study including credibility, dependability, confirmability, and transferability. The strategies to enhance credibility in this study consisted of time and investigator triangulation, peer debriefing, and member checking. For time triangulation, this study was designed to collect data with the same pregnant adolescents at different points in time. This was to help to determine the congruence of the studied phenomenon over time. For investigator triangulation, the researcher worked with the advisor who has extensive experience in qualitative research. She read the transcripts and coded the data independently. The researcher discussed the codes and the themes with the advisor until 100% agreement was reached. Peer debriefing, another technique to enhance credibility, was used by the researcher. A Thai doctorally prepared qualitative researcher who is an expert in grounded theory was asked to validate the researcher's

interpretation of data. Member checking was conducted by asking participants to check whether all collected data were interpreted correctly by the researcher. To assure confirmability, an audit trail, a systematic process of organizing all documents during data collection and data analysis, was used. Using theoretical sampling helped the researcher to obtain transferability that referred to findings of the study that can predict and explain similar situations.

Procedure

The following steps were used to guide the conduct of the study.

1. The researcher met with the director of Uttaradit Hospital to discuss the research proposal and asked for support and permission to conduct the study. Subsequently, she met the head nurse of the prenatal care clinic and clinical staff to explain the study to them. The head nurse identified potential participants who met the inclusion criteria. The clinical staff informed the potential participants about the study through a study information sheet (Appendix B).
2. If interested in participating, participants contacted the researcher by one of two methods. (a) The researcher was available in the clinic to meet with potential participants or (b) the potential participants called her.
3. At the first contact with the researcher, either in person or by telephone, the potential participant was screened to determine eligibility (Appendix C).
4. Once eligibility had been determined, arrangements were made to meet to further explain the study and obtain a signed consent/assent (Appendix D and Appendix E).
5. The first appointment with potential participants and/or their parent(s) or guardian(s) was scheduled at their convenient/preferred time and location. At this meeting, the

researcher explained the purpose of the study and study procedures, including potential risks and how they would be minimized. Issues regarding participants' confidentiality and anonymity were explained to them. They were allowed to ask any questions regarding the study. When they agreed to participate, an informed consent form was obtained from participants aged 19 years old. A signed consent form was obtained from participants aged 14-18 years old and their parent(s) or guardian(s).

6. Participants who requested additional time to consider study participation were given as much time as needed. They were encouraged to discuss their decision with their families and/or friends. Another appointment was scheduled at a mutually agreed location and time to obtain consent. They could also contact the researcher any time before the appointment if they decided not to participate in the study. To make sure they understood the information provided to them, a consent form was written in simple Thai language which was easy to understand. If any participant/parent or guardian was uncomfortable with reading, they could request having the researcher read the consent form to them. Every effort was made to assure that participants/parents understood the study and the written consent form before they signed it.

7. After obtaining informed consent, the researcher scheduled an appointment to interview the participant at her convenient/preferred time and location. Each participant was interviewed three times for approximately 30-60 minutes per interview. The first interview was conducted when her gestational age was between 24-28 weeks. The next interview was conducted around 36 weeks gestational age. The researcher visited her at the hospital when she delivered a baby. The purpose of this visit was to build rapport

with her and to arrange the postpartum visit. The last interview was conducted when she was 8-12 weeks postpartum, at a time and place of her convenience, usually at home.

8. At the first interview, the researcher began by asking if she had any questions about the study. Demographic data (Appendix F) were collected and then she was interviewed about her experiences of being a pregnant adolescent (Appendix G). For the second interview, the participant was asked about her experiences of being pregnant, similar to the first interview. During last interview she was asked additional questions about her demographic data and to share her experiences of being an adolescent mother and to reflect on her experiences during pregnancy. The researcher also reviewed medical records of each participant at the postpartum unit in Uttaradit Hospital.

9. The conversations between the participants and the researcher were recorded by using a digital recorder and were transcribed verbatim. Every effort was made to protect confidentiality of the participants by meeting with them separate from parents or guardians in a private place. The researcher was the only person who transcribed all interviews. Pseudonyms were used to code each transcript. The researcher reviewed the transcripts with an advisor and a doctorally prepared qualitative researcher. All data and documents were retained in a locked and secured area and a password protected computer. Only the researcher and the advisor had access to the digitally voice recorded interviews. The digitally voice recorded interviews and the digitally voice recorded files were completely erased at the completion of the study. No identifying information was retained in the transcribed text.

10. The participant was paid 100 Baht (~ $ 3.00) in cash at the completion of each interview. A baby gift worth 200 Baht (~ $ 6.00) was given to the participants at the

hospital after she delivered the baby. Each participant was paid a maximum of 500 Baht (~ $ 15.00) including 300 Baht in cash and a baby gift worth 200 Baht, when they completed three interviews. After data collection was complete, the participant received a thank you card.

Data Analysis

All interviews were transcribed in Thai language and were translated to English. The pilot study conducted in 2005 helped the researcher find a direction and a solution to overcome some difficulties in translating the transcripts from Thai to English. Thai words that could not be translated without distorting their meaning were noted by using the exact Thai words in English transcriptions with a written explanation of the meaning of each word. In addition, the researcher had a colleague who is bilingual in both Thai and English check the documents and provided back-translation. Obtaining this expertise assisted the researcher to articulate correctly the voices of participants and increased her self-confidence to translate from Thai to English. This added to the rigor to the study. Data were analyzed using the grounded theory technique of constant comparative analysis described by Glaser and Strauss (1967) and Strauss and Corbin (1990, 1998). Data collection and analysis were done concurrently. The steps of data analysis were below.

1. The beginning point of analysis was to understand the meaning of the whole text. All transcripts were read and reread as a whole. Then, the researcher analyzed data by coding line by line and when she got accustomed to the interviews, the data were coded by sentence or by paragraph. In open coding, the researcher created as many codes as needed. During this process, the researcher compared old and new codes, recoded, and

constructed new categories as the analysis progressed. Properties and dimensions of each concept were explored and described in detailed memos.

The following examples are given to illustrate the process of open coding. One participant stated “I think I’m too young, only 16. I shouldn’t have been pregnant.” The assigned code to these sentences was “too young”. Another example was “I wasn’t ready. I didn’t finish my study. I had no money, and so on” The assigned code to these sentences was “unreadiness.” Two open codes were clustered with other codes that were similar and conceptualized as responses to self when getting pregnant and set under the concept of feelings of unreadiness.

As open coding progressed, properties and dimensions were revealed by using questions and comparisons. This could help the researcher develop ideas for theoretical sampling in order to capture relevant data. For example, the concept of lack of readiness was frequently found in the data. The questions were “Whose readiness” and “whose perception” The following were examples of questions that were asked, “What are the properties of lack of readiness of being pregnant at a young age?”, “What do they think when the doctors said that they’re not ready to get pregnant?”, and “Why do neighbors think that they shouldn’t get pregnant?” It emerged that lack of readiness could be dimensionalized as lack of body maturity, age maturity, mental/emotional maturity, economic status, and job stability. The thoughts of the pregnant girls in this study whether they were ready or not to get pregnant were often based on both their and others' viewpoints. People surrounding them might judge whether they were ready or not to get pregnant depending on the circumstances such as body and mental maturity, social norms, economic status, and responsibility.

2. The second step was to create axial coding from the open codes. It was the process of relating categories to their subcategories. The researcher continued to ask questions beginning with why, where, when, and how to seek answers that lead to the discovery of relationships among categories. A category was saturated when the researcher could not find new properties, dimensions, conditions, actions/interactions, or consequences in the data. Example of axial coding follows. The category of "surrender to an unintended pregnancy" was a condition that led the pregnant adolescents to prepare for becoming a new mother that was another category. Consequently, the category of "adolescent mom: I can do this mission" related to "preparation to become a new mother."

3. The third step was selective coding, the process of integrating and refining the theory (Strauss & Corbin, 1998). The researcher tried to identify a central category and to establish links among categories. The major question that helped to explain the whole story were: What's going on in their lives since they became pregnant, delivered a baby, and became a new mother? How did each process influenced to them? The researcher wrote a memo as follows:

> The first time I met the pregnant adolescents, they were still innocent teens who lacked knowledge, life skills and had low self-confidence. When the pregnancy was unintended, their lives were chaotic and they suffered. Their lives were also going on with fear and painfulness. Although they did not want to keep their pregnancy, they had to come to terms with it. They had to face changes both within their bodies and mind as well as in the community they resided in that brought about difficulties in their lives. However, they tried to prepare themselves for becoming a mother by using various strategies to overcome these changes. In addition, with the support from their significant others, it was like nourishment for their soul which got them through a difficult time. They were growing up simultaneously with the growth of the babies inside their bodies. They tried to adapt themselves to solve the mistake they made. They learned to take care of themselves, be patient and tolerate the pressures surrounding them. They realized their mistake and thought that it was a lesson learned in their lives. Soon they experienced pain during labor processes and passed them with various experiences depending on each circumstance. They learned and practiced how to raise a baby and how to be a mother. When time passed by, they had developed more self confidence. Several feelings such as

love, attachment, etc. occurred and led them to have goals in their lives as well as good hope for their babies. All situations happening to them progressively helped them to develop as more mature and responsible persons. They have learned both good and bad parts in their lives from being pregnant to being a new mother. Finally, they understood the word "mother". What happened to their lives was the maturation process form innocent teen to motherhood (December 15, 2007).

From the memo, the researcher gave the name of each phenomenon by using the dynamic time from antepartum to the postpartum period. They included surrender to an unintended pregnancy, preparation to become a new mother, and adolescent mom: "I can do this mission." Each phenomenon had its subcategories and related to each other. However, the three phenomena could not cover the whole story. Reviewing the story by reading it again and again, asking the questions, reading the memo, looking at the diagram, and rethinking, finally the core category was given a name that could explain the whole phenomenon. It was "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood".

4. During data analysis, the researcher worked with a Thai doctorally prepared qualitative researcher and advisor who had extensive experience in qualitative research. They read transcripts and coded the data independently and then the researcher discussed the codes and the categories with these people until 100% agreement was reached. The researcher asked the participants to check whether collected data were interpreted correctly and requested their feedback during the second and third interview.

5. Theoretical memos and diagrams were used as the tools to build theory during the analytic process (See chapter 4). The researcher used memos as a reflection of ideas and thoughts and diagrams as an illustration of properties and dimension of categories.

6. ATLAS.ti, a qualitative analysis computer program, was used to organize and manage collected data. This program helped the researcher assign, modify, group, and retrieve

codes. The researcher created quotations, wrote memos or diagrams, code families, and built a simple network with this program during data analysis.

7. To minimize the risks or discomfort to participants, every effort was made to interview pregnant adolescent participants on a day that they were already at the prenatal clinic or at the place chosen by them such as in their homes. The interview was conducted at a time that was convenient for them. They were reminded that they might stop the interview at any time and they did not have to answer all questions. The researcher assured the participants about confidentiality.

Summary

The methods chapter describes how the data were collected. The semi-structured interviews were the data generation methods. It provides the strategies used to ensure trustworthiness of the study. Finally, the chapter concludes with details of each step of the research procedure.

CHAPTER FOUR

RESULTS

Introduction

This chapter is a summary of the characteristics of the participants and a description of the findings. The chapter includes eight parts. Part 1 focuses on the characteristics of the participants, followed by part 2, an overview of the core category "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood." Part 3 provides sociological context of the analysis. Part 4 describes the 'causal condition': surrender *(Yom jum non)* to an unintended pregnancy. Part 5 introduces 'action/interaction' strategies in preparation to becoming a new Thai adolescent mother. Part 6 discusses the 'intervening conditions': support from their close circle is like nourishment for their soul *(Yad nam tip chalom jai)* and which gets them through difficult time *(Tee peung yam yak)*. Part 7 describes the 'consequences': Adolescent Mom: "I can do this mission." Part 8 summarizes the needs of Thai teen mothers during pregnancy and the postpartum period.

Part 1: Characteristics of Participants

The demographic characteristics listed are for participants, participants' boyfriends, and participants' children. The word "boyfriend *(fan)*" was used commonly by married Thai women when they mentioned to their husbands. Likewise, the participants felt comfortable to use this word instead of partners or husbands.

Demographic Characteristics of Participants

The participants included 20 Thai adolescent girls who experienced an unintended pregnancy. This study focused on the experiences of these girls. The ages of the

participants ranged from 14 to 19 years old with a mean of 16.4 years and a standard deviation of 1.69. Three participants (15%) were 14 years old or in the early adolescent phase, twelve (60%) were in the middle adolescent phase, 15-17 years old, and five (25%) were in the late adolescent phase, 18-19 years old. All of them were Thai and Buddhists. The majority finished junior high school (70%, n= 14); three finished elementary school (15%); one finished vocational school (5%); three are seniors at the Non Formal Educational Center (a program for all ages of people) (15%); and one is studying for a bachelor degree at Rajabhat University (5%). Eleven participants dropped out of school because of becoming pregnant (55%). Five participants did not continue their studies after birth (25%). All participants were unemployed at the time of the first and second interviews (100%, n= 20, Gestational age between 24-28 weeks and around 36 weeks, respectively). Nineteen participants remained unemployed at the time of the third interview (95%, at 8-12 weeks postpartum).

One participant returned to work one month after the birth of her baby (5%). Four participants were still studying after delivering their babies (20%). All of them reported receiving financial assistance from their families and/or boyfriends during all interviews. The majority of participants lived with their own families (50%, n= 10). Eight participants moved in with their boyfriend's family during pregnancy (40%, n=8) and one returned to live with her family after delivery (5%). One participant and her boyfriend moved out and lived nearby her family during the pregnancy and returned to her family after birth (5%). One participant and a boyfriend lived far away from their own families (5%). Twelve participants organized an uncommon Thai traditional wedding called *a Wak sen ceremony* during pregnancy (65%, n=13). One of these participated in this

ceremony a month postpartum (5%). One participant married when she was 5 months pregnant to a male who was not the biological father of her baby (5%). Seven participants cohabited (35%). Most participants had cared for other children before (80%, n=16).

The participants in this study lived in a rural area of Thailand. Eleven participants grew up in the non-municipal area of Uttaradit Province (55%). Five grew up in the municipal area of Uttaradit (25%). Four participants grew up in rural areas of the northern region, one from Pethchaboon Province and three from Phrae Province (20%). All participants had an unintended pregnancy. Fourteen participants (70%) used birth control, whereas six (30%) never used any birth control. Eleven participants (55%) never thought of attempting an abortion. Seven (35%) decided to attempt an abortion by themselves, whereas two (10%) were compelled to have an abortion by their parents and a boyfriend. The demographic characteristics of the participants are summarized in Table 4.1.

Data were collected during interviews with the participants three times. Eighteen participants were interviewed twice during pregnancy and once after delivery. Two participants were only interviewed twice due to delivery prior to the second interview. Gestational age in weeks at first interview ranged from 24-28 weeks (M=27.3 weeks, SD=1.37). Gestational age in weeks at second interview was about 36 weeks (M=36.5 weeks, SD=0.71). The third interview conducted at 8-12 weeks postpartum (M=9.6 weeks, SD=1.50).

Birth Characteristics

Table 4.2 provides and covers the characteristics of mode of birth, hospital stay, and infants.

Table 4.1

Demographic Characteristics of Participants (N=20)

Characteristics	Frequency (%)
Age (years) ($\overline{X}$ = 16.4, SD=1.69)	
14	3 (15)
15	3 (15)
16	7 (35)
17	2 (10)
18	1 (5)
19	4 (20)
Ethnicity	
Thai	20 (100)
Religion	
Buddhist	20 (100)
Educational Background	
Elementary school (grade 1-6)	3 (15)
Junior high school (grade 7-9)	15 (75)
Vocational college	1 (5)
Bachelor degree (Sophomore)	1 (5)
Educational status	
Dropped out of school when getting pregnant	11 (55)
Continued studying	
At Non Formal Educational Center	3 (15)
At Rajabhat University	1 (5)
Did not continue studying	5 (25)
Working status at 1st and 2nd interview	
Unemployed	20 (100)
Working status at 3rd interview	
Unemployed	19 (95)
Employee	1 (5)
Type of Family	
Nuclear family	2 (10)
Live near maternal family	1 (5)
Live far away from maternal family	1 (5)
Extended family	18 (90)
Live with maternal family	11 (65)
Live with boyfriend's family	7 (35)
Marital status	
Married during pregnancy	12 (60)
Married after delivery	1 (5)
Cohabited	7 (35)
Hometown	
Uttaradit Province	

Table 4.1 (continued)

Demographic Characteristics of Participant (N=20)

Characteristics	Frequency (%)
Municipal area	5 (25)
Non-municipal area	11 (55)
Phrea Province	
Rural area	3 (15)
Pethchaboon Province	
Rural area	1 (5)
Childcare Experience	
Yes	16 (80)
No	4 (20)
Birth Control	
Yes	14 (70)
No	6 (30)
Decision to Get Abortion	
Never	11 (55)
Decided by themselves	7 (35)
Being compelled by others	2 (10)

Table 4.2

Demographic Characteristics of Participants' Children (N=20)

Characteristics	Frequency (%)
Type of delivery	
Preterm delivery (Vaginal birth)	2 (10)
Normal delivery	14 (70)
Cesarean section	2 (10)
Vacuum extraction	2 (10)
Fetal Birth Weight	
< 2,500 grams	3 (15)
2,500-3000 grams	9 (45)
> 3,000 grams	8 (40)
Length of stay in hospital	
≤ 5 days	18 (90)
6-10 days	1 (5)
≥10 days	1 (5)
Nutrition	
Breast feeding	13 (65)
(Combination) Breast and Formula feeding	7 (35)
NICU admission	
Yes	2 (10)
No	18 (90)

Demographic Characteristics of Participants' Boyfriends (N=20)

There were 20 participant's boyfriends whose age ranged from 17 to 29 years old ($\overline{X}$ = 21.7, SD=3.82). All of them were Thai and Buddhists (100%). Nineteen were the biological fathers (95%), and one was a non biological father, willing to get married with the five month pregnant participant and to adopt the baby (5%). The demographic characteristics of participants' boyfriends are presented in Table 4.3.

Table 4.3

Demographic Characteristics of Participants' Boyfriends (N=20)

Characteristics	Frequency (%)
Age (years) ($\overline{X}$ =21.7, SD=3.82)	
17-20	11 (55)
21-24	4 (20)
≥ 25	5 (25)
Ethnicity	
Thai	20 (100)
Religion	
Buddhist	20 (100)
Status	
Biological father	19 (95)
Non-biological father	1 (5)
Educational Background	
Elementary school (grade 1-6)	4 (20)
Junior high school (grade 7-9)	10 (50)
Senior high school (grade 10-12)	1 (5)
Vocational college	2 (10)
Educational status (continue studying)	
Vocational level certificate	1 (5)
Bachelor degree	2 (10)
Occupation	
Conscript	1 (5)
Employee	16 (80)
Monthly income	
No income	3 (15)
≤5,000	11 (55)
5,001-10,000	6 (30)
Hometown	
Uttaradit Province	19 (95)
Sukhothai Province	1 (5)

Part 2: Overview of Core Category

"*Kwa ja ru diang sa*: A Life Journey of Thai Adolescents from Unintended Pregnancy to Motherhood"

The goal of this grounded theory study was to understand experiences of pregnancy and becoming a new mother for Thai adolescents who decided to carry an unintended pregnancy. This section will provide a brief summary of the findings which will be described in more robust detail with supporting quotes later in the chapter. The core category "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood" was identified as a basic social psychological process. The paradigm model of Strauss and Corbin (1990) was employed to generate all categories including 'causal conditions,' 'action/interactions strategies,' 'intervening conditions,' 'consequences,' and 'context'. This is illustrated in Figure 4.1.

"*Kwa ja ru diang sa*" is a Thai expression used to describe the maturation process from innocent adolescence to motherhood. In this situation, the pregnancy was unintentional and the participants had to come to terms with it. Their life journeys were full of difficulties. They had to adapt to many changes that they had never imagined before. They were young and innocent, but ended up traveling the path to motherhood. The participants described both rewarding and difficult experiences that happened during the journey. Lessons learned during pregnancy and becoming a new mother progressively helped the participants develop into more mature and responsible adults. Finally, they enacted their role as a mother, realized the meaning of 'mother,' and continued hope for both themselves and their babies.

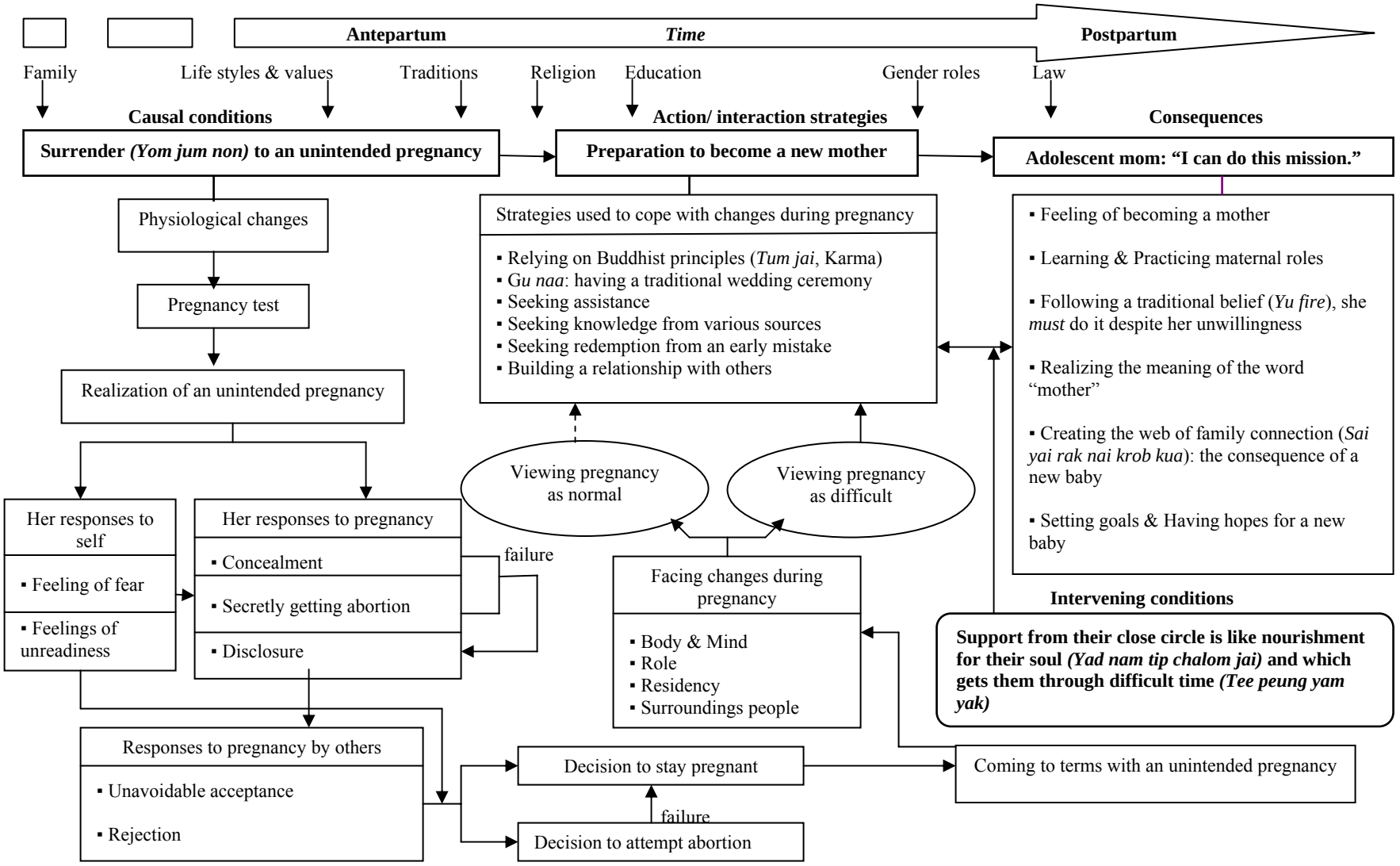


Figure 4.1: A diagram illustrating the process of ***"Kwa ja ru diang sa:* A life journey of Thai adolescents from unintended pregnancy to motherhood"**

The causal condition, beginning the "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood", is the process of how the participant surrendered *(Yom jum non)* to an unintended pregnancy. Because the participants were naïve about the pregnancy, the discovery process of their pregnancy was challenging. They noticed some physiological changes such as missing periods, nausea and vomiting, fatigue, and dizziness. They tried to understand the changes by asking for advice from others like the boyfriend, mother, or friends. Some participants confirmed the pregnancy by testing themselves with a home pregnancy test. When the test was positive, their responses to pregnancy included responses to self and responses to the pregnancy.

The responses to self consisted of feelings of fear and unreadiness. The adolescents were afraid of being condemned, blamed, talked about, and abandoned by their boyfriends. They also feared having a difficult labor and/or a death while giving birth. They worried about a lack of money to raise the baby. In addition, they were afraid that the baby might be weak, crippled, dead, or hated by significant others.

Their responses to the pregnancy included concealment, secretly attempting an abortion, and disclosure of the pregnancy. Those who concealed the pregnancy had many ways to camouflage themselves, such as dressing styles, doing their routine daily life as usual, or lying when asked about becoming pregnant. Most waited around 2-5 months, or as long as possible, only revealing the pregnancy because they could not conceal it any longer. Some participants attempted an unsuccessful abortion and finally had to disclose the pregnancy. A few revealed their pregnancy as soon as their pregnancy was recognized by their significant others, such as boyfriends or parents.

When the pregnancy was disclosed, the responses from others were usually negative. The responses were divided into unavoidable acceptance and rejection. Decisions about the pregnancy depended on responses to self, her responses to pregnancy, and responses by others. It included a decision to stay pregnant or a decision to attempt an abortion.

Unavoidable acceptance was the decision that the participants and their family had to make to accept the pregnancy because it had already occurred. Those who decided to stay pregnant had many reasons. This included a belief that a baby needed to be born with them, approval from significant others, they had a father for the baby, and religious beliefs.

Rejection of the pregnancy led to the decision to have an abortion. Some adolescents felt that they were unready; other received disapproval from their significant others. Consequently, they tried many ways to get rid of the baby, including taking a blood expelling drug, jumping from a high place, and having others perform an abortion. However, all of the participants in this study failed to abort and had to continue with the unintended pregnancy.

During the pregnancy all the participants faced many changes: physical and psychological, roles, residency, and people around them. They had many physical discomforts during pregnancy, especially in the last trimester. They reported backache, constipation, and frequent urination. Their roles changed from a student to housewife, and from a child to a mother. Some had to move into their boyfriend's house. In addition, they were confronted with negative responses from people surrounding them such as sarcastic comments, strange looks, and gossip about their pregnancy.

The causal condition, surrender *(Yom jum non)* to an unintended pregnancy, stimulated different actions and reactions from the participants. The surrendering process to an unintended pregnancy depended on their circumstances. All had gone through the appraisal process of their pregnancy before becoming a mother. Some adolescent mothers had gone through this journey with major changes in their lives and many difficulties. Consequently, they appraised their pregnancy as difficult. Others, who did not have that much difficulty, appraised their pregnancy as normal. No matter what the appraisal of the pregnancy was, the participants developed strategies, 'action/interaction strategies' to cope with the situation. The action/interaction was the preparation process the participants used to become a new mother.

At first, their responses to pregnancy included concealment, secretly attempting an abortion, and disclosure of pregnancy. Later, after they accepted the pregnancy, they used many strategies to prepare themselves for motherhood. One strategy included relying on Buddhist principles such as *Tum jai* and karma. Other strategies included *Gu naa* by having a traditional wedding ceremony, seeking assistance, seeking knowledge from various sources, seeking redemption from early mistakes, and building a relationship with others.

The first strategy was relying on Buddhist principles. These principles lead people to their spiritual practices. The majority of Thai people are Buddhists who believe in the Buddha's teaching, and which is embedded throughout Thai culture. The Buddha taught how to confront problems with *"Sati"* or "mindfulness" so people who have *"sati"* will carefully think about what they have to do or what they should do to handle those problems (Thai Junior Encyclopedia, 1982). In addition, the Buddha's teachings also

guide people to "accept the truth" or *"Tum jai"* about unexpected situations. Therefore, when they face an unexpected situation or situations that they can not change or have very little control over, their minds would promptly accept any consequences of that situation. Thai people have to accept the truth (*Tum jai*) when the situation involves the life cycle of *kerd* (birth), *kae* (old age), *jeb* (sickness), and *tai* (death). This life cycle is the truth that everybody faces in their lives and about which one has little control. The *Tum jai* concept leads to the process of accepting the situation. This process can be called *"Arai ja kerd mun kor tong kerd"* or "what ever will be, will be." The sooner they accept the truth, the better they can handle crisis situations in their lives.

The other strategy that the participants used was the belief in karma. The Buddha taught *"Sad lok yom pen pai tam karma"* which calls people to accept responsibility for what they have done (Thai Junior Encyclopedia, 1982). Actions have consequences; so people's lives are conditioned by their past actions. When people adopt the Buddha's teachings, it helps them deal with stress. Thai people use the teachings to heal troubles in their minds, relieve their fears and sadness, and create warm feelings that enhance their spirit to face any changes during hard times. In the study's results, the participants expressed that it was their karma that they had to face the consequences of their actions (*pen pai tam karma)*.

Not only did the Thais' religious beliefs help the participants deal with their pregnancy, the Thai culture also helped with their journey to becoming a mother. Culturally, most Thai girls get married before becoming pregnant. When the participants in this study accepted the pregnancy, some of them arranged to have a traditional wedding ceremony in order to save face. The strategy, "*Gu naa"*, literally means saving

faces, and thus, the participants abided by the expectation of their roles in society. If they violated the normal expected life trajectory (finish education, then get a job, then get married, and then have a baby), they would have a difficult life. The value, *rak nuan sa-nguan tua*, means to take pride in being "untouched" and "sexually reserved." Therefore, when they became unwed pregnant adolescents, they disappointed everybody in the family. This situation was a violation of the social norms, values, and culture. It was considered a crisis situation not only to the pregnant adolescent, but also to her immediate family. There is a Thai cliché, "having a daughter is like having a lavatory in front of the house" which is a common knowledge in Thai society. This cliché is a metaphor that if the daughter is a good girl, she will bring honor to the family. On the other hand, a bad daughter, such as one who becomes pregnant before getting married, will bring humiliation and shame to the family. They compare "woman" to "lavatory" because if the lavatory is not clean, the stinky odor will spread all over. In this study, the participants lived in a small village. The news about the pregnancy tended to spread rapidly from mouth to mouth in the community. Family with an unmarried pregnant adolescent were condemned by others, in particular, parents were looked down upon by the neighbors. The pregnancy represents the parents' inadequacy in their discipline skills of their daughters. Consequently, to save their faces or *gu naa*, they followed the tradition of society by organizing an 'uncommon" wedding called *"Wak sen"*. The *Wak sen* is a not like the traditional wedding. It is a wedding that is only performed when there is an unexpected event like an unintended pregnancy. The *Wak sen* is a ceremony that helped the participants and family maintain their status in society.

The next strategy was seeking assistance. Since they were young and dependent, most sought assistance from their significant others such as parents, guardians, or others in terms of advice, accommodation, finance, and their emotional needs. They knew who would be the right persons to help them. For example, they sought advice about how to relieve discomforts during pregnancy from the nurses when they attended a prenatal clinic. They expressed their feelings to their friends who always stayed by their sides. They asked for money from their parents for expenses. Assistance gained from their requests helped them face problems occurring in their lives.

Another strategy was seeking knowledge from various sources. Sources of knowledge could be other people and the media. The participants might gain knowledge from others such as their mothers, friends, neighbors, and nurses. They also sought knowledge from the media, the Internet, publishing, or broadcasting. They used varied techniques, depending on their styles. Some participants liked to watch television instead of reading a book. Some might access the Internet to search for information about pregnancy. Knowledge gained from others or media sources influenced their practices during pregnancy.

The unintended pregnancy was considered to be a mistake by all families of and surrounding people of the participants in this study. The strategy that the participants adopted was to seek redemption from this early mistake. They tried their best to correct the mistake they had made after they had come to terms with the unintended pregnancy. In particular, those who attempted an abortion, but failed, were afraid that their babies might not be healthy, as a result. They tried to nurture themselves, to protect the fetus from harm, and to take care of themselves. They changed their lifestyles and behaviors by

eating healthy, riding the motorcycle more slowly than usual, and/or avoiding smoking areas. They hoped that by doing these things, it could help them deliver a healthy baby.

The last strategy was building a relationship with others. In order to remain in the family and community, the participants had to adjust themselves to the new roles from a student to a housewife and then to becoming a mother. They employed several ways to build a relationship with others such as talking to others, and working around the house. They offered to do chores around the house. In addition, they became more pleasant and patient. They gained self worth by doing house chores. By doing this, they were accepted by others. Subsequently, other people had a better understanding of the participant and cared for her. This strategy reduced stress during pregnancy.

In this study, the journey of "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood" was accomplished by using the strategies as described above. The intervening condition related to this journey involved the support from their close circle of significant others. During the journey, there were difficulties that the pregnant adolescent faced. When their close circle, friends, boyfriends, or relatives showed support and understanding, the participants described the feelings like *Yad nam tip chalom jai* and *Tee peung yam yak*. *Yad nam tip chalom jai* means warm feelings and encouragement that can strengthen somebody's spirit. *Tee peung yam yak* means someone who will always there for you through the difficulties in life. The participants felt supported when they perceived that they could lean on their close circle. *Yad nam tip chalom jai* and *Tee peung yam yak* were like nourishment for their soul which got them through difficult times. Supports varied depending on the circumstances, such as number of supporters, types and continuity of support. For

instance, some participants had many people to take care of them, whereas other had only a few people. Supporters might be parents, boyfriend, relatives, boyfriend's family, health care providers, neighbors, and others. The continuity or the degree of consistency of support varied greatly. There were actions that showed the support, for instance, taking care, showing concern, reminding, giving advice, giving massage, paying attention, protecting from harm, touching, bringing/giving food, helping financially, giving some money, teaching health practices, encouraging, monitoring, accompanying, transporting, and cooking. All of these were actions and interactions that gave the pregnant adolescents perceptions of support. These kinds of support were divided into emotional, physical, financial, material, and informational support. Without such support from their significant others, these young people could not survive.

Because of the use of different strategies and the support from their close circle, the participants could complete their journeys from unintended pregnancy to becoming a mother. This phenomenon was labeled as "Adolescent Mom: "I can do this mission." in this research finding. This phenomenon illustrated the ability and experiences that the adolescents went through during their journey to become a mother. They reached motherhood with varied difficulties depending on the individuals. In addition, they still needed continuing support from significant others.

The new mothers in this study had feelings of becoming a mother similar to adult women. However, the occurrence of such feelings was later than those who intended to have a baby. For example, some reported that they felt like they were a mother when they felt quickening. Others felt it when they saw their babies or breastfed for the first time.

There were several emotional responses that occurred after giving birth to the baby, namely feelings of love, bonding and attachments, concern and protection, pride, responsibility, and difficulty. Difficult feelings occurred due to changes in daily life after birth, sleep patterns, relationships with others, expenses, and body and mind. Additionally, the difficulty raising a baby was also stressful to these new mothers. To relieve stress, they changed their lifestyle and adjusted their activities and time to fit the needs of the baby. Strategies used to reduce stress included reading, watching television, listening to songs, having others take care of the baby when they needed a break, talking with others, sharing experiences of raising a baby with a friend, maintaining relationships, seeking assistance, seeking knowledge, and not expecting help to raise the baby from their boyfriends.

Other outcomes of the consequence of "adolescent mom: "I can do this mission." were learning and practicing maternal roles, following a traditional belief (*Yu fire*), she must do it despite her unwillingness, realizing the meaning of the word "mother," creating the web of family connection *(Sai yai rak nai krob kua)*: the consequence of the new baby, and setting goals and having hope for the new baby.

"Kwa ja ru diang sa: A life journey of Thai adolescents from unintended pregnancy to motherhood" was influenced by the context of the family, life styles and values, traditions, religion, education, gender roles, and the law. All of the adolescents in this study were Thai and Buddhists. All of them lived in the Meaung district, of the Uttaradit Province where people in the community are still strict in practices which follow their values, traditions, and religion. The community believes that the group is more important than the individual. Most of them stayed with their extended family so

that family members are related to each other. They did anything to maintain the relationship within the family as well as with other people in the village in order to maintain their status in the community. They were poor, minimally educated, and dependent on their parents or guardians. Their beliefs, values, and social norms were shaped by their culture.

In Thai society, abortion is illegal and radically immoral. About 95% of Thais are Buddhists who believe that life originates when fertilization occurs. Killing life is forbidden and sinful. Following the Buddha's teaching is a way of normal, spiritual, and intellectual training leading to complete freedom and mind. The people in the community use Buddha's teaching to guide their ways in practice. Today, educational systems in the province are varied and easy to access, with a choice of formal and non formal education. The various educational systems permit adolescents who drop out of school during pregnancy to select a study at the Non Formal Educational Center that fits their time and need. Some of them planned to continue studying in college or university and find a job after finishing school to earn money for their lives.

Thai society is highly patriarchal. Gender biases are found in socialization and sexual norms which are strongly rooted in family life. In this study, the male dominant relationship appeared to influence adolescents' decision and practices. For example, despite their unwillingness to abort the baby, attempts were made because of the desire of their boyfriends.

The last context that provides the background to understand the participants' experiences is the law. Most people in modern Thai society have some knowledge about the law. The news broadcast on television or radio provides information about the law

more than in the past. Particularly, the Thai criminal law, section 277-282, is known to the Thais. This law penalizes any persons who have sexual intercourse with a girl whose age is below 19 whether that girl may consent or not. This law implies to the pregnant adolescents because the girl's parents can use the law to force the boyfriend to take the responsibility for the pregnancy. If the boyfriend refuses, the girls' families can report this to the police. The boyfriend can be arrested and put in jail. Thorough details of each of the categories and subcategories are described in the following sections.

Part 3: Context

Socio-Cultural Contexts

The aim of this section is to describe and analyze the impact of socio-cultural contexts on the experiences of pregnant Thai adolescents who decide to continue an unintended pregnancy and her process of becoming a mother. The socio-cultural contexts play an important role as conditions relate to the phenomena of pregnant adolescents until motherhood. In this study, the socio-cultural contexts that influenced the phenomenon "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood," included family, life styles and values, traditions, religion, education, gender roles, and the law. Each of them is discussed as follows.

Family

Traditionally, Thai culture values family connections. The family is the smallest unit in society and has a major impact on childhood development. It is the place where Thai children learn codes of behavior or enact their socially expected roles that will guide them throughout the rest of their lives (Aewsriwong, 2006). The family emphasizes the importance of staying together, places a high value on marriage and children, and expects

financial and social support from family members. In the rural area, the family unit is most typically an extended family with many generations in one house, or many houses within the same compound. The residence is usually a simple house. There are domestic animals, like buffaloes, chickens, and other livestock living under the house with the family living above. There is little privacy because every family member lives and sleeps together in one big room.

Typically, the oldest male enjoys the highest-ranking position in the Thai family. Younger persons show respect to their elders by listening, being obedient, following suggestions, and refraining from arguments. Because of these family traditions and respect for the elders, the participants in this study could not make any decisions related to pregnancy on their own. For example, during pregnancy, a decision to stay pregnant or attempt an abortion should be approved by the elders. Some participants wanted to have an abortion, but could not do it because of disapproval of their parents. Some were unwilling to attempt an abortion, but they had to do it because of direction from the elders in the family. One participant said that the grandmother and uncle knew about the pregnancy and bought abortion drugs for the participant. She said,

> …When my grandmother and my uncle knew about it, my grandmother bought me a bottle of blood-expelling drugs, hoping to get rid of the baby. But he [the baby] survives… My uncle took me to see this woman. She expelled the gas by pressing and squeezing my abdomen, yet I wouldn't bleed (P 18/I 1, line 37-47)[1].

Adolescents are part of the family unit. They live and interact with other family members, such as grandparents, parents, siblings, or other relatives. Because of this tight

[1] Example quotations were derived from the transcribed interviews. P = participant identification number, I = Time for each interview. Example I 1= first interview, I 2 = second interview, and I 3 = third interview.

connection, when a family member is in trouble, all the family members are affected. In the case of an unintended pregnancy, the pregnancy brings humiliation and shame to the family. The participants realized that they had made a mistake according to Thai culture. They had to abide by their family's wishes and decisions. They could not do as they wished, otherwise, they could not stay in the family. Some participants secretly attempted an abortion because they were afraid of the shame that they would bring to the family.

During the postpartum period, the family's influence on the participants continued. They had to follow the traditional beliefs for postpartum practices, despite their disagreements. The family members, especially their mothers or grandmothers, did not allow them to take care of the babies alone during early postpartum. The adolescent mothers were seen as immature and lacking in child care experiences. The participants were not allowed to make decisions or to take care of their babies, although, they believed that they could do it without suggestions from the elders.

> Mom is afraid of everything. She is afraid that my baby may not have enough milk or I may drop her on the floor. During the first month, she didn't let me bathe the baby. I was only allowed to prepare some clothes. She said I did not know how to take care of the baby well enough. She kept on teaching me how to do this and that. Whenever she went out, she would call me and would ask me if I had already given the baby a bath. That's the only time I could bathe her. And I could do it by myself. I never dropped the baby. I could do everything for her when mom was not home (P 9/I 3, line 119).

> I had my mother-in-law take care of the baby while I was studying during the day. I found that our ways and ideas of taking care of the baby were quite different. I followed what I read from new handbooks and magazines, but my mother-in-law still followed the old ways. For example, she wanted to feed the baby with ground rice and banana since he was a month old. I disagreed. I told her that it's too early for the baby. His stomach isn't ready for solid food. He may have a stomachache. I also told her that doctors and nurses suggested that I feed the baby only breast milk. They suggested starting solid food when the baby is six months. My mother-in-law said she had raised my boyfriend and her kids this way. They're

> OK, healthy, like this. She didn't listen to me. I thought to myself that it's useless to try to explain to her all these reasons. She always think that I'm young, lack experience and don't know anything about taking care of the baby (P 17/I 3, line 536).

Lifestyles and Values

The communal life style in village homes instills a strong sense of social harmony and compromise. Most people in the rural area are farmers who depend on nature. The geographical features, climatic conditions, and natural resources play vital roles in their lives. There is a strong sense of connection among the village community in which lifestyles and values are shared. Although they may not be blood relations, they treat each other like everybody is from the same family. They maintain the close relations in the community by keeping their conservative values from generation to generation. These conservative values and the close community are different from those of people who live in the big cities, such as Bangkok or urban areas (Aewsriwong, 2006; Meesil, 2006). Unmarried couples living together are more accepted in a big city like Bangkok. However, in rural areas like Uttaradit, it is unacceptable to the community. The participants in this study were from a small village and experienced negative responses from people around them. They were condemned, stared at with a strange look, and/or gossiped about.

> I guessed they [neighbors] might gossip about me. I remembered hearing them talk about an unmarried teenager who lived in a same village, and got pregnant like me. The neighbors said that she's too young to be pregnant. They think it's not good to be pregnant at a young age. They disapproved of teen pregnancy (P 10/I 1, line 52).

One participant did not think that marriage was particularly important to her as an individual. However, she realized that it had significant impact on her parents' status in the community.

> Sometimes their neighbors asked them [parents] when their daughter was going to get married. I didn't care what they said. To me, getting married or not didn't matter. Many couples were married but they separated. Some of them were younger than me. The important thing is how long we stay with each other. It seems that because I'm the only daughter, when people gossip about me, my parents keep thinking about it (P 4/I 1, line 11).

However this same participant got married a month after she gave birth. The participant expressed that she and her parents were happy to have the wedding. The conservative value of how important it is for girls to get married and then have children is still very strong. Even when the adolescent girls already have babies or become pregnant, it is still better to have a wedding ceremony.

> After giving birth, my dad wanted me to have a wedding party. My family saw my boyfriend's family and discussed the marriage. My family said they wanted us to follow the tradition so it would bring good fortune to my family...At first, I didn't think about this too much, whatever they wanted to do was OK. But when I had the wedding party, I felt good and so did my boyfriend. Our families felt happy about it. They wanted us to have this day. All of them were good to us. If we didn't have them, I would still have been in a crisis situation. When this ceremony made them happy, I felt happy too (P 4/I 3, line 205).

Many people in rural areas still believe in fate, ghosts, hell, heaven, accultism and practices centered on long held beliefs. There is a strong belief that the pregnant women and the new mothers need to follow traditional practices. This period is crucial for women's health for the rest of their lives. The traditional practices include eating certain types of food and performing certain activities. These beliefs influenced what they could or could not do.

> Mom didn't allow me to sleep much in the afternoon. She said *"Phi prai"*[2] would take me. It's like *Phi prai* would sing me to sleep and take me away. Then, I wouldn't wake up anymore. I believed her so I didn't dare to sleep all day long (P 9/I 1, line 115).

[2] *"Phi prai"* refers to the type of ghost who lives in the water.

Traditions

Thai traditional norms set the standard for females to remain virgins until after marriage. Thus, the expectation of people in Thai society is that all females should follow the traditional life trajectory of getting married before becoming pregnant. If they cannot follow the traditions, they will be condemned and their families will be dishonored. As a result, most female adolescents do not purchase contraceptive products because it reveals their sexual activity. However, sexually transmitted diseases and adolescent pregnancy may result from the decision to forgo contraception. For these reasons, when the participants became pregnant outside marriage, they typically concealed their pregnancy, attempted abortion, or delayed attending a prenatal care clinic.

> At first, I wore a big cloth to hide the pregnancy. I didn't want anybody to know. At that time, my tummy wasn't big. When I walked past someone, I would suck my tummy in [laughs]. I wore a big blouse. People noticed that I've changed my dressing style. It was different from it used to be. People suspected that I was pregnant and asked me about that (P 6/I 1, line 99).

Some families still to follow the tradition of organizing an uncommon traditional wedding called a *Wak sen* ceremony for them in order to retain their status in the community. *Wak sen* ceremony is performed when the woman became pregnant before marriage. For example:

> The adults came over once again to my house to discuss the matter. The village leader was also presented as the witness. They made a deal about *sin sod tong mun*[3] and other arrangements for the marriage. The agreement was that I would move to my boyfriend's place after the marriage. After everything was agreed, the news broke out rapidly. Everyone knew that I was pregnant and about to get married. Whenever I went out, I would be asked questions like. *"How many months have you been pregnant?"* or *"When is your marriage?"* You know, my village is like a very small and close

[3] "*Sin sod tong mun*" refers to monies and gold given by a groom's parents to a bride's parents as a pledge.

> community. Each house is very close. So, if any thing happens, people hear the news….When my grandma first found out about the pregnancy, she was mad. She held her fist tightly saying that she felt like beating me up. But when my boyfriend's dad went over to her and made wedding arrangements, that was good for me. I didn't get kicked out of the house to live a hard life. Now if anyone comes and asks about me, she can proudly say that my boyfriend's family is going to be responsible for me. They are not only are arranging the marriage but also are going to support my education after the delivery. They are going to be fully responsible for the expenses of my child. Everyone knows about it (P 16/I 1, line 175).

A tradition during the postpartum period dictates that women must *Yu fire* in order to recover from the labor and birth processes. *Yu fire* is the traditional Thai practice that a postpartal woman should lie near a fire in order to be healthy. Normally, it should be done as soon as the baby is born. The length of this practice varies depending on each community. This Thai tradition has been practiced from generation to generation. People believe that whoever does not practice the *Yu fire* may experience weaknesses and mental disorders in the future. Complete details about *Wak sen* ceremony and *Yu fire* will be described in parts 5 and 7.

Religion

Ninety percent of Thais are Buddhists who believe that the origin of life begins at the time of fertilization (House Committee on Religion and Culture, 2001). Abortion is unlawful and considered sinful. It is forbidden to have an abortion, therefore, whoever attempts abortion is believed to be immoral and known as a killer. Religion influences practices of the people in society. Many participants in the study decided to continue their pregnancy because they were afraid of sin.

> I wanted to terminate the pregnancy, but it's sinful. So I kept the baby and did nothing. I postponed having an abortion until my belly was bigger and bigger (P 5/I 1, line 37).

Thai people gather at the temple for religious activities. Some participants went to the temple during pregnancy for peace and serenity of their mind. They followed the Buddha's teachings as one of the strategies used to reduce stress during their hard time. These issues are discussed more fully in part 5.

Education

The Thai educational system provides many options for people to select a schedule and curriculum that fit their needs. There are two educational systems including, the formal and non formal educational systems, that are more flexible compared to the educational system in the past. In 2006, the Ministry of Education changed the rules to allow pregnant students to continue their study in the formal educational school (Thoranin, 2006). This can be beneficial to adolescent girls who become pregnant. However, some participants decided to quit school because of their feelings of shame. Currently, it is not common to see pregnant students sitting in class at a formal educational school. So they typically dropped out of the formal education school when they became pregnant. Some participants decided to go to a non-formal school after giving birth. The Non-Formal Educational Centers have a site in every province so that the pregnant adolescents have an opportunity to continue their studies. These centers have open enrollments for anybody with no age limitation.

> I think when the school opens, mom and I are going to see the teacher and tell her that I want to drop out of the school for a year. I will return to study next year. If the teacher doesn't allow me to do that, I will quit school. Later on, I may study in a non-formal educational center (P 2/I 1, line 37).

> I used to think of going to school. But now I will just keep on raising my baby until he goes to school. My boyfriend told me not to work now, just keep on taking care of the baby. He can take care of both of us. If my kid goes to school, I will have time to finish 12th grade at a non-formal education program. That's my plan (P 12/I 3, line 250).

The Thai government has recognized the importance of education for its people. The educational system was reorganized and available to people of all ages (Government Gazette, 1999). This change provides an opportunity for adolescent mothers to return to school. Prior to 2006, adolescent mothers would not have a formal educational school as an option.

Gender Roles

Generally, Thai society sets a male as the head of the family and gender biases are rooted in family life (Tangmunkongvorakul & Bhuttarowas, 2004). Ways to raise a girl and a boy are different. Young Thais are raised and disciplined according to cultural rules and standards regarding role expectations and appropriate conduct. A traditional Thai proverb *"Man is padi, Woman is rice"* depicts the traditional Thai attitude toward male and female roles. Men can grow everywhere like padi, while the woman as rice reflects the lack of opportunity to grow (Suriyasarn, 1993). Historically, men and women were expected to enact roles in different ways. The male roles were to work for financial support, act as the head of the family, make decisions for the family members, and protect the country. On the other hand, the women looked after the home, took care of family members, and managed family expenses. However, Thai men have not always had a status that was superior to women (Suriyasarn, 1993). In fact, Thai women were placed in high esteem and were treated accordingly as illustrated in this statement from the Sukhothai era (seven centuries ago). *"Women, especially the intelligent women should control expenditure of money, men who are husbands should listen."*(Chulachata, 1980, p. 10).

Traditionally, Thai women do not have an opportunity to obtain educational and spiritual training. Women learn about social and cultural norms within the household. Socially acceptable behaviors for females are to be a good housewife, a caregiver, to be patient and obedient. Their way of life is marked by a change of status from maiden to wife. The birth of a woman's first child symbolizes her full transformation to adulthood. At this time, a woman can manage and be responsible for her own property, decide an arrangement within her family, and is expected to be able to provide what is needed or a place to meet the husband's and family members' needs (Suriyasarn, 1993).

The gender biases reflected in Thai society, including the male dominant relationship, were found in this study. The participants made a decision to stay pregnant or attempt an abortion, depending on their boyfriends' opinions.

> We've never used any birth control. At that time, I almost finished school, I knew if I didn't use a birth control, I might become pregnant. But my boyfriend wanted to have a baby. I felt he was very jealous of me. At that time, I had a good figure. He might think that if we had a baby, it could tie me to him. As for me, whatever is okay. I didn't want to get pregnant, but I wanted to please him (P 4/I 1, line 22-26).

On the other hand, one participant decided to attempt an abortion because she was compelled by her boyfriend.

> I was frightened. I talked to my boyfriend. He said we're still trying to save money. We're not ready. He told me to get rid of the baby. I also wanted to do so, but when I saw that many people in the restaurant were pregnant such as the owner's wife, a waitress, when I saw that others were having a baby, I wanted to have one, too. My boyfriend didn't want me to do that. So we argued. He said he wasn't ready. But I felt for the baby. I wanted to keep it so we got into a fight. The owner saw we were arguing so he said getting rid of the baby was good for us. He had somebody who worked in his restaurant and had an abortion. That person gave me a blood expelling drug. At first, when I took it, I vomited all the drugs. They came in a capsule and a solution. I took drugs around a handful wisp. I guessed around 40 capsules. She suggested that I hold my breath while taking the drug. After taking them, I suddenly vomited them all out. I had no idea why it happened like that. I felt the drugs were regurgitated. After that, there was no

> blood coming out as she said it would. I did the drugs once and when they failed, my boyfriend forced me to do them again. He said if the baby came out, it's good (P 3/I 1, line 29).

After giving birth, their boyfriends enacted roles that were expected by society, for example, they worked hard to provide financial support for the family and made decisions for the family members, especially the participants' future. They wanted their wives to take care of the baby and manage expenses in the family. Some of them did not want the participants to return to study.

> After having the baby, he [boyfriend] worked very hard. We did not have time for each other like before (P 12/I 3, line 199)… I used to think of going to study. But now I just keep on raising my baby until he goes to school. My boyfriend told me not to work now, just keep on taking care of the baby. He can take care of both of us (line 250).

Current national economic development under a capitalist economy has significantly influenced Thai family life by stimulating a need for women to work outside the home to provide financial support (Meesil, 2006). This was commented on by one participant.

> My husband has a hard job, making a four-lane street. It's good that he has daily income to support the family, but it's still not enough because of having the baby. Dad has to help us. We spend lots of money on raising her. There are expenses like water, electricity, detergent, the baby's clothes, a boiling pot, gas and so on. Today everything is expensive. I think when she grows up, I will work in Bangkok, at a factory. Friends of mine work there and have good incomes. They send money back home (P 9/I 3, line 205).

The Law

People who violate the law will be punished following the provisions of the law. For Thai people, abortion is illegal. If a woman is found out to have had an abortion, she could be found guilty and be penalized by law. However, in the study, 40% of the

participants who attempted abortion either by themselves or by other illegal persons did not mention the fear of penalty.

> I also had thought for a long time whether to keep or kill the baby. Because mom didn't want me to kill it, I was very confused for a month. My boyfriend and I planned to go to Phrae. I heard that there was a place where I could get an abortion. But we didn't go because my mom heard about the plan. My friend who knew my plan told mom. Mom was afraid that if the abortion failed, it would be dangerous. I talked with the doctor who would do the abortion for me. He would charge me eight thousand baht. I had an appointment around 3 pm, but mom insisted on keeping the baby (P 9/I 1, line 26).

Many Thai people have knowledge about the law through several sources such as television or radio broadcasting as well as publications including newspapers and magazines (Office of the Educational Council, 2004). These sources provide programs with content related to law, especially the criminal code section 277-282. The code section 277-282 says that any persons who have sexual intercourse with girls younger than 19 years old, whether the girls consent or not, will be fined and punished with imprisonment. The younger the girls are, the higher cost of the fine and the longer the imprisonment of those persons. However, if the persons are granted from the Court to marry with girls, the persons will not be penalized. The criminal code sections 277-282 are well known and have made front page news in the Thai newspaper. The details of criminal code 277-282 are in Appendix H.

Because of knowledge about these criminal code sections, the participants or their families used the law to negotiate with the boyfriends and their families to take responsibility as fathers of their babies. They threatened to bring the issue to the police and if the boyfriends refused, they would be put in jail. As a result of fear of the penalty, the boyfriends agreed to be the father of the babies or to be married.

> I told the news [getting pregnant] to both my grandmother and my uncle who said that I was too naïve. I was resentful and thought that I should never have gone out with him [boyfriend]. My uncle went to talk to him to see what he would do if I happened to be pregnant. He said he would take responsibility. Then, my uncle went over to make the deal with his parents. But they got off on the wrong foot. So, my uncle used the law to threaten them. He said if they still insisted in not taking responsibility, he would sue the man for committing rape (P 18/I 1, line 23).

> I told my boyfriend that I want to get married. I told him to tell his parents. At first, they didn't organize a wedding party for me. They wanted me to be engaged to him. But I said I got pregnant. I needed to get married otherwise I would report this to the police. They were really scared because they worked for the government, so they did everything following my requests (P 11/I 1, line 107-110).

In summary, the socio-cultural contexts provide the background for the analysis of the results related to the phenomenon of pregnant adolescents until motherhood. In this study, the socio-cultural contexts that developed the phenomenon "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood" included family, lifestyles and values, traditions, religion, education, gender roles, and the law. This background provides contexts to better understand the phenomena that the participants' experienced during pregnancy until motherhood.

Part 4: Causal Conditions

Surrender *(Yom Jum Non)* to an Unintended Pregnancy

This part discusses the causal conditions of events or situations occurring during pregnancy among Thai adolescents. The causal conditions are presented in chronological order of events told by the participants. The causal conditions illustrate their experiences and reasoning of why they came to the acceptance of their pregnancies, 'surrender *(Yom jum non)* to an unintended pregnancy.' Sample excerpts from the data are given to support the analysis. Surrender *(Yom jum non)* to an unintended pregnancy comes from

the realization of an unintended pregnancy, responses to self and her responses to pregnancy after her realization of the pregnancy, responses to pregnancy by others after her disclosure of pregnancy, decision making about pregnancy, coming to terms with an unintended pregnancy, facing changes during pregnancy, and appraisal of the pregnancy. These causal conditions led the participants to go through the life journey from unintended pregnancy to motherhood ("*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood.")

Realization of an Unintended Pregnancy

The process of "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood" starts with the adolescent's realization that she is pregnant. The life journey began when the participants found out that they had become pregnant. The participants had different ways of confirming their pregnancies. At first, they noticed the signs and symptoms of the pregnancy and suspected that they might be pregnant. They reacted to their suspicions in three different approaches. These three different approaches are part of the subcategory, the process of realization of the pregnancy.

Using the first approach, the participants asked for advice from others such as their boyfriends, mothers, relatives or friends about what they had to do in this situation. In the second approach, some participants did not ask for advice from others. They decided to take a pregnancy test on their own. The last approach is when the participants did nothing to confirm the pregnancy. After finding out on their own, either by themselves or by advice of their boyfriends or family, some participants confirmed their pregnancy again with a health care professional. They went to see a doctor at the clinic,

at a hospital, or at a health center. Regardless of the approach the participants chose, they eventually came to the realization that they were pregnant. The following quotations supported this sub-category:

The participants suspected that they were pregnant from several signs and decided on their own to take a pregnancy test.

> I vomited, felt dizzy. Some nights I threw up until I had a nosebleed. I also missed my period. I began to wonder. It happened like this for about a month. So I bought a home pregnancy test. I tested by myself. When it was positive, I then quit my job (P 4/I 1, line 29).

Some participants asked for advice from their boyfriends or friends before taking a pregnancy test.

> When I missed my period, I wondered if I might be pregnant. So my boyfriend bought me a pregnancy test device. I did the test and it was positive (P 2/I 1, line 20).

> I couldn't eat anything. I threw up. I had a lot of morning sickness. When I had rice, even though I wasn't full, I threw up. I felt nauseated. I also missed my period. When I got pregnant, I was in grade 9 in the second semester. My friend invited me to have lunch together, but I didn't go because I would throw up. My friend said I might be pregnant and told me to do a pregnancy test. After that I told this to my boyfriend and he took me to a clinic so I knew that I was pregnant (P 8/I 1, line 39).

Some had their mothers help them; whereas the others had asked advice from their relatives to deal with this situation.

> I didn't know how I got pregnant. I never missed taking the pills [contraceptives]. My breasts were sore. I told my mom. She took me to see a doctor at a clinic. The doctor did a urine test. The test stick showed two clear bands that appeared in a dark color. He told me that I was pregnant. On that day, my close friend came with me, too (P 9/I 1, line 20).

> I consulted with my cousin and she suggested that I have a pregnancy test at the hospital. My husband also told his mom. She touched my tummy. She encouraged me to take a test at the hospital. My husband took me there so I knew that I was pregnant after having a urine test (P 10/I 1, line 28).

Unlike other participants, one participant did not take a test. She learned that she got pregnant from her signs and decided to attend a prenatal clinic, as she stated:

> At first, I missed my period. I thought that it's ok, just a couple of months. I had missed period for a couple of months in the past but then it came. Anyway, I missed a period for three months, four months; I thought I might be pregnant. I had no symptoms. I could eat everything, not vomit. My belly was bigger. I felt fetal movement. My friend told me that if pregnant, in the morning, the belly would protrude like a fish belly. It would be solid. My friend said I was pregnant for sure. I didn't test for anything. I came here to attend the prenatal clinic (P 5/I 1, line 31).

After going through the realization process of the unintended pregnancy, the participants experienced different responses. Because the pregnancy was unintended, some participants thought or attempted to get rid of the pregnancy. There was emotional turmoil occurring in response to the realization of the pregnancy.

Her Responses to Self

Responses to self described the thoughts and reactions the participants felt about themselves when realizing they were pregnant. These were expressed in both positive and negative emotions. All of them reported more negative feelings than positive ones. There were generally two types of responses from the participants. One group of the participants responded to the pregnancy by not even thinking of having an abortion. The other group thought of having an abortion in response. The participants in this group attempted an abortion or were compelled by others to do an abortion. However, the participants in both groups still had personal emotional responses which included feeling ashamed, afraid, worried, shocked, confused, sad, discouraged, upset, shy, stressed, and so on. The negative feelings were found consistently in both groups.

In the group of the participants who did not consider abortion, the participants reported feeling discouraged and worried. Although the pregnancy was approved by

significant others such as boyfriends or parents, the participants still reported negative feelings. For example:

> During pregnancy, I focused more on myself. Sometimes I felt discouraged and I cried (P 1/I 1, line 77)… I was worried about money. I was afraid that I didn't have enough. I felt discouraged. Today I still don't have enough money. When I have a baby, I have no idea about what I am going to do (line 80).

Those participants who felt compelled to have an abortion or decided to have an abortion by themselves had similar feelings as those who did not. Some were compelled toward abortion by their boyfriends and others by their mothers. The reasons behind their actions to have an abortion might be different, however, their feelings about the pregnancy were the same.

> I felt kind of like I didn't know what I was going to do. I was frightened (P 3/I 1, line 29).

> I felt sorry that I didn't use birth control. I cried. I felt shocked (P 7/I 1, line 38)… At first, I felt ashamed of being around people (line 76)… I felt sooooo stressed (line 93).

The participants also had emotional responses to people around them. When a participant's father knew about the pregnancy, the participant said "I felt sad that I had disappointed him" (P 7/I 1, line 125).

Whether the participants had any thoughts about getting rid of the baby or not, they all shared many fears. They feared the unknown journey of becoming a mother. They were afraid of what might happen to the baby. They were afraid of not knowing what to expect for themselves and the babies.

Feelings of Fear

Feelings of fear were reported frequently by most participants. Fear was discussed in two ways. The first way was "fear about self" and the second way was "fear about the baby" Table 4.4 summarizes feelings of fear of the participants.

Table 4.4

Feelings of fear of the pregnant adolescents

Fear	
About self	**About the baby**
Being condemned, Being blamed	Weakness or Crippled
Being hated	Death
Being gossiped about	Being hated by significant others
Being abandoned by her boyfriend	
Fear of difficult labor and death giving birth	
Fear of lack money to raise a baby	

Fear about self

Many participants were afraid of being condemned, being blamed, being hated, being gossiped about, and being abandoned by their boyfriends. Once they decided to keep the baby, they continued to have fear. These also included fear of difficult labor and death during giving birth and lack of money to raise a baby. For example:

> I was afraid that they [friends] might gossip about me (P 2/I 1, line 75)
>
> He [boyfriend] said he wanted to break up if I decided to keep the baby (P 3/I 1, line 35).
>
> At first, I was scared. I wasn't brave enough to tell them [parents]. I was afraid they would blame me. I thought they would say that I didn't work, hadn't had any savings or questioned why I let the pregnancy happen (P 4/I 1, line 32).
>
> Fears. I was afraid of being blamed. I was afraid that I wouldn't have enough money to raise the baby (P 5/I 1, line 34)… I feared that people would look down on me. I feared that they would look at me as a bad girl (line 76).

Fear about the baby

Many participants were afraid that their babies would be crippled, and dead as consequences of failure of attempting abortion. In addition, one participant reported that her baby would be hated by significant others since the pregnancy was disapproved of by others.

> I think I'm too young, only 16. I shouldn't have gotten pregnant (P 5/I 1, line 70)… I'm afraid that if he [grandfather] hates me, he might also hate my baby. I want him to love my baby (line 115)… I think it looks bad because we're too young, to get pregnant. It may affect the baby. The baby may be weak or crippled (line 130).

> I'm afraid that being pregnant at my young age may cause difficulty during the delivery. I am afraid that the baby and I may die during the delivery. I'm afraid of danger (P 8/I 1, line 57).

The pregnant adolescents faced many fears about the pregnancy. They also faced the responses from others, and possible problems of the baby. However, some participants reported positive feelings about the pregnancy. These positive feelings occurred for participants who had a wedding or when their boyfriends took responsibility for fathering the baby. The other factor that stimulated the positive feelings was the support and acceptance by their families.

> I was glad because my boyfriend wanted to have a baby (P 2/I 1, line 28)…My grandma didn't complain about anything. She was glad to have a grandchild (line 43)… His relatives were quite good to me. They accepted me (line 51)… My mother was glad for me (line 84)… When I was pregnant, people loved me more, took care of me more. If people are good to me, I'm also good to them (line 120).

> I'm luckier than her [a friend] that my boyfriend takes responsibility. He never says something that makes me sad. If I hadn't had him, I would have faced many problems. Especially, if his parents hadn't accepted me, it would have been a big problem. I realized that I was lucky that his parents were kind to me (P 6/I 1, line 138).

Feelings of Unreadiness

Feelings of unreadiness to be pregnant were commonly expressed by most participants. They expressed the feeling that they were not ready to be pregnant, but at this point of their journey, they had accepted the pregnancy. However, it did not mean that they were ready to be a mother. The feeling of lack of readiness was complex and dimensional because it included not ready to be pregnant, not ready to maintain the pregnancy, and not ready for motherhood. The dimensions of feeling of lack of readiness included lack of body maturity, age maturity, mental/emotional maturity, economic status, and job stability.

Lack of readiness created conflict between the participants and the people around them such as, their boyfriends, parents, relatives, friends, etc. It was one of the reasons for them or others to decide whether to maintain the pregnancy or to have an abortion. The sense of readiness was not only felt by the girls, but also by the people around them, including parents, relatives, boyfriends, friends, health care providers, and neighbors in the community and society. For the participants, the readiness was influenced by what they knew and others' viewpoints. For example;

> I thought I shouldn't have gotten pregnant, I'm not ready financially (P1/I 1, line 17). I should have had higher education… I should have had a good job before getting pregnant (line 50).

> When I asked a doctor at the first visit, he said a girl shouldn't get pregnant before 17 years old because her pelvis isn't big enough (P 3/I 1, line 76).

> I'm not ready. I told my mom… I don't know what I have to do, how to raise the baby. I have never raised a kid before. My boyfriend is in school. I want him to finish school. If my mom doesn't have enough money, we will have to try to make money by ourselves (P 9/I 1, line 86).

People around the participants greatly influenced the adolescents' level of readiness. In general, they tended to agree that the participants were too young to be pregnant based on the social norms, economic status, and responsibility. However, what made people accept the pregnancy was when the participants were married or they had seen other pregnant adolescents. For example:

> I think they [neighbors] thought about me negatively. I noticed from the way they looked at me. They stared at me with a strange look. It seems like they thought that I was too young to raise a baby (P 1/I 1, line 41)… He (dad) complained that I don't really have money, how am I going to raise the baby?, My aunt, who is my dad's younger sister, said that I shouldn't have let myself get pregnant (line 53).

> He [boyfriend] said he was ready. He wanted to have a baby (P 2/I 1, line 20)… We did a *Wak sen* Ceremony. Since that day, my aunt hasn't said anything (line 43).

> We're not ready [the participant and her boyfriend]. He told me to get rid of the baby (P 3/I 1, line 29)… They [neighbors] didn't criticize because their grandchildren were like me, kind of having a boyfriend at young age and then having a baby. A lot of families in my neighborhood have seen the same thing (line 51).

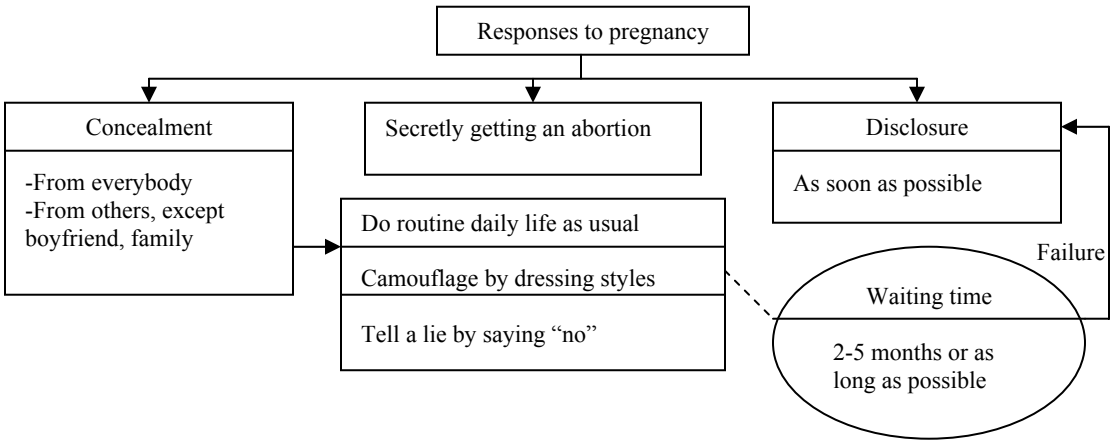
Her Responses to Pregnancy

After they were certain that they were pregnant, the first response was concealment. Their concealment action included not telling anybody or telling only their significant others such as boyfriend, mothers, or family members. The participants tried to conceal their pregnancy by leading life as usual, such as, going to school and hanging out with friends. They might wear loose-fitted dress in order to hide being pregnant. They might lie or deny when asked by another if they were pregnant. Some of them reacted to the pregnancy by secretly attempting an abortion. Others immediately disclosed the pregnancy. When they disclosed, they usually told their boyfriends and/or mothers first. Many participants tried to conceal the pregnancy for 2 to 5 months before disclosing,

waiting until their appearance became too obvious to hide. Figure 4.2 summarizes her responses to pregnancy.

There were different ways of concealment. One participant concealed her pregnancy from everybody. She hid it from her boyfriend for 3 months and her grandparents for 5 months.

Figure 4.2: Her responses to pregnancy



> He [boyfriend] said why I didn't tell him earlier. I told him when I was three months pregnant… He said, *"Stay pregnant, and don't have an abortion".* At first, grandpa and grandma didn't know. When they knew, they wanted my boyfriend's family to *"su khor"*[4]me. That day, my boyfriend took his relatives to ask grandpa and grandma for permission to marry me. They all agreed. My boyfriend would be responsible for the pregnancy (P 5, line 40)… At first, they [neighbors] asked me directly *"Are you pregnant?"* I said *"No".* They said I said no when actually I was pregnant (P 5/I 1, line 61).

One participant tried to hide her pregnancy until her mother noticed the changes in her body. She lied to her mother at first. She decided to tell the truth to her mother a day later when she could no longer keep the secret. She stated:

[4]"*Su khor"* is a Thai traditional activity when a male's family formally asks a female's parents permission to get married to their son. After female's parents agree with this, they then set date, month and time for the engagement and a wedding ceremony.

> Then I decided to tell her [mom] because if I didn't tell her, I wouldn't have had any money. Nobody would help me raise the baby, so what would I do? So I decided to tell her. Actually, before this she asked me if I were pregnant. I used to be skinny and wore fitted clothes. But I changed to wear loose ones. She noticed that and asked me. I said that I didn't know if I was pregnant or not. I told her that I would buy a home pregnancy test. But I'd already bought it and had known that I was pregnant. I lied to her [laughs]. A day later, I told her the truth (P 6/I 1, line 20).

Three participants decided secretly to attempt an abortion. They tried to get rid of the baby before disclosing it to their mother or boyfriend.

> During the first month I took a blood expelling drug which didn't work. I didn't know whether the tablets weren't effective enough or I didn't take enough. I took it only for one week because the baby didn't come out. I didn't let my boyfriend know about this (P 11/I 1, line 32).

> When I missed my period for one month, I decided to tell her [mom]. I went to get the medicine right away. It was something like a blood expelling drug. I had two small bottles. I didn't like it at all. It tasted bad. My mother had no idea that I had tried this drug. It wasn't working (P 20/I 1, line 35).

There were some participants who immediately disclosed the pregnancy to their significant others, for example;

> I told my mom first. She didn't scold me at all because I was living with my boyfriend. She told me to take good care of myself (P 1/I 1, line 53).

> When I had the pregnancy test done, I was so sure that I was pregnant. I told grandma first. Then she told my mom (P 10/I 1, line 46).

Responses to Pregnancy by Others

The responses to the unintended pregnancy by others were mostly negative. By Thai society standard, the participants had violated the social norms and the culture. They lived in a close community in the rural area. They were subjected to criticism by people around them. The negative responses to pregnancy were expressed openly or secretly. The responses were from their parents, boyfriends, relatives, friends, boyfriends' families, and neighbors. Some people criticized verbally; however, even in those who did not

show it, participants could sense the negative responses. Table 4.5 summarizes the responses to pregnancy by others;

Table 4.5

Responses to pregnancy by others

Responses to pregnancy by others	
Open responses	Non open responses
By words; questions, sarcastic words, blame, complaining	Gossiping
By manners; Stare with a strange look, tense looking	Silence, Indifference

The following quotations portray the negative responses to the pregnancy by various people.

Responses to Pregnancy by Parents

> He [father] complained that I didn't have money. How I was going to raise the baby? He didn't complain too much, but he worried. He worried that I might have problems (P 1/I 1, line 53).
>
> She [mom] felt worried because she thought that I was too young, I didn't have a long relationship with him [boyfriend] (P 3/I 1, line 55).
>
> It seems that because I was the only daughter, people gossiped about me. They [parents] might have thought a lot, but they didn't complain much. When I told them I got pregnant, they didn't complain too much. At first, they complained a little bit why I got pregnant, something like that (P 4/I 1, line 11)… She [mother] asked why I let myself get pregnant, why I didn't use birth control, why I rushed to have a baby… But for my dad, he kept quiet, said nothing. He didn't complain either. But I guessed he might have been upset for having a daughter who got pregnant (line 32).

Responses to Pregnancy by Boyfriends

> He [boyfriend] said we're still saving money. We weren't ready. He told me to get rid of the baby (P 3/I 1, line 29).
>
> It [pregnancy] made no difference to him. He wasn't really happy (P 6/I 1, line 26).

> I talked to my boyfriend that I suspected that I might be pregnant. He said nothing (P 7/I 1, line 35).

Responses to Pregnancy by Friends

> She [girlfriend] said I was stupid to let this happen. She also went on saying that I was pretty; I should have found someone better than this. I shouldn't have made this move because my boyfriend didn't have a good job. She said she knew that having a baby isn't an easy job. She didn't want me to get pregnant (P 1/I 1, line 29).

> I was afraid that they [friends] might gossip about me. Anyway, if they knew, I didn't care. If they talked about it nicely, it would be OK. But if they gossiped, I wouldn't like it. I have friends who are nice and sincere and not very sincere to me (P 2/I 1, line 75).

> Friends who know about having babies said when the baby's born, I will know how it is. When the baby cries at night, wakes up, needs milk, the mom must also wake up and take care of the baby and also stay up late. It is a hard time (P 6/I 1, line 135).

Responses to Pregnancy by Boyfriends' Families

> I thought she [mother-in-law] was upset that I was pregnant (P 1/I 1, line 68).

> They [boyfriend's family] didn't get involved with the pregnancy. Although we stayed in the same house, we went different ways. They kept it to themselves and so did I. I'm not very close to them (P 4/I 1, line 50)… My boyfriend's sister has had two kids, but she didn't give me any advice. I had to ask first, I'm not close to her. I sometimes asked her because she got cramps before (when she was pregnant). I got the cramps twice. I tried to exercise to reduce them. But when I asked her about this, she didn't teach me even though she had had some experience with them (line 107).

> She [boyfriend's sister] didn't talk to me directly. She talked to her mom. I heard them talk in a room. She talked sarcastically [about my pregnancy] (P 6/I 1, line 35).

Responses to Pregnancy by Relatives

> My aunt, who is my dad's younger sister, said that I shouldn't have let myself get pregnant (P 1/I 1, line 53).

> For my aunt, she likes to tease me about whether my boyfriend will really come to marry me. If he doesn't, what will I do? She would tease me like this until I got angry (P 2/I 1, line 43).

> Grandpa scolded us [the participants and boyfriend]. Later on, he said *"Let them keep the pregnancy."* Grandma thought too much about this. She got so angry that she was sick. She had some heart condition. She asked why I didn't tell her earlier. The next morning, she was admitted to a hospital. She got sick (P 5/I 1, line 40)… My aunt said *"Do you think that it's fun to be pregnant? Do you think it's easy to be pregnant? It's not that easy, you know!"* (line 55).

Responses to Pregnancy by Neighbors

> They said to my face, *"Aren't you ashamed?" "Will your baby be normal?"* They often teased me (P 2/I 1, line 60).
>
> I was afraid that they [neighbors] would criticize me. I heard people criticized other pregnant adolescents. Even me !! when I see other pregnant teens who are about the same age as I am, I think of them as bad girls, kind of having negative thoughts (P 3/I 1, line 76).
>
> Sometimes they asked my mom why your daughter doesn't have a wedding. This made my mom embarrassed. My dad might have felt like that too (P 4/I 1, line 38).
>
> They hated me. At first, they asked me directly *"Are you pregnant?"* I said *"No"*. They asked why I said no and I became pregnant. They hated that I had lied to them. But I didn't know what they would say about my pregnancy. I think they don't approve of it (P 5/I 1, line 61)… They said when I lied about the pregnancy or hid the truth, it wouldn't be good for the baby. They believed that. I think they looked down on me. They said that I had no money (line 76).

Decision Making About Pregnancy

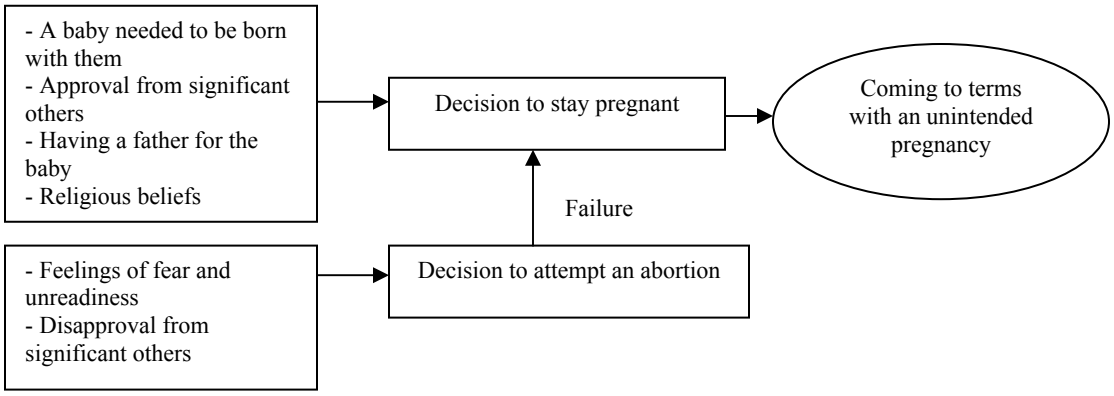
Traditionally, Thai women get married before they become pregnant; this was broken by the participants. This unintended pregnancy stirred up negative responses by the participants themselves or by others. As a result, the participants had to take some actions to deal with the unintended pregnancy. The greatest decision was whether to continue the pregnancy or to get an abortion.

The decision making process depends on several issues. Some participants decided to continue the pregnancy because they thought that it was necessary for the baby to be born to them. Approval from their significant others was important in the decision

making. If the participants had a father for their babies, they tended to continue the pregnancy. Their religious beliefs also contribute greatly to the decision.

The participants who decided to have an abortion were more likely to experience disapproval by their significant others. They also had great fear and sense of unreadiness for motherhood. Some were forced to have an abortion by others. Because of all these reasons, seven participants made a decision to attempt an abortion. When they failed, they had no other options but to keep the baby. The decision process is illustrated in Figure 4.3.

Figure 4.3: Decision making about pregnancy



Decision to Attempt an Abortion

Not only did pregnant adolescents decide to attempt an abortion by themselves, other people might have played a crucial role to force them to do it. For example:

> I felt bad that I didn't use birth control. Mom was sorry too. She was sad. I cried. I felt shocked. I only thought of getting an abortion because I'm not ready. I didn't finish school. Dad wanted me to finish 10th grade (P 7/I 1, line38).

> I wanted to have an abortion. I wanted my boyfriend to finish his education first. My boyfriend also wanted me to have an abortion. He wanted to finish his school. His mom wanted him to become a monk [first before having kids] (P 9/I 1, line23).

> I was shocked at first since I didn't expect it. My hands were trembling. I went totally blank. When my grandmother and my uncle knew, my grandmother bought me a bottle of blood-expelling drugs hoping to get rid of the baby (P 18/I 1, line 38).

For those who failed the abortion, they finally decided to continue the pregnancy as they stated;

> My boyfriend forced me to have an abortion done again. He said that if we can get rid of the baby, it's good. If not, he didn't know what to do. Probably, we have to raise the baby. But I was afraid of being crippled. So he forced me to drink the solution again, but I couldn't stand it. I vomited again because it's like the solution was mixed with strong smell of alcohol. I couldn't swallow it down so I vomited again. After we failed, we had to keep the baby (P 3/ I 1, line 29)… His mom said *"don't get rid of the baby, it's sinful.*" She said that I could return and stay with her in Uttaradit (line 42)… I thought about what his mom said, then I've never wanted to get rid of the baby. I will raise it (line 45).
>
> In fact, I'm afraid of the danger too. At that time I thought I had to get it [baby] out. So I did. But when it didn't work I thought the baby would like to be born so I had to keep it (P 7/I 1, line 62).
>
> My mom knew about this [abortion]. She told me that the baby is tough. The baby needs to be born. I had used many different methods [to get rid of the baby], but I decided to stop. My mom scolded me and my boyfriend, when we went to Phrae for the abortion. I was more than 3 month pregnant (P 9/I 1, line 31)… She said "*keep it*" so that I could experience how life is going to be when I have my own baby...She said I would learn how much love that a mother could give to a baby (line 139).

Decision to Stay Pregnant

There were several reasons participants used to decide on continuing their pregnancy, for example;

> A baby needed to be born with them.
>
> I think the baby is meant to be born with us, we should continue the pregnancy (P 1/I 1, line 23).
>
> Mom told me *"Go to a prenatal clinic. The baby wants to be born, so let it to be born. It's pitiful."* So I went to a prenatal clinic (P 6/I 1, line 20).

Approval from significant others. Just as disapproval from significant others increased the chance of obtaining an abortion, when they were approved of by their significant others, they tended to keep the pregnancy. The people who were most influential in this decision making were their boyfriends and parents.

> My boyfriend asked me whether I want to keep the baby or get rid of it. He said he was ready. He wanted to have the baby. I said *"It's up to you"* so he said *"keep the baby"* (P 2/I 1, line 20).

> My boyfriend wanted to have a baby. He might think that if we had a baby, I would be with him. As for me, it didn't really matter (P 4/I 1, line 23)… I wanted to please him (line 26).

> That day, my boyfriend brought his relatives to tell my grandpa and my grandma that they would be responsible for the pregnancy (P 5/I 1, line 40).

Having father for a baby.

> Because I thought the baby has a father. He [boyfriend] can raise it. I didn't think anything at all because I believed that my boyfriend could take care of the baby. I don't have to do anything. My boyfriend is really glad to have the baby so I never thought of getting rid of it (P 8/I 1, line 45).

Religious beliefs. Strong Buddhist beliefs also factored into many of the participants' views about what to do about the pregnancy.

> I wanted to terminate the pregnancy, but feared that was a sin (P 5/I 1, line 37).

> I wanted them [other adolescents] to continue their pregnancy. Killing a baby is sinful. They must be responsible (P 6/I 1, line 201).

In conclusion, after the participants found out that they were pregnant, they went through a decision making process about whether they should continue the pregnancy. However, all the participants eventually accepted their pregnancy.

Facing Changes During Pregnancy

After the participants accepted the unintended pregnancy, they continued to face many challenges and changes. The obvious changes were their physical (body) and

psychological (mind). Other challenges included the role changes from student to housewife, or from daughter to motherhood. They sometimes had to change their residency to adjust to these new roles. Some moved to the boyfriends' family or just stayed with the boyfriend alone. The last change concerned the people around them. Some participants are more noticeable and perceived as "bad". They could sense the change from other people by their manners. Each change is discussed in detail. Figure 4.4 summarizes changes during pregnancy.

Changes in Physical (Body) and Psychological (Mind) Because of Pregnancy

All participants reported physical discomforts during pregnancy, in addition to mood swings.

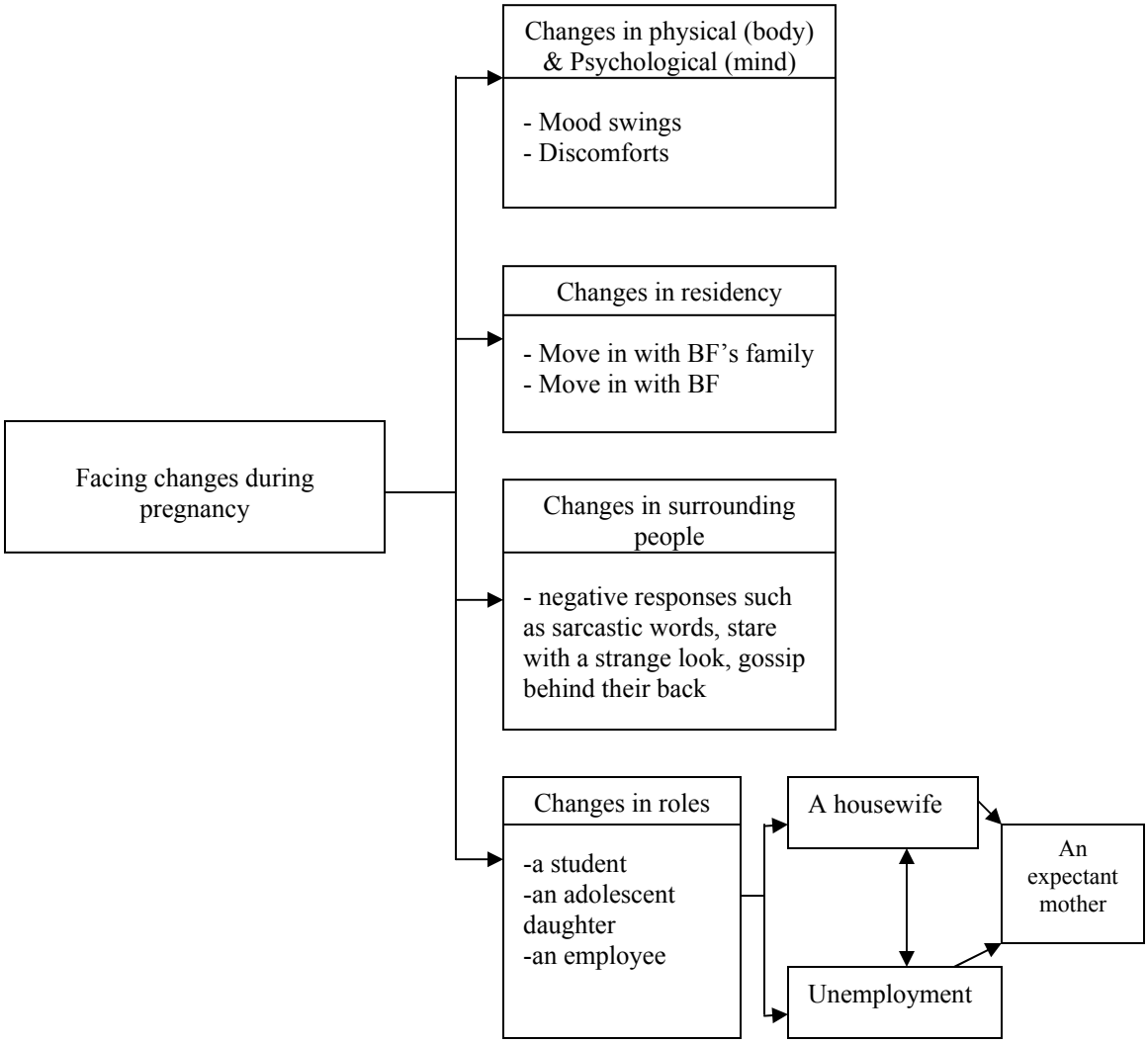
> My body has changed so much. My breasts are so painful. They are bigger. Each breast is engorged. I feel they're not equal and uncomfortable. Sometimes I have a stomachache. When I have a pain, I feel dizzy, like morning sickness. It's hard to sleep at night. It often occurs after a meal. When I lie down for a couple of hours, I have this symptom. I also feel pain around the belly. I feel my heart beat fast. I also have to go the bathroom more often. My belly is bigger. My clothes are too tight (P 2/I 1, line 96).

> My legs and body are fatter. I feel uncomfortable. Sometimes it was hard to have a bowel movement. Sometimes I have a stomachache or have a pain when I have bowel movement. I sometimes feel like my stomach doesn't digest food, I feel that food is stuck in my neck. Some nights, I feel annoyed when I have to get up to go to the bathroom. I frequently feel like I have to go to the bathroom to empty my bladder. My body is heavy and hard to move. I sometimes can't sleep (P 4/I 1, line 62)… During the third month, I vomited. I had too much morning sickness. (line 110)… Now I still go to the bathroom often at night. Sometimes only lying down makes me tired. But I sometimes feel so tired, I have to switch to lie on my right side. When I sit for a long time, I have more backaches (line 128).

Examples of psychological changes during pregnancy are as follows:

> Since becoming pregnant, I easily get angry. It happens more and more. Sometimes I yell at my boyfriend, when he does something that I am not pleased with. I've never been like this before. I think I am more irritated, easily angered. It just happens (P 2, line 123).

Figure 4.4: Facing changes during pregnancy



BF= Boyfriend

> At first, I felt irritable, more irritable. My mother- in- law told me not to get moody when I am pregnant because the baby will be easily irritable like the mommy. I feel like I get angry so easily, especially when it's hot out (P 10, line 8).

Changes in Role

When the participants decided to continue their pregnancy, their roles were changed. For instance, they changed from student to housewife, from employed to unemployed, or from daughter to mother. Changes in role affected their lifestyle which frustrated some of them. Others tried to adapt to the new roles. The destiny of this journey was when they became a new mother which represented the most profound change in their lives.

Participants who dropped out of school usually stayed at home and often feeling lonely. They did house chores or helped take care of other young children in the family.

> It was so regretful because I was doing quite well at school. I wanted to become a teacher and to receive higher education. Even though pregnant, I feel the same about myself. But there are some changes. I have lost school life experiences. I miss studying and being with my friends. Life at home is so boring and lonely. When my dad and my boyfriend go to work, I'm left by myself, all alone (P 12/I 1, line 50)… Being the only woman in the house requires me to be in charge of food. I prepare lunchboxes for my dad and my boyfriend. We have dinner together, though (line 98).

All participants had some expectations of becoming a good mother. They shared some thoughts of how to be a responsible mother.

> I shouldn't behave like I used to. I shouldn't stray. For example I wandered or played like a kid. I think I should be more mature. I don't know how to describe it. I feel like my thinking is more mature. A good mom means not wandering; not doing something that is too heavy or dangerous. Getting more rest (P 2/I 1, line 150).

> [I will] talk to the baby. Play with the baby. Don't compare my kid with other kids. It's like that when kids make a mistake, teach them politely. Don't say rude words to them (P 4/I 1, line 101)… I'll be a mother; I have to raise my baby to be a good person. When I got pregnant, my life style changed. I have to worry more

> about the baby. How the baby is going to live and who the baby will stay with. I have to plan for the baby. I have to think more. Where is a kindergarten for a kid to study? What do they teach? (line 125).
>
> I plan to breastfeed him for three months but it really worries me. Whenever I think of holding him in my arms, bathing him and cleaning his poop and pee, I become quite worried since I've never done them before. I want my kid to have a complete and perfect family with both father and mother, not like mine. I'll give my baby the best care (P 11/I 1, line 148).

Changes in Residency

After becoming pregnant or getting married, some participants moved to stay with their boyfriends' families, for some in a different district or province. In the new residences, these young girls were confronted several difficulties, as they adapted to the boyfriend's family members. They wanted to get along with the family, but they had to learn how to live with other people.

One participant had to move in with her in-laws, but the house was in the same district as her own family. She felt that her mother-in-law disapproved of the pregnancy. When she wanted to visit her parents, she got into arguments with her boyfriend who did not want her to go back home. The participant expressed feeling sad and angry about the change in her situation and living arrangement.

> My boyfriend's mom, I think she is upset that I am pregnant. She said something like when I have my own baby I will forget her grandchild that I am taking care of now (P 1/I 1, line 68)… I cry a lot because of my boyfriend. One time he didn't want me to visit my family. I just wanted to go back to my house sometimes, but he didn't understand. I got angry and cried. When I get angry with him, I don't want to talk to him (line 80).

One participant in a different district moved to stay in her boyfriend's family without telling her parents. She said the reason that she had to do that was to cut down on the expenses. However, staying with the boyfriend's family, she had to live with many family members and faced many difficulties.

> My boyfriend's house has many members, too many expenses. They eat a lot. There are 7-8 people in his family, his sister, a brother-in-law, two kids. When there are a lot of people, a lot of things happen. His mom is moody. Probably, she drinks too much coffee. She complains about dad, my boyfriend, and everybody. I feel irritated and don't want to listen. But she keeps talking. She talks everyday. She is kind but grumpy. She always stays home. She never goes out to work. Every day I see her, 24 hours a day (P 4/I 1, line 47)… My boyfriend's house has a lot of people. Noisy! I have to adjust to it since I arrived. I am not used to the noises. The kids are noisy. I sometimes get annoyed by them. But I keep quiet. I sometimes stay only inside my room, my private part of the house. I and my boyfriend have privacy in our room. We aren't involved with others. At first, I thought about his parents. Do they like me? (line 86)… I feel uncomfortable with his mom when she complains. When I hear a complaint, I feel uncomfortable. Even when it's not about me (line 110).

Changes in Manners of People Surrounding Them After Getting Pregnant

Since the pregnancy was unintended, it took some time for people around the participants to accept, "*Tum jai"* or "accepting the truth", of the situation. As a result, their comments and manners when they interacted with the participants suggested negative responses. The changes in their behavior when they saw the participants were obvious and could be illustrated by the participants' description as they said:

> It was a whole week that I had to listen to them [relatives and people around the neighborhood] telling me off and nagging. Some would say how stupid of me to get pregnant. Some would say that girls are always damaged when it comes to the matter of an unplanned pregnancy. Plus I was still a student. People thought of me as a 'slut.' It hurts my feeling a lot. I have to hear the same thing over and over again every time they see me and all I could do is to walk away. I am not mad at them because they are right. But, I can't stand it. The house is depressing. It is so quiet because we hardly talk to each other. My parents don't talk to each other. I am left alone (P 20/I 1, line 52).

Many of the comments and manners of people around the participants hurt their feelings. When the participants faced negative responses, they felt ashamed and embarrassed about their unintended pregnancy.

> He [grandpa] often complains. When I hear that, I want to cry. I sometimes hide and cry alone. I feel sad. As for grandma, she doesn't complain much. She does everything as usual. But she has lots of worries. Sometimes she says things like

> she wants me to go to school. But I don't want to. I didn't really go to school before I got pregnant. She encourages me to go, but I don't want to. Particularly, when I got pregnant, I quit school. I felt ashamed, ashamed of my friends (P 5/I 1, line 40).
>
> I really want to go out, but they [friends] won't let me. I know that they do it for my own good but I can't help feeling lonely whenever I think that the group is hanging around together without me. All I can do now is spend my day watching T.V. I'm quite upset (P 14/I 1, line 72).

The changes in residency and in the responses from people around the pregnant adolescents had some impact on relationships, conflict, and misunderstandings between the participants and others. The difficulties brought tension to all participants.

Appraisal of Pregnancy

The participants appraised the pregnancy through two different views; difficult or normal. The participants expressed their viewpoint of the pregnancy as being difficult because they were young. The difficulties stemmed from the fear, feelings of unreadiness, and the changes during pregnancy. Some participants expressed their viewpoint of the pregnancy as a normal process of life even though they were young and the pregnancy was unintended.

Seventeen participants (85%) appraised the pregnancy as being difficult.

> I should have learned that raising a kid is hard. The baby costs too much money. She [her friend] doesn't have any time for herself. We have to devote almost all of our time to the baby. She said something like she has realized that having a baby is not an easy job (P 1/I 1, line 29)… Pregnancy makes me lose opportunities like going to school. If I want to go to school, it will be very hard because I have to raise my baby. It's difficult, if I want to go to work. Who is going to help me raise the baby? The freedom that I've had will never be the same. I have to share my time with the baby (line 50).
>
> They said when a baby's born, I would realize how it is. When a baby cries at night, wakes up, needs milk, the mom has to wake up, to look after the baby. Also to stay up late, it is a hard time (P 6/I 1, line 135)… It can be difficult like I don't have money to buy milk, but doctors said I must drink milk, eat that, eat this and I don't have money. How can I get that? When I can't follow their advice, I

> am confused. About eating, I am forced to eat things that I don't like. My boyfriend forces me to eat since I am told that I'm anemic. The doctors told me to eat liver, Chinese kale, eggs. When I told him, he boiled eggs for me. Although I hated it, he forced me to eat. I sometimes do what he says, but I could only eat a little bit. It's difficult (line 153)… I think it is going to harder to do things because I will have a big burden. Having the baby may cause a lot of difficulties (line 192).

However, three participants (15%) viewed pregnancy as normal, describing it as neither difficult nor easy for them, as they stated:

> I don't think it's hard. Maybe because I have experienced raising my sister and my husband's niece (P 4/I 1, line 89)… As for me, it's not difficult. Some teens who say it's difficult because they might not be ready. Their minds don't want to have a baby. They don't plan to have a baby. They make a mistake and get pregnant. The thing I worry about is the expenses (line 92)… It's a normal thing [being pregnant] (line 95).

No matter what their appraisal was, they had to deal with the changes. The strategies that the participants used are described in Part 5.

In summary, the "causal condition'- surrender *(Yom jum non)* to an unintended pregnancy sequentially included: (1) realization of an unintended pregnancy, (2) responses to self and pregnancy, (3) responses to pregnancy by others, (4) decision making about the pregnancy, (5) coming to terms with an unintended pregnancy, (6) facing changes during pregnancy, to (7) appraisal of pregnancy. These causal conditions led the participants to the preparation to become a new mother by using strategies to cope with the changes during pregnancy.

Part 5: Action/Interaction Strategies

Preparation to Become a New Mother

The journey to motherhood continued after the participants accepted the unintended pregnancy. They had responded to the changes within themselves and of the people around them. They had different strategies and ways to deal with the changes and

the stresses. Part 5 is the descriptions of how the participants prepared themselves to become a new mother, including the action/interaction strategies that they used to cope with changes during pregnancy. Several strategies included relying on Buddhist principles, *Gu naa*: having a traditional wedding ceremony, seeking assistance, seeking knowledge from various sources, seeking redemption from what is considered to be an early mistake, and building a relationship with others. Each strategy is discussed as follows.

Relying on Buddhist Principles

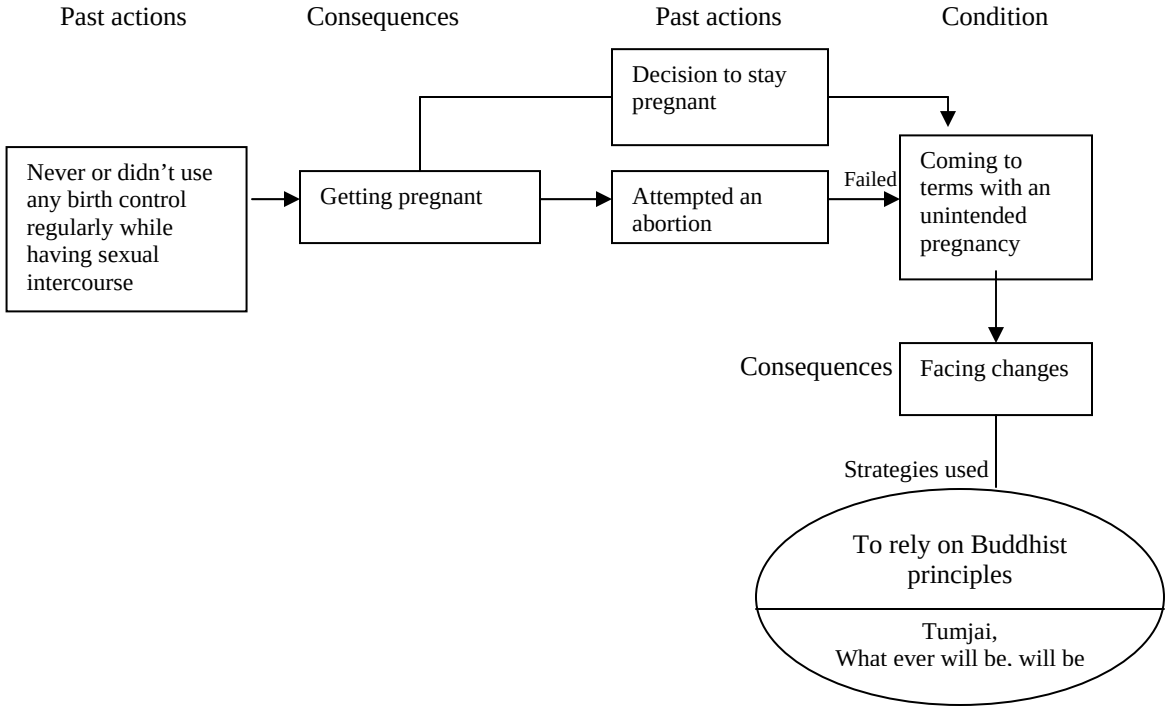
All of the participants were Buddhists, reflecting the religions' principles which are embedded into the Thai culture. During the crisis of an unintended pregnancy, the participants relied on Buddhists principles. The Buddha taught how to confront the problems with *"Sati"* or "mindfulness," so people who have *"sati"* will carefully think about what they have to do or what they should do to handle those problems (Thai Junior Encyclopedia, 1982). The participants expressed trying to be mindful and using "*Tum Jai*" in dealing with the pregnancy. *"Tum jai"* or "accepting the truth" helps with unexpected situations like unintended pregnancy. The *Tum Jai* concept leads to the process of accepting the situation. This process can be called *"Arai ja kerd mun kor tong kerd"* or "what ever will be, will be." The sooner they accept the truth, the better they could handle crisis situations in their lives.

The other strategy that the adolescent girls used was the belief in karma. The Buddha taught *"Sad lok yom pen pai tam karma"* which teaches that people are responsible for what they have done. Actions have consequences; so people's lives are

conditioned by their past actions (Thai Junior Encyclopedia, 1982). In the study's results, the pregnant teens expressed that it was their karma so they have to face the consequences of their actions (*pen pai tam karma)*.

The participants in this study eventually came to terms with the unintended pregnancy and took responsibility for their actions. Figure 4.5 illustrates the process of how they performed actions and how the condition of "coming to terms with the unintended pregnancy" was shaped by relying on Buddhist principles. This process is based on *"Sad lok yom pen pai tam karma"* which teaches that people are responsible for what they have done.

Figure 4.5: Pregnant Thai adolescents and *"Sad lok yom pen pai tam karma"*



The following quotations illustrate the participants' cultural and religious beliefs that they relied on in coping with their pregnancy. The participants who did not use any

birth control accepted the pregnancy because they thought it was the consequence of their action of not using contraceptives.

> I don't think that it's difficult [to accept the pregnancy] because it's already happened. I have to accept it. If we didn't want this to happen, we should have used some protection (P 10/I 1, line 99).

Many participants expressed fear about the pregnancy, fear for themselves, and fear for the baby. They feared entering an unknown territory like motherhood. When asked about how they are dealing with the fear of giving birth, the participants used *tum jai* or *arai ja kerd mun kor tong kerd* as their strategies.

> I heard from a neighbor who had given birth, that it was really painful. I am very afraid of giving birth. I know that it might be too much pain. I try to *tum jai*. [I think] if I am not too afraid, I will not be in too much pain (P 4/I 2, line 260-261).

> I think *ja kerd arai kor tong kerd* [what ever will be, will be], I'm ready to face anything. They said when it's time to give birth, you' will push spontaneously. I don't worry too much. I'm ready to give birth now. I am counting the days (P 11/ I 2, line 221-223).

> I sometimes feel afraid [of giving birth] and sometimes feel brave. I have no idea about this [giving birth], what will happen to me?, will I survive? I'm not sure if I could give birth by myself or will need an operation. The doctor said I'm small and my pelvis may not be big enough. I may need an operation. In my mind, I want to give birth by myself. Sometimes I think about the operation, but [giving birth] by myself would be better. In the past, when I went to the hospital, I was scared of the needle. But now I must *tum jai* because I will have to give birth no matter what (P 16/I 2, 194-198).

According to Buddhist principles, some participants performed overt religious activities, including prayer, going to the temple, making a merit *(Tum boon),* and meditating. They reported feeling good, comfortable, and relaxed after performing these activities.

> Mostly I pray, and then sleep. My boyfriend's mom taught me how to pray. She brought me *Pra Tripidok*[5]. I pray the *Chinnabunchon chant*[6]. I do it almost every day. I fall asleep easily. When I pray, I feel comfortable. I hardly go to the temple but I often make a merit and virtue in front of my house (P 4/I 1, line 59)… I pray. It makes me feel good. I used to do it before but I pray more since I became pregnant (line 110).

One participant had nightmares every night since becoming pregnant. She expressed feeling afraid so she prayed before bedtime. After she started praying, her nightmares ceased.

> I pray every night. I don't want to dream like this anymore (P 8, line 104)… That night, I prayed and didn't dream. But if I didn't, I would have had it (line 101).

When the researcher asked another participant about how often she goes to make a merit at the temple (offer food to monks). She answered:

> [I went to the temple] a couple of times because it's been difficult to sit on the floor and listen to the services. Usually, my mom doesn't let me go there because it's hard for me to sit or to stand for a long time. But, when I go there, my mind is peaceful (P 9/I 1, line 190).

> My mind is ready [to give birth] now. I go to the temple, to *wai phar* [pay respect to the monk]. Some said the *wai* [paying respect] can help people feel happy so I do it. Although I don't go to the temple that often, I do pray before bedtime everyday. I pray to be protected for myself and my baby. I pray for the baby to be born healthy. When I pray, I only ask good things for my baby, I hardly ask for myself. I wish for the baby to be good and have a good life. Everything that's good, I want it for my baby (P 17/I 2, Line 278).

In summary, relying on Buddhist principles helped some of the pregnant adolescents come to terms with the pregnancy. The principles reminded the participants to have mindfulness (*Sati*) and to accept the fact that they were pregnant. By accepting that truth, the participants were ready to face challenges during pregnancy and motherhood.

[5]*Pra Tripidok* or *Tripitaka* refers to the Buddhist scriptures.

[6]*Chinnabunchorn chant* is one of the chants that Buddhists pray in order to be healthy, happy, and peaceful.

Gu naa: Having a Traditional Wedding Ceremony

Gu naa literally translates to saving face, and during an unintended pregnancy can be accomplished by having a wedding. The wedding ceremony is called *"Wak sen."* Thai society has a long tradition that "families that have a daughter should have a wedding ceremony for her and if they have a son, he should be ordained" (Suriyasarn, 1993). If a Thai family has a daughter who gets pregnant before marriage, the family will be condemned from people in their community for not teaching its daughter to follow the norm of the community. This situation causes the family to "lose face" and stress within the family. To "save face" after the mistake or damage had been done from an unintended pregnancy (saving face or *Gu naa* for a lineage), the participants' families tried to follow the tradition by organizing a *Wak sen* (wedding) ceremony. The *Wak sen* ceremony was a significant action in saving face (*Gu naa*). The participants' family would invite many people including both participants' relatives and boyfriends' as well as people in the community. This *Wak Sen* allowed the family to make an announcement that their daughter was following the tradition and had a father for the baby.

The *Wak sen* started when the groom's family came to the bride family to *su khor* (asking permission to get married). The bride's family agreed and gave permission. Both families discussed about *sin sod tong mun*. The groom had to give "*sin sod tong mun"* to the bride's parents. Both families helped with organizing a wedding party. After the female's parents agree with this, they then set the date, month and time for an engagement and a wedding ceremony. They decide on *sin sod tong mun*. *Sin sod tong mun* refers to monies and gold given by the groom's parents to the bride's parents as a pledge. Following this tradition, it helped people to accept the pregnancy as well as to forgive the pregnant adolescents for the mistake they had made.

Thirteen participants organized *Wak sen* ceremonies during pregnancy and one did after giving birth. They felt that it was very important for them and their families. The wedding ceremony reduced stress about the pregnancy. They felt like their pregnancies were accepted when they had a father for the baby. Following example conversations are about how important of the *Wak sen* ceremony impacted one participant's life.

> For my aunt, she likes to tease me about whether my boyfriend will really come to marry me. If he doesn't, what will I do? She often says things like this until I get angry. On April 26, my boyfriend's parents came to ask my mom to allow us to get married. We did a *"Wak sen" Ceremony.* Since that day, my aunt hasn't teased me any more. Until now, her daughter hasn't had a wedding (P 2/I 1, line 43)… They [boyfriend's parents] followed the tradition by coming to my house and asking my mom to allow me to marry him. After my mom gave permission, they organized a "*Wak sen*" ceremony for me. His relatives are quite good to me. They accept me (line 51).

Another example of *Wak sen* ceremony for another participant:

> It [*Wak sen* ceremony] was held during the *Kao Pansa* [the beginning of the Buddhist Lent] at my house. My parents-in-law came with some people and with *sin sod tong mun*. We had a small party after the wrist-tying ceremony. Many people were invited to join the function. My tummy was big enough and was easily noticed by then. So, people knew that I was pregnant, but they didn't say anything. After all, I was getting married (P 19/I 1, line 61)… After the ceremony, I didn't hide it anymore. I go here and there as usual not caring how people looked at me, even though they sometimes ripped off my confidence (line 64).

Seeking Assistance

Seeking assistance was one of the strategies used by the participants to prepare for becoming a mother. Many felt lost as they tried to cope with the pregnancy. They usually turned to their significant others such as mothers or boyfriends. Some asked for help from their friends or health care providers before they asked their significant others. They realized that their peers could not help them much in terms of financial, housing or other tangible issues. Friends could only help with emotional support, not financial. The participants realized that they could turn to different people for different things. For

example, they might ask for money from their significant others such as a mother, a father, or a boyfriend. The participants expressed that when they were supported, they felt more prepared to become a mother.

> When I ask him [dad] for money, he gives it to me every time. At first, when he knew that I was pregnant, he got angry. He talked with grandpa. Grandpa told him to take a son-in-law to work with him. My dad said no because he felt ashamed. But if I ask him for money, he'll help me (P 5/I 1, line 121).

> I think it's hard. Parenting the baby is going to be a difficult and embarrassing job. I have no confidence at all. I think I'll be needing my mom to help me after the delivery (P 12/I 1, line 186)… I'll be taking care of the baby on my own for a while before I start working. We don't know who is going to take responsibility after that; perhaps I will ask my mother for help because she said she would (line 193).

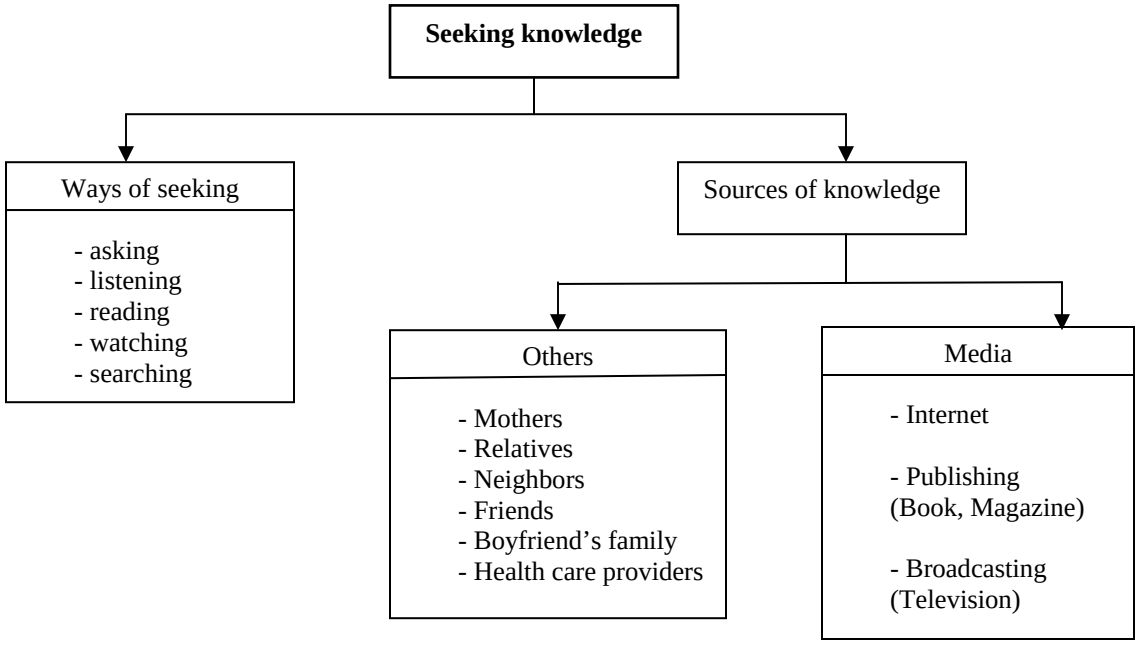
> My aunt asked me once what I plan. The only thing on my mind is to find a father for my baby. As you know, the real one had already ran from his responsibility. I told her that if nobody would be willing to take his place, then I would ask my uncle to be the 'father' (P 13/I 1, line 95).

Seeking Knowledge from Various Sources

The participants faced pregnancy without knowing what to expect. When they traveled through the journey of becoming a mother, they felt stress entering an unknown path. Lack of knowledge about what will be going on in their lives during pregnancy, labor and delivery, and postpartum period were causes of stress. As a result, they sought knowledge from various sources to learn more about the unknown path. They wanted to know what would happen in their lives, how they would take care of themselves during pregnancy or what would be going on during giving birth or how to raise their babies. By knowing these things, it helped relieve their stress. They used different resources, including seeking information by asking, reading, watching, listening, and searching. Sources of knowledge were obtained from others or media. Others included mothers, relatives, neighbors, friends, boyfriend's family, and health care providers. The media

were classified as the Internet, publishing such as books and magazines, and broadcasting such as television. Figure 4.6 summarizes ways and sources of seeking knowledge.

Figure 4.6: Ways and sources of seeking knowledge of pregnant adolescents



Several participants gained knowledge about what kind of food to eat during pregnancy from reading books and suggestions from their mother.

> I read a book suggesting that [pregnant women] shouldn't stand up too fast. It isn't good. I usually read self-help books about pregnancy. One book tells about several exercise options. I do some, but not regularly. I eat everything. I gain so much weight. They tell me not to eat too much oily or salty food. I follow that advice (P 4/I 1, line 65)… My mom told me not to eat salty food, to be careful of this. Too much salt leads to swollen body. Because she sees me getting bigger, gaining so much weight, she tells me not to eat too much (line 107)… A book says that lying on the left side is good to facilitate good blood circulation (line 128).

> If I bottle feed my baby, I won't leave the bottle in the baby's mouth like other moms do because it will cause tooth decay. I read that from a magazine in the bookshop where I used to work. I read all magazines or books about "*Mae lae dek"* [Mother and Kid] or "*Rak look*" [Love kids]. I learned so much from these books. The books taught me many things about pregnancy and birth (P 13/I 2, line 268).

Many participants said that they gained knowledge from watching television.

> Watching television has been useful. There are many programs that show what you should and shouldn't do during the pregnancy. Most of all, I enjoy watching the cooking programs (P 14, line 118).

One participant sought knowledge about physical changes by searching the Internet. She reported how the information on the Internet was informative and reassuring about the body changes during the pregnancy.

> I read about this [stretch marks during pregnancy] on the website. I used the sanook.com web[site]. They have a section called "questions and answers about pregnancy", and about mom's and children's health. I often read it, especially about skin changes during pregnancy (P 15/I 2, line 220)… I like to access the Internet, to read about the health of mother and her children. I learn a lot. I know why things happen to me, why it's not gone, when it's gone. When I know about this, I feel happy. I learn that after the baby is born, everything [the skin changes] will be better, and will fade eventually (line 235).

Seeking Redemption from an Early Mistake

Eventually the participants had come to terms with the unintended pregnancy. Most felt they had made a mistake of becoming a mother at a young age and before they were married. Although they had broken the Thai tradition, they tried to repair the damages and rectify the mistake of their action. Seeking redemption from an early mistake meant the participants changed their behavior to positive ways, trying to improve it. Seeking redemption happened in both groups; those who attempted an abortion and those who never thought of having an abortion. The participants changed their behavior from not planning for the baby to preparing to become a mother. Their actions included nurturing themselves, protecting the fetus from harm, and doing things that would result in a healthy baby. They all cared about the baby's well being, and changed their behaviors and lifestyles in daily life because they believed that the baby would be healthier.

One participant tried to change her behavior by taking a nap more. She was told by the doctor to rest and not to lift heavy objects. The participant followed the advice.

> My life has changed so much. I used to go out and go to bed late. I had to adjust myself. I take a nap during the day. I can't go out often. I can't lift heavy things. I follow the doctor's advice because it may cause danger (P6/I 2, line 186).

Many participants changed their eating habits such as avoiding or quitting soft drinks, sweets, spicy food, and smoking following the suggestions from adults or health care providers. They focused more on eating nutritious food.

> Soft drinks should also be avoided. I shouldn't drink it because it irritates my stomach (P 9/I 1, line 211). I try not to drink soft drinks… I don't eat spicy food (line 217).

> She [mother-in-law] said eating spicy food can heat up the baby, so I've changed my eating habits. I eat more nutritious food like milk. My boyfriend buys it for me (P 10/I 1, line 93).

> I eat healthy food like vegetables, fruits and dairy products. Lately, I haven't been eating any sweets because I've gained too much weight. According to the doctor, this can cause difficulty during the delivery (P 15/I 1, line 129).

Some participants were more be careful of riding a motorcycle and walking. They obeyed their parents' or relatives' advice.

> My mom is the one who has been the most supportive. She doesn't want me to ride on my own. She is afraid that I might have an accident. She doesn't allow me to go out often. I take her advice by not going out alone. But when it comes to going to the prenatal checkup, I do go by myself. To protect myself, I put on the helmet (P 14/I 1, line 102)… My life has a changed greatly. I used to be impulsive and careless at doing things. But having another life inside my body, it requires devotion and carefulness on my part. No matter what I do-ride a bike or sit behind it, I have to watch every step I take. I have to stay at home most of the time because my parents and other relatives don't want me to go out frequently (line 152).

One participant who failed in her abortive attempt felt worried about the baby's health because she took a blood expelling drug for a whole week during the first month of

pregnancy. Consequently, to make sure that her baby was healthy, she kept her appointments.

> I worry about the baby. I have to go there [a prenatal clinic] to check on whether the baby's healthy. When I make a visit, they say the baby is normal. The baby's growing. I gained weight normally (P 12/I 1, line 101)… I don't miss the prenatal care appointments so that I can keep track of the baby's health (line 202).

Another participant had changed her dressing style and became more careful with spending money in order to save it for her baby.

> I would wear tight t-shirts, but my grandmother told me not to do so. She said the baby's head might be at risk for being strangled. I believe in what she said so I began putting on loose trousers she bought for me (P 18/I 1, line 71)… I have to be thrifty. Before I was pregnant, I wasn't careful. Say, I got 50 baht for helping my uncle, I spent it all. But now if I have 100, I would spend half on food and save the rest. I buy only what is necessary. I want to save up for my child (line 86).

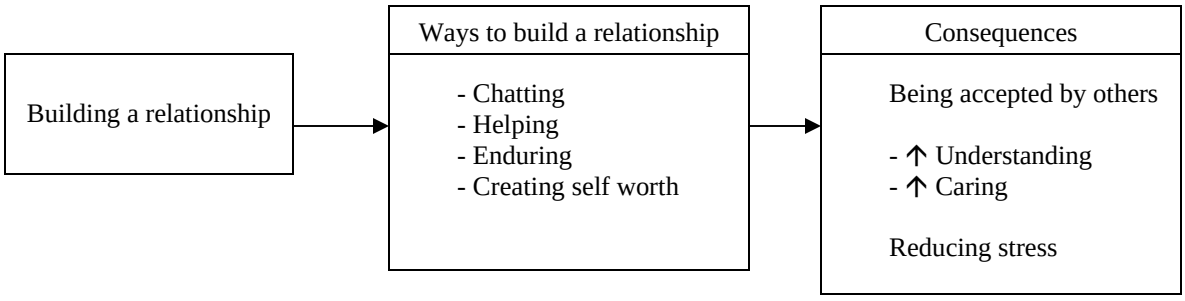
Building a Relationship With Others

Stress accompanied the unintended pregnancy and the participants dealt with many changes. The changes were new experiences to the participants, which precipitated stress. Stress was experienced by the participants who lived with their own families and by the new families (boyfriends'). However, those who moved in with their boyfriends' families seemed to experience more stress as they adapted to their new surroundings. They changed their behaviors to fit to a new role as a housewife and a daughter-in-law. For instance, they woke up early to do the house chores, prepared food for their husbands, contributed to raising other children in the family, and cooking. They were told that they had to become more mature, more diligent, and more patient in order to be a mother. Most of the participants wanted to be accepted by other family members and people surrounding them. They tried to build relationships to overcome the difficulties in

their lives, through talking to others, helping others, enduring situations, and trying to create self worth.

The participants who stayed with their own families experienced the same stresses but to a different degree. They built the relationship in the same ways. They expressed feeling happy when people accepted their pregnancies and forgave them for their mistakes. By being accepted by their families, the participants felt less stress. They felt accepted, cared for, supported, and understood. Building relationships in these three ways helped the participants to reduce the stress and to feel more prepared to become a mother. Figure 4.7 illustrates ways to build a relationship.

Figure 4.7: Ways and consequences of building a relationship



> I get up in the morning, cook rice, and prepare a meal for my boyfriend (P 3/I 1, line 61)… I feel good. Since he accepted my pregnancy, he has taken more responsibility. Before that time, he wasn't interested in doing things. I think he loves me more than he used to. He's even said that he loves me more (line 91)… Many people take care of me more (line113).
>
> My mom generally prepares the meal which includes all the necessary nutrition. If my mom asks for my help, I usually lend my hand with anything, even though I'm not as good as her (P 14/I 1, line 96).

One of the ways to build relationships with others is by "chatting". The participants talked with the neighbors, friends, or relatives. They played with other

children either in the family or in the neighborhood. When they chatted or played, it helped them forget their stress or loneliness.

> Sometimes I go to his relative's house which is near his house to chat or to play with a kid. It helps me forget the stress. I sometimes work around the house. It helps me forget things (P 1/I 1, line 86).

> I walk to the nearby house which is my relative's. Next to my relative's, there is a small store which I often drop by. I sit there, chatting with people for sometime to get away from the loneliness (P 12/I 1, line 131).

One participant dealt with the stress by enduring her situation. Her mother blamed her for attempting an abortion. The participant endured the blame by not arguing back with the mother. Other participants tried to be patient, creating a sense of self worth by getting up early to do housework and adapting to the new environment. They did these things in order to gain more acceptance and understanding from family members.

> I've never argued back to her [mother], no matter how she blamed me about the abortion (P 9/I 1, line 34)… There're more people who are concerned and take care of me including my parents, boyfriend, and everybody (line 209).

> It's a big change. I must adjust myself a great deal to fit in the new circumstances. Chores have become my daily routine. Unlike when I was at my own home, I did or didn't do it. But now, it is my responsibility. I couldn't sleep in here because I thought it was improper to do so. This wasn't my home where I could do anything that I pleased. I have to get up early and work on the chores (P 16/I 1, line 252).

In short, all six strategies including relying on Buddhist principles, *Gu naa*: having a traditional wedding ceremony, seeking assistance, seeking knowledge from various sources, seeking redemption for early mistake, and building a relationship with others as discussed above, helped the pregnant adolescents relieve their stress and help them to prepare themselves to become a mother. All participants might not use all strategies to cope with changes, but rather selected the strategies depending on their circumstances until they became mothers. On the other hand, some participants selected

certain strategies and continued them during the postpartum period. Each strategy could not be accomplished without the intervening conditions which are described in part 6.

Part 6: Intervening Conditions

Support from Their Close Circle is Like Nourishment for Their Soul *(Yad Nam Tip Chalom Jai*) and Which Gets them Through Difficult Time (*Tee Peung Yam Yak*)

The intervening conditions are the conditions that make the strategies in dealing with stress effective. The strategies used to cope with changes and stress during pregnancy until motherhood cannot be helpful without these intervening conditions. The most supportive intervening conditions in this study were the supports from their close circle. This part explains *Yad nam tip chalom jai* and *Tee peung yam yak*.

Yad nam tip chalom jai is literally translated to holy water to nourish the heart and soul. *Tee peung yam yak* means depending on someone during difficult times. The participants were going through the pregnancy and entering motherhood for the first time in their lives. They expressed the challenges they faced in the previous sections. The supports from their close circle were like the nourishment for their souls when they really needed it. To have someone to be *Tee peung yam yak* (someone that they can depend on during difficult times) is a significant intervening condition. Support meant the perception of being supported by the participants. The actions or words that other people did or said to the participants made them feel supported, usually by their significant others. These individuals were parent(s), a boyfriend, boyfriend's parent(s), relatives, health care providers, neighbor(s) or others.

Support was perceived in terms of actions, which are consistent with symbolic interaction. There were actions that demonstrated support, for instance, taking care,

showing concern, reminding, giving advice, giving massage, paying attention, protecting from harm, touching, bringing/giving food, helping financially, teaching health practices, encouraging, monitoring, accompanying, transporting, and cooking. All of these were actions and interactions which the participants perceived as being supportive. The support could be categorized as emotional, physical, financial, material, and information support. Most of the participants experienced such support during pregnancy until the postpartum period.

From the data below, the properties of support can be divided into the amount of support (number of supporters during pregnancy and postpartum period), the type (the nature of the relationship), and the continuity (the degree of consistency of support). Each property can vary in its dimensions. For instance, one participant had seven supporters, whereas another participant had only one supporter. One property can have many dimensions.

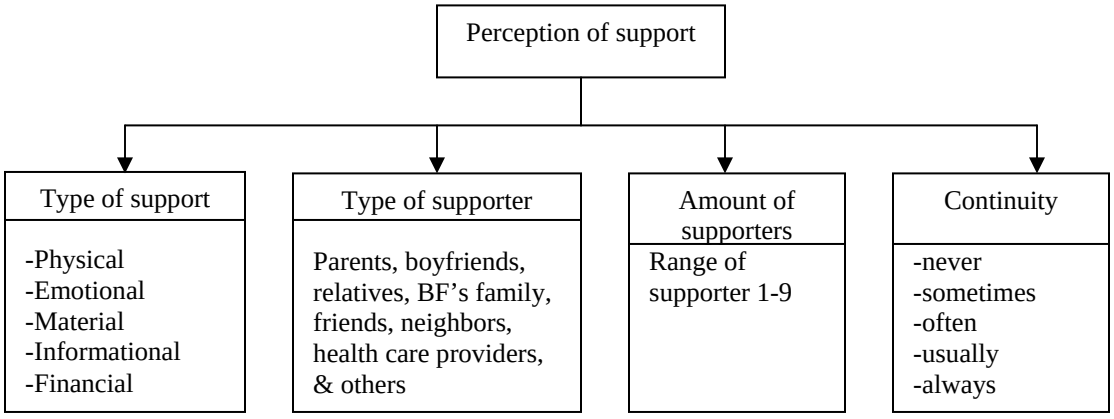
The second property is the type of support. Type means what kind of the relationship the participants had with the supporters. The possible dimensions and types of the relationships expressed were parent(s), boyfriend, boyfriend's family, relatives, friends, health care providers, neighbors, and others. Each participant felt supported by different types of relationships and supporters. For example, some participants did not feel supported by their own parents, more often because they did not live with the parents or their mothers died when they were young.

The third property is the continuity of support, defined as the consistency of the supports. The possible dimensions that the participants expressed were varied. Some said

that they never had any support, they expressed that they were supported all the time or sometimes.

This part explains *Yad nam tip chalom jai* and *Tee peung yam yak* from their close circle in two different phases; support during pregnancy and support after birth.

Figure 4.8: Perception of support



Support During Pregnancy

Support during pregnancy refers to the actions that the participants perceived as supportive actions from significant others during pregnancy. They reported various supports from different supporters. The following are many excerpts as examples of the supports that the participants received during pregnancy.

Support Received from Boyfriend

Boyfriends were frequently reported as the most significant persons for support perceived by the participants. The actions that were supportive included helping with housework, providing food, reminding to take medicine, protecting from harm by not allowing them to lift heavy things, giving money, soothing, accompanying the adolescent to the prenatal care clinic, expressing concern, and massaging. Those actions were emotional, physical, financial, and material support. They stated:

> Since I became pregnant, he has been helping me with the housework. He has never done it before. He doesn't allow me to lift heavy things. He would do it for me. He sometimes buys me some healthy food. Every night, he put the mattress out for me and makes the bed in the morning. He keeps asking me how I am doing. He takes me to doctor's appointment at the clinic every time. He always takes me everywhere I want (P 1/I 1, line 116).

> I think my boyfriend is the most helpful person who takes care of me. Others are okay. My boyfriend helps me wash clothes and clean the rooms. Sometimes he cheers me up. If I have a backache, he does a massage for me (P 4/I 1, line 80)… My boyfriend helps by massaging me when I get a cramp. When I tell him that I have pain, he would get up and give me a massage (line 107)… He is good to me. He helps me wash clothes. Normally, he doesn't do this kind of thing because I mostly do this at home. But on Sunday, he washes clothes for me (line110).

Support Received from Parent(s)

Another person who the participants reported as being supportive was the mother. They saw that mothers provided emotional, physical, financial, material, and informational support. The fathers were perceived as being supportive in providing financial support, but not so much emotional, physical, and material support. The participants did not report any informational support gained from their fathers.

> She [mom] always takes good care of me… she cooks for me, does housework for me. She doesn't allow me to do things like riding a motorcycle. Mom is the person whom I talk with the most. Before pregnancy, I talked to her a lot. Now that I am pregnant, I still talk to her. She never scolds me. She also takes me to the prenatal care clinic (P 2/I 1, line 132)… Mostly, my boyfriend is responsible for expenses. Sometimes if I don't have enough money, I ask for it from my mom (line 135).

> She [mom] says that she's going to help me to raise the baby. She prepares many things for me very well… He [dad] said when it is near the due date, he will have his cousin give me a ride. My relative has just given birth, my dad asked her for the baby's diapers and kept them for my baby (P 8/I 1, line 51)… My dad and my mom prepare the baby stuff for me… She buys rice for me to eat and tells me not to lift heavy things, to be careful while doing things, and not to walk while eating. She reminds me of the things she has been teaching (line 54)… Mom doesn't allow my younger brother to play rough with me (line 119)… My dad is the only person in the house who works and earns money. If I am short of money, I can ask for it from my dad. Today, he gave me a hundred baht to go to the prenatal

> clinic. If my boyfriend has no money, I can ask for it from dad too, but not often. He gives me money every time I ask (line 137).

Support Received from Relative(s)

Participants without mothers received support from other relatives. The relatives were their guardians such as a grandmother, a grandfather, an aunt, an uncle, or a cousin. They provided the participants material, information, and financial support.

> My cousin is older than me. She gives me some baby's clothes and diapers. She gives her kid's stuff to me. My aunt, who didn't want me to have a baby, is good to me now. She teaches me how to take care of myself during pregnancy. She had some experiences. She advises me to take good care of myself so my baby will be healthy (P 1/I 1, line 113).

> My aunt works. Grandpa and grandma only stay at home, doing nothing. My boyfriend has just got a job. He gets 120 Baht a day. It isn't enough. My aunt works 2 jobs, as a laborer and a farmer. She's responsible for all the expenses (P 5/I 1, line 58)… Grandma always cooks for me. She doesn't let me eat a lot. My aunt tells me to drink a lot of milk. When I had a stomachache, grandma told me to see a doctor. Grandpa also asks me what I want to eat and then gives me money to buy it (line 112).

Support Received from Boyfriend's Family

When the participants moved in with the boyfriends' families who often provided an additional form of support. The people whom the participants perceived as being supportive were the mothers-in-law and sisters-in-law. They provided emotional, material, financial, informational, and physical support. However, many participants did not feel very supported by the male relatives in their boyfriends' families.

> My boyfriend doesn't make enough money. His mom has been giving us some money. She may think that I am helping her take care of her grandchild. It is sort of like she is giving me some salary. She also takes care of the food and other expenses in the house. She always gives us money (P 1/I 1, line 104)… She sometimes asks me how I am doing. She always tells me to eat healthy food. When she takes me to the market, if I want something to eat, she will buy it for me. She never offends me. She spoils me so much (line 107)... She has been giving me money. She is really generous to me. Whatever I want, I could tell her and then she will get it for me (line 128).

> She [boyfriend's sister] teaches me how to take care of myself during pregnancy. Now her son is 2 or 3 years old. She always tells me what kinds of food I should eat or not. Some kinds of food might cause vomiting or stomachache. She advised me not to do hard work (P 2/I 1, line 129).

Support Received from Health Care Providers

All of the participants attended prenatal visits at the clinic and reported feeling supported by the nurses. The nurses provided information and physical support. During the time that the participants attended the prenatal care clinic, they reported receiving health care promotion, prevention, and nursing care from the nurses. The participants did not get supported with emotional, material, and financial support from the health care providers.

> They [nurses] take care of my health and the baby's. They touch and measure my tummy. They listen to the baby's heartbeat and check my blood pressure. They ask if I have any concerns. They teach me what to do, such as don't do the hard work, rest a lot, eat healthy food… They tell me to drink a couple glasses of milk a day, to eat more healthy food, to take medicine that helps the red cells in the blood, and remind me to take it everyday. They say after giving birth, I might be anemic, so I should take the vitamins to prevent it (P 3/I 1, line 114).

> I keep myself clean; brush my teeth more every day. Before this, I never brushed my teeth before bed time. Now I do it every night. Somebody [mom and nurses] advised me to do that (P 8/I 1, line 60)… They [nurses] tell me what to do during pregnancy. They give good advice about health education and diseases, what healthy food to eat, to be careful while doing things, what diseases are dangerous and not dangerous. When my weight wasn't increased, they referred me to see a doctor. He did an ultrasound and said that the baby was growing normally. Then they made a follow-up appointment and gave me vitamins to take everyday (line 155).

Support Received from Friends

The kind of support received from friends was emotional support. However, the participants found that friends were less supportive in the aspects of information, material, physical, and financial support.

> They [friends] calm me and give me advice because I worry that the baby may have jaundice (P 6/I 1, line 141).
>
> Today, my mom has a knee pain. My boyfriend goes to work, so she [friend] came with me [to the clinic] (P 8/I 1, line 81).
>
> But now most of my friends know [about the pregnancy]. They worry about me and ask when the due date is. When my time is due, they want me to call them. A friend of mine who works at a gas station calms me down and cheers me up (P 9/I 1, line 71).

Support Received from Neighbor(s)

Although the participants reported less support from the neighbors, some received support informational and material support.

> Neighbors who know mom give me some milk to nourish me. Some have a pity on me that I may not have something healthy so they bring those foods to mom. My mom brings them to me. Sometimes they lend me a cell phone so I could contact other people (P 8/I 1, line 125).
>
> Neighbors tell me not to eat a durian. They also remind me not to drink soft drinks (P 9/I 1, line 71).

In summary, their mothers and boyfriends were the most supportive to the participants. They provided all dimensions of support, including emotional, physical, financial, material, and informational support. For other people, they provided different kinds of supports. For example, health care providers tended to focus on informational more than material support; whereas friends gave more emotional support and less financial support. The friends were students and still depended on their parents. Therefore, the friends could not support the participants financially. Nonetheless, the supports were described as *Yad nam tip chalom jai* (water for their soul) and *Tee peung yam yak* (someone to depend on during difficulties) during the pregnancy. These intervening conditions were necessary in continuing on with their pregnancy.

Support During Postpartum Period

The life journey of participant progressed to maturity and motherhood; "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood." The participants arrived at their destiny, motherhood, with support from various people and sources. Some participants continued to receive support after the baby was born. Some participants gained more supports after birth from surrounding people than while pregnant. The more support they had, the stronger relationship they built with the supporters.

It was more difficult for participants who had never had any child care experience. They had a hard time taking care of the new baby during early postpartum. Therefore, they depended on their significant others, especially their mothers or guardians.

Support Received from Parent(s)

The participants continued to get support from their parents during the postpartum period. Those who had both parents reported that they received more support from the mothers than the fathers. The mothers helped them more in the aspects of emotional, physical, and informational, whereas the fathers helped them more in the aspects of material and financial supports.

> Mom cooks banana flower soup to help with increasing my milk everyday. She said "*it helps increase milk*" (P 9/I 3, line 42)… My mom warns me not to let her (the baby) sleep too long. I must wake her up to feed her periodically (line 116)… Dad often asks me if I already have anything to eat. He tells me to take good care of myself. I must be strong and have much breast milk for the baby. He made a cradle for her and told me to put her in the cradle. We have to use the cradle and swing it all the time. That will help her [he baby] have a long sleep without the mosquitoes bothering her. When she cries, grandpa hurries to watch her and helps me hold her. He is crazy about his granddaughter because he had only a grandson. He said he takes care of the granddaughter more than his children (line 130)…

> [When the baby got sick]I worried so much and cried. I didn't know what to do. Mom had to teach me all the time. My husband also didn't know what to do. Without mom, we would have been in so much trouble (line 181)… If there is not enough (money), dad and mom will help (line 226)… Mom helped me, taught me how to do things for two months. Then I began to be able to do it by myself. Without mom's help, I would have been dead already (line 311).

> The first night [after birth], my mom came to stay overnight and took care of me (P 13/I 3, line 26) … Sometimes my mom buys grilled fish for me (line 33)…My dad held the baby and gave her 50 stang gold which cost about 2,000 Baht. It's good that he didn't scold me or get angry. He accepted us (line 85)… Sometimes mom helps look after the baby, cleans pee and poop. I do the main work while others are helpers so it's good to have helpers (line 118).

Support Received from Boyfriend

After birth, some participants reported being supported by their boyfriends as usual. However, the support in taking care of the baby was less since most of them went to work during the day. The boyfriends also could not help with childcare at night, but the participants seemed to understand the situation. They felt supported by their boyfriends financially. They also felt supported to have the boyfriend by their side after giving birth.

> He [boyfriend] asked me if I wanted to eat anything. He would go to buy it. At night, my mom and he sleep there. They take care of me, but the baby cries a lot (P 9/I 3, line 55)… He helps me carry the baby, take care of her. When anybody says that she looks like him, he would give a big smile. He feels proud that his baby looks like him (line 76)…Whatever I want to eat, he would buy it for me (line 82)… In the first week, he helped me wash the cloth diapers. Now he has to go to work early in the morning (line 110)…He always gives me good things to eat. He lets me and the baby eat first (line 196).

> Later on I let my boyfriend do it [bathe a baby] for the whole month. He took care of me and the baby. I didn't do much. Other people say that he is a good care-giver. They want to have a husband like him [laughs] (P 11/I 3, line 18)… He was always with me at the hospital. He supported me so much. I felt good and warm (line 37)… He carries the baby without any fear. He gives her a bath, takes care of my food, especially food that is good for my breast milk. He stays close to me, helps me wash the baby's cloth diapers. That time we have 2 dozen of baby's cloth diapers. They are still not enough. He takes care of the baby even her poops. He smells it. He wants to know how it smells. He doesn't mind [to help] when I want to go to the bathroom. He helps me wash my body, changes my clothes. I

> was so tired on the first day and I felt pain on my wound. He helped me during my hospital stay (line 62).

Support Received from Relatives

Besides boyfriends and parents, many participants received support from their relatives after birth. For the participants who did not have parents and depended on other relatives, they reported that they received the same kinds of supports as those who received support from their parents. The relatives could be grandparents, a cousin, an aunt, an uncle or others. These people could provide them with several supports.

> I have my aunt and my older sister [take care of the baby]. My aunt gives me advice on how to take care of the baby when he is sick or has a stomachache. I just follow her advice because she has raised her children. She knows how to do many things (P 12/I 3, line 184).

> Grandma gives me 500 Baht a month to help out. If it's not enough, I may ask for more. She'll help me more. Sometimes she [grandma] brings food for us (P 13/I 3, line 55).

> My grandma helps me a lot. She takes care of the baby, bathes him everyday. If I do the bath, he hates it and cries. He loves having grandma do this (P 18/I 3, line 59) … I don't feel lonely because I have a cousin who used to look after the baby, she loves him, kisses him (line 80)… She encourages me to drink a lot of water. I follow her advice because while nursing, I feel like I'm thirsty. Grandma is the most helpful person to help me take care of the baby, followed by my boyfriend. Grandma has taken care of everything since I was at the hospital. At home, grandma washes clothes, cooks food, teaches me to avoid sweet food. She helps to hold the baby. So I have some free time. My mom's younger sister helps me look after him, when I take a bath. If he cries, she will tell me. She helps feed the baby. She sometimes helps swing the cradle while he's sleeping (line 125).

Support Received from Boyfriend's Family

The participants received support by their boyfriends' families in the aspects of material, emotional, financial, and physical support.

> You know on the first day they [boyfriend's parents] brought so many gifts for the baby. My parents didn't need to prepare anything. My boyfriend's parents had already bought them for me and the baby. Every Sunday I return to their house. They buy more stuff for me again. Whatever we don't have, we can let them

> know (P 11/I 3, line 162)… They come to visit us frequently on Thursday, Friday, Saturday and Sunday. They drive here in the evening. They usually give some money to me and the baby (line 171)… My parents and his parents are so good to us. They help us financially (line 263).
>
> My boyfriend's mom stays with me that night. She said *"It's OK, your baby will get better soon"* (P 12/I 3, line 20)… At first, I had no milk. My boyfriend's mom boiled salted water for me to drink instead of water. After that I have so much milk (line 67)… She cooks for me (line 70)… My boyfriend's mom often comes to visit us. She comes here a couple times a week (line 94).
>
> My boyfriend's dad [father-in-law] helped me to boil water and prepared warm water for the baby. I wasn't allowed to lift heavy things after birth (P 13, line 39).

Support Received from Health Care Providers

The participants reported that they continued to get support from the nurses even during the postpartum period. During the postpartum period, the nurses provide support covering four dimensions of nursing care: providing direct treatment, prevention, promotion, and rehabilitation. The participants reported more of the promotion dimension that was useful and most commonly provided to them and their babies.

> A nurse taught me how to hold the baby while breastfeeding. She told me that I have to give the baby a bath in the morning. She taught me how to bathe the baby. My mom also watched me when I first tried it (P 9/I 3, line 68)… She [nurse] told me to clean it [umbilical cord stump] well, keep it dry and observe at the base of the stump. If there were blood, foul odor, or moisture, I was to take her to the hospital right away. The nurse checked her temperature. She was normal without fever. The nurse suggested wiping her body with warm water if she got a fever at home. Don't let her have a seizure. The baby's brain might not get enough oxygen. The baby would not be strong (line 178).
>
> The nurse told them [friends] to visit me only one at a time. Let me rest. I hardly carried my baby because they helped me carry her. When the nurse told me to breastfeed the baby, the baby could suck milk. I was told that I had to nurse every two hours (P 11/I 3, line 18)... When a nurse came to see me, she said the wound was healing well with a bit of swelling. She applied some medicine and the swelling was gone (line 21)… The nurse taught me many things. But it's hard to remember. She taught me how to bathe the baby, clean the belly button stump. The doctor examined the baby's body only two days later and told me to go home. The nurse also made an appointment for me for follow-up after giving birth and another date for the baby to get a vaccination (line 32).

Support Received from Friends

One participant hid the pregnancy from friends and decided to reveal the pregnancy after giving birth. She expressed feeling more relieved and happier when she learned that her friends accepted the news without any negative feelings. This revelation was an important factor for the participant to face the truth of being a mother. Having good relationships with friends was significant in the participants' journey to motherhood. They developed the sense of belonging to the group, relieved their tensions, and did not feel lonely.

> I must accept the truth [of being a mother]. When they know the truth, they feel happy with me. Nowadays some friends still call me, ask me how I am. Most of them go to school. They don't have much time to visit me. So they call me and chat on the phone (P 11/I 3, line 58)… More than 30 friends have visited me. They hugged me, kissed me. Some cried because we are close friends and haven't seen each other for a year. They said next time I must not hide the information from them. In any situation, even if it's bad, just let them know. Don't keep it alone. It will make me too stressed out. Now I feel so free, so relaxed. I have nothing to hide. Nothing's heavy on my mind. They all love me, encourage me. Nobody makes me feel sad. Everybody wants to help and to give support. Anyone who could not visit me, calls me on the phone (line 213).

One participant had a friend who was younger and just had a baby. They shared their experiences of raising babies. The participant did not feel lonely because many friends came to visit her. As she said:

> I have a friend who is younger than me. She gave birth to a baby 9 days after me. She likes to carry her baby to see me. We like to talk about our babies (P 18/I 3, line 80)… They [friends] visit me. That makes me feel not lonely. I also have a friend who has just given birth. So we talk and share our experiences (line 128).

Support Received from Neighbors and from Others

The participants did not feel supported by the neighbors and others much when they were pregnant. The pregnancy in adolescence and before marriage is unacceptable in Thai culture. The participants still felt that the neighbors did not give them much support

after giving birth. Some participants got some support and acceptance from the neighbors which made them felt good.

> My neighbors sometimes come to help me carry him (P 12/I 3, line 160).

> They admired me that I'm good at taking care of the child. I [have proven that] can do everything (P 13/I 3, line 88)

One participant whose baby was in the nursery intensive care unit reported emotional support from the new mothers whom she met for the first time at the postpartum unit after birth.

> I couldn't sleep the first night after birth because I missed the baby. I wanted to see him. New mothers around me had their babies with them. They assured me that it would be all right soon (P 12/I 3, line 20).

In summary, the participants experienced many changes and challenges during the pregnancy. The challenges continued even more after having the baby. They became a new mother at a young age. They had to perform mothering duties 24 hours a day. It was more difficult for participants who never had prior child care experience. They had to learn how to take care of the baby and be a mother. They had to adjust to their new role. They had the perception that both new mothers and their babies could not survive without any support from people surrounding them during pregnancy. Their mothers and boyfriends were reported as the most helpful persons during their challenging time. Each participant had various support in terms of amount of support, type of support, and the continuity of support. Different supporters could provide them with various supports. However, it can be said that "Support from their close circle is like nourishment for their soul *(Yad nam tip chalom jai)* and which gets them through difficult times *(Tee peung yam yak)*.

The participants used many strategies to cope with changes and challenges along their journey. The factors that were helpful and made it possible for the survival of the participants and the babies were the support from people around them. The journey from innocent mother ended with mature mother. The participants were able to achieve maternal duties at some level. The action/interaction strategies resulted in the consequences that happened in their lives. The consequences of the participants are discussed in part 7.

Part 7: Consequences

Adolescent Mom: "I Can Do this Mission."

This part discusses the outcomes and results of the action/interaction strategies used to cope with changes during pregnancy. The support received from the people surrounding them was an important influential factor to the good outcomes. The new mothers' experiences were different depending on each participant's situation. However, the participants shared similar results and outcomes which included having the feeling of being mother-to-be, learning and practicing maternal roles, following a traditional belief (*Yu fire*), she *must* do it despite her unwillingness, realizing the meaning of the word "mother", creating the web of family connection *(Sai yai rak nai krob kua)*: the consequence of having a new baby, and setting goals and having hope for the new baby. Each outcome might happen in a linear fashion for some participants or more simultaneously for others. Although they might not be a perfect mother, each of them accomplished a maternal role from a low to a high level and had potential to reach the highest level with support from people surrounding them.

Adolescent mom: “I can do this mission.” illustrated that they could embrace and enact maternal roles. However, it took time for the development of self-confidence for some participants to do some skills such as bathe a baby, take care when the baby was sick, etc. In addition, these young mothers varied in their skill depending on the social network they had or different backgrounds.

Feeling of Becoming a Mother

The feeling of becoming a mother was first recognized differently by the participants. However, several feelings occurred similarly among these young mothers after taking care of the baby. These feelings are discussed as follows.

Recognition of Being a Mother

When the participants were asked during the third interview “When did you feel that you were a mother?,” they provided different answers. Some participants felt they were a mother during their second or third trimester and/or when they experienced fetal movement (N= 3, 15 %). Others felt it was when they saw their babies for the first time at the birth (N= 11, 55%). Finally, some (N= 6, 30%) felt it when they breastfed or held the babies for the first time. None reported at the third interview that they did not feel like a mother.

> Since I got pregnant, felt the fetal movement. It seemed like the baby knew everything I knew, she heard the dad's voice or when I talked to her, she responded by kicking inside my belly. I felt like she was my baby, she was coming, I had to take good care of myself so she would be healthy (P 4/I 3, line 162).

> Since the day I delivered the baby. Once I saw her, I realized I am her mother. I must give her good care. I want her to be strong, not naughty, obedient (P 9/I 3, line 245).

> Just asked myself if I really had become a mother already. When mom does everything for me, I didn't realize it. But when I was alone, I did everything, then I realized that I am a real mother already (P 11, line 176).

Feelings that Occur When Taking Care of the Baby

Beyond the recognition that comes from understanding her role as a mother, the feelings of being mother-to-be also included several feelings which occurred when taking care of the baby. These various feelings included feelings of love, bonding and attachment, concern and protection, pride, responsibility, and difficulty. Each feeling is discussed as follows;

Feelings of love. The participants reported feelings of love for the baby after giving birth. They stated:

> I can feel how a mother loves her child. It's so much love that I can't explain (P 16/I 3, line 249).

> He [the baby] always has something for me to do, to love, to make the relationship grow. His crying makes life not as quiet (P 20/I 3, line 160)… I feel that I love the child more than him [boyfriend] because I'm with the child all the time. I begin to love him more and more (line 205)… I love him and I'll never give him to anybody even if they offered me a lot of money (line 220).

Feelings of bonding and attachment. When the participants took care of their babies, they created relationships with each other and felt bonding and attachment. Breastfeeding especially promoted these feelings.

> The first time that the baby sucked milk, he sucked strongly. I felt very attached to him. It was my first time to hold my baby for breastfeeding. I felt worried about him for everything. I worried that when the doctor injected him, did he feel pain? I hugged him tightly (P 1/I 3, line 37).

> I feel I can't live without her. I never stay away from her. I take care of her in everyway (P 11/I 3, line 178)… After giving birth, I have not gone out. I have to take care of her all the time, even when she is asleep. I watch her from time to time (line 278).

> When I breastfed, she didn't know how to suck a nipple, only how to lick it. I didn't know why she did it like that. But when she latched on, I felt so happy and loved her so much (P 13/I 3, line 20)… I felt good, warm, attached, and loved her more and more (line 23)… When I breastfeed her, she sucks my milk, I feel good, She looks cute. It's warm, it's love. These are good feelings that happen (line 103).

One participant whose baby was in the Neonatal Intensive Care Unit (NICU) while she was in the postpartum ward, said about bonding with her baby:

> When I saw any women carrying their babies, I missed him so much (P 12/I 3, line 58)… I couldn't give the baby to anybody. He is my flesh and blood. I must raise him by myself. We have created a bond more and more (line 220).

Feelings of concern and protection. Many participants worried about the baby because some were afraid of the consequences of attempting an abortion during pregnancy. In addition, either those who gave birth to a healthy baby or those whose baby got sick after birth, worried about the baby's health. They reflected these feelings during the conversation as follows:

> I feel very worried when somebody carries her too carelessly or too hard. I don't like her to get hurt or get sick (P 9/I 3, line 234)… I am glad to have a baby, to raise her, I don't want her to get sick (line 250)

When the baby was vaccinated and got a high fever, this participant stated:

> I worried so much and cried. I didn't know what to do. Mom had to instruct me all the time (line 181).

One participant told her feelings of concern when she had left him with others:

> I felt good and happy that the baby was healthy, nothing wrong. At first, I was afraid the baby might have something wrong because I had attempted an abortion. I feared his body might not be complete (P 18/I 3, line 38)… Last month I went to do my business at a bank. I left him with grandma. Within an hour, he got hungry and cried. Grandma didn't know what to do so she decided to have him suck her nipple, but there was no milk so he cried a lot. I felt so much for him. He was so hungry. When I was back, he still cried for a long time. Finally, he got full and slept. So I can't go anywhere alone. He must be with me all the time (line 53)… The doctor said he was normal, but his body was rather yellow. He needed to be in an incubator and he was sent to the pediatric building. All his

> clothes were taken off and his eyes were covered with white pieces of cloth. The light was turned on to shine on his body. I saw his condition and cried (line 59).

Another participant whose her baby was in the Neonatal Intensive Care Unit because of complications from a vacuum extraction reported her worry about the baby's condition. She did not leave her baby with others because she believed that no one could take care of him better than her.

> When I knew that the baby was in ICU, I was frightened because staying in the ICU means that the baby was in a serious condition (P 12/I 3, line 14)… I couldn't sleep the first night after birth because I missed the baby. I wanted to see him (line 20)… After ICU, the baby was sent to stay at the children's ward on the fourth floor. His body still looked a little bit yellow. So the doctor tested his blood by drawing it from either his arm or leg a couple times a day. The doctor said it's hard to find his blood vein. When the needle was inserted, he cried so loudly that his chin was trembling. I didn't want to see that, but the doctor asked me to hold his leg while puncturing him (line 26)… Sometimes I feel tired and he cries, I'll tell him *"keep on crying", don't stop"*, but just for a while, I won't allow him to cry too long. I'm afraid he might not catch his breath (line 118)… I worry about him; who can raise him better than his mom. He needs my breast milk. So far, I have never left him with others for I'm not sure if they can give good care like me. I'm afraid that he will get hungry for breast milk. So I decided to raise him until he can stop breastfeeding (line 220).

The participants protected the babies from accidents, injuries, sickness, communicable diseases, and insects.

> While I did this [*Yu fire*], I had to be careful of carrying the baby during nursing otherwise it might burn his skin (P 18/I 3, line 83)… Though these days there are many mosquitoes. Grandma and I keep looking after him. I covered him with a mosquito net while sleeping. And before putting on his clothes, I checked if there were ants or not (line 119).

> Anyway, I hate it when my mother-in-law likes to put her nose near the baby's mouth. I fear that the child might get some diseases from her breathe. But I also don't want to be fussy toward his mom. I told her once. If I talk about this again, she may think that I don't want her to carry my child so I asked my boyfriend to remind his mom not to do this… I worried about her sensitive skin. So I had to complain a lot, especially about mosquitoes. I keep on telling my boyfriend to close the door quickly. If he didn't do it fast, I would blame him immediately because the child's skin is easily allergic to mosquitoes (P 13/I 3, line 48).

Feeling of Pride. The participants reported a feeling of pride when they saw their babies or when people admired them for taking good care of the baby.

> When somebody says I am a good mother, I am very proud (P 9/I 3, line 251).

> They [friends] sometimes call me, visit me, but they don't know how to carry a baby. I, at times, feel proud of myself that I can do what they can't (P 12/I 3, line 169)… When I see him grow, I feel proud that I can make it (line 178).

> I felt proud [when I first saw my baby's face] (P 18/I 3, line 17)… I'm happy and proud of myself [when people admired me for doing a good job of taking care of a baby] (line 62).

Feeling of responsibility. When they had their own babies, many participants reported a feeling of responsibility for taking care of the baby.

> I don't think much because I have the baby, I must accept it and raise him up, make him healthy, and teach him to be a good person. I must take care of him all the time (P 12/I 3, line 175)… But I think the good part is that I'm with the baby, I take care of him. Although I have more burden, it's my duty that I must do it (line 217).

> It's weird that when I used to take care of another person's child, I didn't want to clean pee and poop. I minded doing that, but when it's my child, I'm willing to do everything for her. I didn't mind her pee or poop. After I was home, I did everything for the baby by myself (P 13/I 3, line 39)… They admired me for being good at taking care of the child and I can do everything. When compared with others, they don't know how to care for a baby. Some do it badly. But for me, I don't think that raising the baby is a burden at all. When we have her, we must take care of her (line 88).

Feeling of difficulty. Feeling of difficulty occurred due to the difficulties that adolescent mothers faced after giving birth. While taking care of the baby, many participants realized how difficult it was. Such feelings happened because of the many changes in their lives after giving birth and raising a baby. These changes included changes in their daily life after birth, sleep patterns, relationships with others, expenses, and body and mind. Example quotations are as follows:

Changes in their daily life after birth. When the babies were born, the participants could not continue their routine daily life as it used to be and reported many changes in their lives.

> Because it's difficult to raise a child, I can't go to any places as I used to. Since I gave birth, I have gone out only twice. First, went to the hospital for a check-up after birth. Second, I took my baby to get a vaccination (P 9/I 3, line 204).

> My life has changed a lot after birth. During pregnancy, I ate what I wanted and I slept whenever I wanted (P 12/I 3, line 20).

> I would say having a baby inside my belly is much better. The baby out now makes me have so many things to do. She wakes up at 5 am, but I wake up at 4 am. After breastfeeding, she sleeps, but I have to be quick at washing clothes everyday. Sometimes I feel bored and too lazy to wash even though I use the washing machine. Without it, I can't wash by hand. After washing, I sweep floor, clean the floor, take a bath then bathe the child. After that, it's time for breastfeeding for the whole day, carry her almost the whole day, change diapers and so on. It's like this day after day (P 13/I 3, line 52).

Changes in sleep patterns. After birth, they reported that they had not enough sleep because of the baby's demand for breastfeeding and caring 24 hours a day.

> Because she [the baby] frequently wakes up, I don't get enough sleep. I feel so dizzy and my head is so heavy that I almost drop my head down to the floor (P 9/I 3, line 116).

> I usually get sleepy in the daytime. I want to sleep, but the baby doesn't want to. So whenever she sleeps, I have to sleep with her (P 13/I 3, line 49)… Formerly, I had time to sleep in the daytime, but now she doesn't sleep in the daytime, she wants to talk with me. If I fall asleep, she'll cry (line 52)… It may be a result of getting less sleep since delivery. I have to breastfeed every 2 hours at night and now I can't sleep in the daytime because the baby doesn't sleep (line 58)… When I got less sleep at night it seemed difficult, boring (line 103).

Changes in relationships with others. The participants had changes in relationships with others, such as boyfriends or other friends, during the postpartum period. Since they had to take care of the baby all the time, they felt like they had less

time for others. As a result, some participants felt lonely, whereas others accepted the changes and understood the situation.

> My husband works hard everyday. When he arrives home, he's always tired and goes to sleep. We hardly go out together. And we don't want to leave our baby, she needs to get breast milk and it's not good to carry her out. I wish she could grow up quickly so that I would be free to do what I want (P 9/I 3, line 206).

> When I have a baby, they [friends] are away from me. I don't belong to the group as I used to. On weekends they usually go out together, but they don't invite me to join (P 12/I 3, line 169)… After having a baby, he [boyfriend] works hard. We don't have time for each other like before. I also have many things to do with the baby though. I have less time for him too. But he is OK. He tells me to take good care of the baby. He is so diligent, he also works on weekends (line 199).

Changes in expenses. Having the baby caused greater expenses for the young mothers. They were still dependent on financial help from others.

> But it's [money] still not enough because of having the baby. Dad has to help us. We spend much on raising her. There are expenses like water, electricity, detergent, the baby's clothes and stuff, a cooking pot, gas and so on. Today everything is expensive (P 9/I 3, line 205).

> The expense has increased a lot since giving birth. I had to sell one piece of gold jewelry to afford the expenses. Most of the money has been used for food to nourish my health. I have to provide a thousand baht a month for powdered milk; this brand is so expensive (P 13/I 3, line 55).

Changes in body and mind. Changes in body and mind mean physical discomfort that the participants experienced and psychological changes after birth, respectively.

> I let her frequently suck my nipples. She sucked so strong that one nipple broke. But mom encouraged me to let her keep on sucking (P 9, line 61)… I felt pain in the broken nipple. I felt pain in my wound (line 75).

> In fact I still had pain and was so tired [a couple days of postpartum] (P 11, line 17)…I was afraid of dropping her, and I also felt pain from my wound. I had been tired for a week (line 21)… Sometimes I felt lonely but I must accept the situation, I cried every night during the first week after birth. I feel it's easy to cry. Later on I felt better. My emotion seems to move up and down. Now I know

> why I cried. I felt lonely when I was far away from my boyfriend. Sometimes I worried that he will go out to see other girls when he wants (line 117).
>
> I had been tired for a long time. My wound still hurt. It took me around a month for the wound to heal (P 12, line 64)… He [the baby] likes me to put him on my shoulder while walking around the house. I rock him to sleep. I also got a backache. I sometimes feel terrible and so tired (line 136).

Difficulty in raising the baby. Many participants, especially those who did not have personal child care experiences, had a more difficult time raising the baby by themselves. Since the baby could not speak, they did not know what the baby wanted. For example, they did not know why the babies had non-stop crying episodes, how to respond to their needs, or how to take care of them when they got sick. The participants were frustrated and realized how difficult it is to raise the baby.

> It's pretty difficult. At first I was afraid of dropping her. I didn't know how to carry her properly while giving milk. My nipple broke and it hurt a lot. I had to be patient. When she cried, I didn't know what happened. It's the hardest when she can't tell me and I don't understand. As a new mother, I didn't know what to do, how to raise the baby. Everything seemed difficult (P 9/I 3, line 150)… I can feel how difficult it is to raise a baby (line 249)… It [the difficulty to raise a baby] is that the child is unable to talk. When it cries, I felt frustrated that I don't know what she wants (line 283).
>
> It [bathing a baby] looked easy to see, but it was hard to do (P 12/I 3, line 94)… It was difficult in the evening at about 6 P.M. He usually cries at that time until 7 P.M. I don't know why he cries. He looks sleepy, but he doesn't sleep (line 100)… But if I want to pee or go to the bathroom and he's crying, that's the hard time. I almost couldn't hold my pee. That's difficult (line 115)… It's difficult when he cries and I don't understand what he wants, and he keeps on crying because he can't speak. That's hard (line 244).
>
> Difficult. So difficult, especially when he wakes up at irregular times, eats at odd times (P 18/I 3, line 68)… Other people say that it's easy to raise him. If he is carried, he will stop crying. If he is teased, he will smile. He has a good temper. He gets moody when he feels sleepy or gets hungry. But for me, it's not easy to look after him (line 74)… When he had a yellow body, he was put into an incubator. He didn't get used to it and kept on crying. All I could do was to watch over him, feed him, and carry him until he got better. When we returned home, I had to watch to see if his body was yellow again or not. I also observed his sucking, whether it was good or not. After that, he was all right. When he got the

> vaccinations, he had a low fever. He got medicine and the fever was gone in one day. They said it's easy to raise my baby, but for me, it's pretty difficult (line 101).

Difficulties raising a baby and all the other changes caused stress for the participants. However, the participants adapted themselves during this time, as well as used strategies to relieve their stress. There were several ways to adapt themselves to the situation. Mostly, they adjusted their activities and time to fit the baby's needs. For example, they got up earlier to do housework, slept in the daytime simultaneously with the baby, and did personal work while the baby was sleeping.

> In order to get time to work, I must wait until the baby slept. When he woke up, I ran to him first and left my clothes to dry later. Sometimes I wake up to wash clothes at 4 am., 5 am. I had to wake up earlier and let my boyfriend sleep with the child. Though I returned to stay at my house, I had to take care of the child by myself as I used to. Nobody helps me. My mom and my sister aren't diligent. The house is messy. My sister does nothing at all. The bathroom is dirty and smells bad. She just hold her breathe while using it, but I can't stand it. So I have to clean it and my boyfriend sometimes helps me do it (P 13/I 3, line 33)… But I usually get sleepy in the daytime. I want to sleep, but the baby doesn't want to. So whenever she sleeps, I have to sleep with her (line 49).

In summary, the feeling of difficulty after birth of the participants occurred from changes in daily life, sleep patterns, relationships with others, body and mind, and the difficulty in raising a baby. To reduce stress because of these changes, the participant had several strategies as discussed below.

Strategies Used to Reduce Stress After Birth

Many participants had several strategies to reduce stress, such as adjusting their activities and time to fit to the baby's needs, reading, watching TV, listening to songs, having others take care of the baby when getting moody, talking with others, sharing experiences of raising a baby with friends, maintaining the relationship, seeking assistance, seeking knowledge, and not expecting help with raising the baby from their

boyfriends. These actions could be grouped into seeking entertainment, having others take care of the baby when getting moody, sharing experience of raising a baby, maintaining relationships, seeking assistance and knowledge, and not expecting help raising the baby from their boyfriends.

Many participants adjusted their activities and time to fit the baby's needs. They stated:

> Before I had time to work, I must wait until the baby slept. When he woke up, I ran to him first and left my clothes to dry later. Sometimes I wake up to wash clothes at 4 am., 5 am. I had to wake up earlier and let my boyfriend sleep with the child (P 13/I 3, line 33).

One participant sought assistance from the nurses because of discomfort after birth such as how to relieve constipation.

> [Because of constipation] I cried and went to the health center. The nurse didn't want me to take any medicine because the medicine would affect the breast milk. She suggested that I have much water and oranges. And I put a small piece of soap into my anus, and ate a kilogram of oranges. In that evening I could poop easily (P 9/I 3, line 134).

She also sought advice and help from the nurses about how to take care of the baby's navel and how to take care of a sick baby.

> Her umbilical cord stump was ok. It fell off within a few days. But later on, there was a little stain of blood from the navel. I called the nurse to ask for advice (P 9/I 3, line 177)… She [the baby] got a cold too, but no fever. I took her to the health center. The nurse checked her temperature. She was normal without fever. The nurse suggested that I rub her body with warm water if she got a fever at home (line 178).

Many participants sought entertainment after birth by reading a book, listening to songs, watching television, and talking with somebody.

> When I am with the child, I have no time to be lonely. I have to do many things. I sometimes read a book when she sleeps (P 11/I 3, line 271).

> I watch T.V., listen to songs or carry him to talk to the neighbors. When I see him smile, all my seriousness is gone. When I see him in a good mood, him talking to himself, I can't help smiling (P 12/I 3, line 181).

One participant shared her experience of raising the baby with her friend.

> I also have a friend who has just given birth. So we talk and share our experiences (P 18/I 3, line 128).

She also had her grandmother take care of the baby when she got angry.

> I only yell because grandma said *"he is very young. Don't yell at him, don't hit him. If you begin to be bad-tempered, go a way from him, leave him with me until you feel better"*. So I follow her advice. When I get angry, I will have grandma or my boyfriend look after him (P 18/I 3, line 71).

One participant sought knowledge about how to promote child development by reading a book.

> I read it from the pink book. It tells me how to stimulate development, what additional food is. I read it when the baby goes to sleep or while I'm swinging the cradle in the daytime (P 12/I 3, line 229).

Another participant sought knowledge from watching television and listening to others.

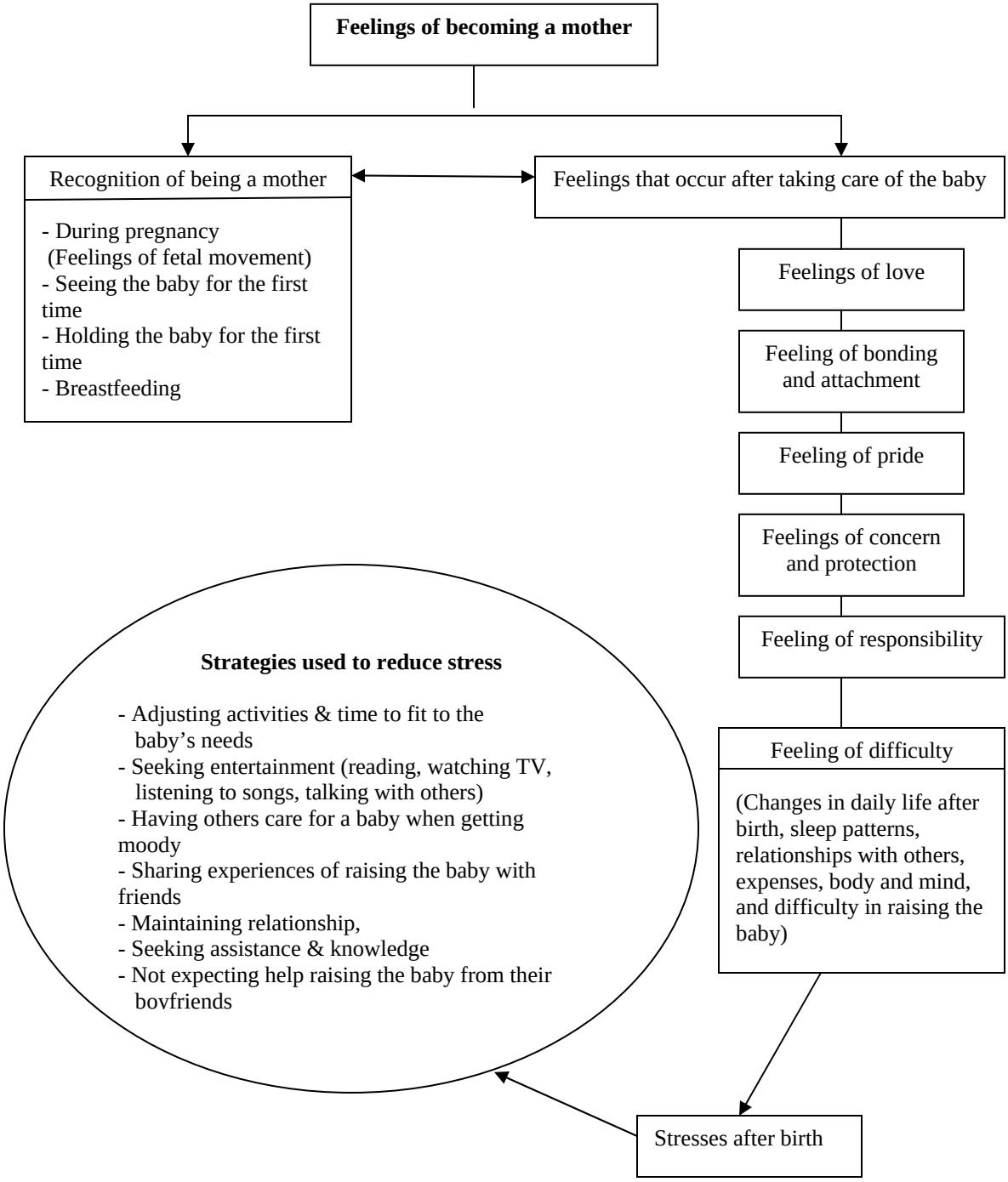
> But I dislike reading a book. I learn from watching TV, listening to what others say. I remember the advice to apply to the child. When the time passes by, I'll be better. When I do something, talk to somebody, I'll forget (P 13/I 3, line 67).

Although she was tired of raising the baby for the whole day, one participant did not expect her boyfriend to help her because she understood the situation that he worked hard.

> I see that he [boyfriend] works hard so I don't expect him to help with taking care of the baby. I should do it. I just want him to love the child very much. That's all right if he can't help me (P 13/I 3, line 67).

Figure 4.9 summarizes "Feelings of being a mother-to-be" and strategies used to reduce stress after birth.

Figure 4.9: Feelings of becoming a mother and strategies used to reduce stress after birth

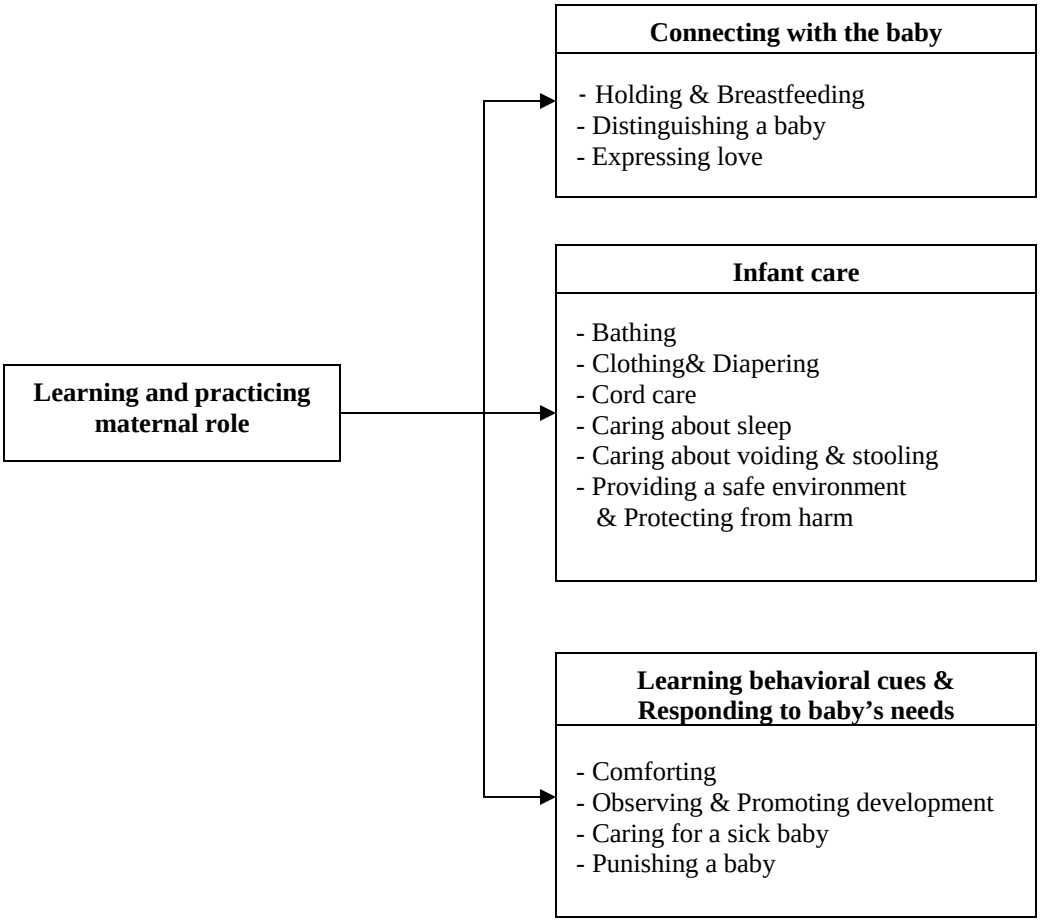


Learning and Practicing Maternal Roles

When they gave birth, the participants learned and practiced how to take care of their babies. Although some of them reported that they had personal experience raising a baby, such as their siblings' or others' children, they still had low self-confidence and worried during the early postpartum period. Subsequently, they reported more skill and had self-confidence as time passed by. Some participants were more dependent on their significant others and took a longer time to become confident about caring for their babies when compared to those who did not have significant others by their sides. Particularly, the participants who had their mothers or guardians staying with them all the time mentioned about the lack of freedom to make a decision about caring for the babies. Some skills were easy for them, such as diapering, whereas some skills were hard, such as bathing the baby, caring for the sick baby, etc.

The participants had learned and practiced several skills of caring for the baby, including holding and breastfeeding, clothing and diapering, bathing, cleaning baby stuff, comforting, cord care, caring for the sick baby, promoting sleep, providing a safe environment and protecting from harm, expressing love, observing and promoting development, learning behavioral cues and responding to baby's needs, punishing the baby, and caring about voiding and stooling. Figure 4.10 summarizes learning and practicing maternal role of the participants and each basic skill in baby care is discussed as follows.

Figure 4.10: Summary of learning and practicing maternal role of the participants.



Connecting With the Baby

Holding and breastfeeding were initial skills the participants experienced a maternal role. These skills brought about acquaintance between the young mother and the baby. Some participants who had no child care experience felt afraid the first time they held and breastfed the baby. As time went by, they felt more comfortable and became more confident. They could distinguish, learned how to communicate, and expressed love to their baby. Connecting with the baby gradually developed when the participants held and breastfed, distinguished, and expressed love to the baby.

Holding and breastfeeding

Some participants stated that they were afraid of dropping their babies when holding and breastfeeding them for the first time. They lacked confidence and worried about this because the babies were small and their necks were not strong. However, they felt good when they breastfed their baby.

> At first, I dared not to touch her [the baby], she lay near me and moved beside me. I felt excited, I had no idea, I just touched her for the first time. I felt so good that I forgot my stomachache (P 3/I 3, line 20).

> When a nurse carried her [the baby] to me, I was afraid that I might drop her. So I lied down and hugged her (P 9/I 3, line 52)… Another thing, I am afraid of carrying the baby for fear of dropping her. Her neck is very weak, too (line 116).

> When I breastfed, she didn't know how to suck a nipple, just only licked it. I didn't know why she did that. But I can tell that when she latched on, I felt so happy and loved her so much (P 13/I 3, line 20).

Later on, they were more comfortable holding and breastfeeding. They followed the suggestions by the nurses and could find many positions to hold the babies such as side-lying position while breastfeeding at nighttime.

> I felt ticklish [when I first breastfed her]. I didn't get used to it. Later on, I got used to breastfeed. Right now, I'm good at holding and breastfeeding (P 3/I 3, line 231).

> It wasn't so long until I was good at holding a baby. It's not difficult. Actually, I could do it since I was in the hospital, but at that time I felt painful in my wound and couldn't sit comfortably so I lay on my side and breastfed. When the pain's gone, I sat and breastfed. If I felt tired, I used a pillow for support. But if it was at night, I used a side-lying position to breastfeed. I couldn't sit because I was sleepy. He kept on sucking until he was full and slept (P 2/I 3, line 228).

> I dared not carry it. It was so tiny, just 2 kg. She told me to stimulate the baby to suck milk. I saw it's tiny and that made my hands tremble at first. I decided to lie down and hug him. I didn't want to sit because I still felt painful in my wound. He could suck the nipple and I had breast milk for him (P 18/I 3, line 8)… At first, it took 10 minutes, but now almost an hour, so long that I sometimes feel numb on my legs. He keeps on sucking, hard to stop (line 47).

Distinguishing a baby

The participants could tell who the baby looked like. They compared the baby's parts to their and the boyfriend's body parts. For instance, the baby's face looked like its dad or the baby's fingers and toes look like those of its mother.

> But I was curious why she was so similar to me, flat nose, unlike her dad. If she had a prominent nose, she would be so beautiful [laughs]. In fact, we wanted a baby boy, but it's OK. She is cute. Her mouth looks like her father. So does her skin. Her body was thin and long, but now she is fat, round, and her fingers look short (P 13/I 3, line 17).

> When it is newborn, most babies' faces look alike. I could not tell until one month later, her face had changed. Some said she is like her dad, some said she's like her mom. But I can tell she has two dimples like mine. Her fingers and toes also look like mine. They're big. I want her to have a prominent nose but it's not [laughs]. I keep on squeezing her nose to make it prominent (P 11/I 3, line 29).

> When he first came out, he looked like neither dad nor mom. A few days later, his eyes looked like his dad. His nose and face were like mine. His skin is rather dark like ours. But when he grows more, his face will be more like his dad (P 12/I 3, line 49).

Expressing love

Another way that the participants connected with their baby was to express love by hugging, kissing, soothing, talking, teasing, cuddling, and carrying.

> When I breastfeed, I hug her, kiss her, talk to her, tease her. I am in a good mood with her all the time (P 11/I 3, line 228).

> I carry him, hug him, talk to him, soothe him when he cries. I kiss him and like to talk to him. It seems that he understands my talk. I heard that a baby will have a guardian spirit of a child talking to him, teasing him so he can play alone and talk loudly alone (P 18/I 3, line 77).

Infant Care

During early postpartum period all participants were fatigue and needed their families to take care of their babies. Meanwhile, they observed and practiced basic skills of caring the babies under the supervision of the significant others, especially their

mothers or elder persons. It took about a couple weeks that they felt stronger and more confident to take care and respond to the physical needs of their babies. Some skills were easy for them; whereas another skill, for example bathing were reported by many participants as a difficult skill that took time for them to become confident to do it by themselves. The basic skills were clothing and diapering, bathing, cord caring, caring about sleep, providing a safe environment and protecting from harm, and caring about voiding and stooling.

Clothing and diapering

During the early postpartum period, the participants reported that their boyfriends helped washing cloth diapers. When they felt stronger, they could do it by themselves and still had their boyfriends help them. This included learning and practicing diapering.

> In fact, the CD teaches many things. I followed the procedure, but I didn't follow something like how to fold cloth diaper. I do it my way. It's easier and faster. If I follow that way, it's too slow, how could I have time to eat anything? [laughs] (P 13/I 3, line 39).

> In the first week, my husband helped me wash the cloth diapers but he had to go to work early in the morning. When I felt stronger, I washed the clothes by myself (P 9/I 3, line 110).

Bathing

During the early postpartum period, many participants lacked self confidence to bathe the baby by themselves. They were afraid of dropping the baby, therefore, they had someone such as their mothers or grandmothers bathe the baby while they helped prepare stuff and observed closely. The participants were taught by the nurses to bathe the baby. It took around one month after birth before they could bathe the baby by themselves.

> At the first time, I was pretty afraid of bathing him because he was tiny, his weight was only 2.4 kg. So I had my mother-in-law bathe him. I dared not to do it by myself (P 1/I 3, line 60).

> In the first week, I didn't bathe him, I dared not to do it, I was afraid of him falling into the water. His grandma does it everyday, she still does it until now. I help her rub him with towel, put on his clothes, diaper him. I stayed with him during bathing. He hated cool water, if using cool water, he cried (P 2/I 3, 89).

> The nurse let me see how to bathe, gave me a CD to see at home. But I haven't watched the CD and I had never given a bath to the baby. Mom does everything for me. During my 2 days at the hospital, I was still so tired from giving birth. I cannot remember what she taught me. In fact, I wanted to practice doing many things at the hospital before leaving… Mom helped me, taught me how to do it for two months. Then I began to be able to do by myself. Without mom's help, I must certainly die (P 9/I 3, line 307).

> I took a whole month before I can do it well. After returning home, I had to do everything, try many things, learning from trial and error (P 12, line 94).

Cord care

Some participants knew how to take care of the cord by cleaning it softly, keeping the stump clean and dry, whereas some dared not to clean it for fear of hurting the baby. They learned how to take care the cord after it was smelly by watching the CD or seeking help from the nurses. They observed the days when the cord fell off.

> At first, I dared not to clean the cord for fear of hurting her. I just cleaned outside the area of the stump and had left the base of the cord so it's smelly. I didn't learn how to clean it from the CD given from the hospital. In fact, the CD teaches many things. I followed the procedure… When the cord was clean, it fell off in the 9th day and she is strong (P 13/I 3, line 39).

Caring about sleep

The participants or their family members such as the father cared about the sleep of the baby by providing a cradle for them. They put the baby into the cradle and swung it continuously. In addition, they learned that if the babies were fed enough milk, they went to sleep easily.

> My dad also worries about the baby. He made a cradle for her and told me to put her in the cradle, swing in it continuously. That will help her have a long sleep without being bothered by mosquitoes (P 9/I 3, line 130).

> When I put her in the cradle, she gets sleepy. Does she feel dizzy while swinging her? [laughs]. Sometimes she cries a lot. I'll put her into the cradle and swing. She'll sleep. When she is full, she goes to sleep easily (P 13, line 42).

Providing a safe environment and protecting from harm

The participants provided safe environment for the baby by cleaning the baby stuff such as cloth diapers, milk bottles, and provided a mosquito net in order to protect the baby from mosquitoes or other insects.

> When it was raining, I protected him from cool weather; I always kept him warm, I hugged him, held him, and closed the window so the drizzle would not touch his body, I tried to protect him from sickness (P 1/I 3, line 382).

> His [baby] clothes were dried in the sun and so were the diapers. I was careful about his mattress, never letting ants or insects close to the mattress. I was most afraid of mosquitoes, and other insects. I provided a mosquito net to cover him (P 2/I 3, line 328).

> I take care of her cleanliness. In winter, I applied cream to her skin. I don't want her to have damaged skin like other babies (P 13/I 3, line 49)… At present I have another additional chore, washing milk baby bottles. I have to use gas to boil water (line 55).

The participants had many ways to protect the baby from harm. For example, one participant was careful when she held the newborn baby by using her hands to support the baby's neck. She did not allow strangers to carry her baby and she responded to a non-stop crying baby by holding him, never letting him cry alone. She said:

> When I held him, I was being careful because his neck was weak, I held him softly and used my hands to support his neck. When a stranger asked to carry him, I didn't allow him and said my baby was sick, my mother-in-law reminded me not to be far away from the baby, keep an eye on him. If he cries, I'm hurry to see him, I never let him cry more than a minute. When I held him, he was quiet. I never let him cry for a long time, I was afraid that he couldn't catch his breath, I feel sorry for him (P 2/I 3, line 109).

Caring about voiding and stooling

The participants said that caring about voiding and stooling were not difficult for them. They also observed whether the baby got constipation or flatulence.

> Sometimes he spits up even I though burp him. He never gets bloated after feeding and he could poop easily (P 12/I 3, line 232).

> I have to provide a thousand baht a month for powdered milk, this brand is so expensive. I dare not to change to another brand because it's good for the baby's stomach. She never has constipation or flatulence (P 13/I 3, line 55).

> It's better than the first month. Now I can do everything, clean pee or poop, that's not difficult (P 18/I 3, line 116).

Learning Behavioral Cues and Responding to Baby's Needs

Many participants did not have experience with child care prior to having their own babies. However, the participants were able to notice the baby's behavioral cues and they responded to the babies' needs. For instance, one participant held, fed, changed clothes, swung the cradle, comforted, and bathed the baby in order to make the baby feel good. In addition they learned how to take care of the sick baby and promote child development.

> She needs carrying, feeding, her clothes changed, swinging a cradle for a long nap. She needs a bath when she's too sweaty. When she feels good, she doesn't bother anybody, doesn't cry (P 9/I 3, line 156).

> I have to talk to him otherwise he will cry. If I let him lie alone too long, he will cry. When he turned 2 months, he stopped taking a nap in the afternoon. I have to be awake and carry him. If I put him down, he will cry (P 18/I 3, line 50).

As the baby grew, new cues were observed. Some participants observed that their babies did not like cool water. The babies would cry loudly when they touched the water. The participants responded to the baby's needs by changing to warm water. The other behavioral cue was the baby's moodiness when the babies were sleepy or angry.

> I have to boil water for him. There was once, I didn't boil water for him. He cried so loud that four or five dogs ran to see what happened. The dogs barked along with his crying [laughs]. He hates cool water because he is used to the warm water. That day I was lazy. However, I never get lazy like that anymore because he hates it (P 12/I 3, line 91),

The participants learned about their babies, what the babies liked and disliked. This learning process was ongoing. The participants responded to what they had observed as time went by. One participant learned different tricks to make the baby stop crying. She understood him after observing him for sometime.

> I have learned as the time goes by. I observe what he likes or dislikes. I give him what he needs. I learned how to make him stop crying (P 12/I 3, line 103)… We look after the child all the time so we understand him more. We know what he likes, what happens to him. Sometimes when I put him down, he will cry and get angry. When he has an angry cry, it will take a long time to make him quiet (line 109).

After learning the baby's behavioral cues, many participants found many ways to respond to the baby's needs. For example, they did not let the baby get too hungry. They held the baby in the way that the baby liked. They used the cradle and swung it continuously so the babies could sleep longer.

> I think I should not let the baby be too hungry and cry like other babies. I saw another mother let her baby cry for an hour or two before feeding the baby. But for my baby she usually doesn't cry. When she finishes with the milk, I carry her to burp. Then she sleeps. She doesn't cry. Even when she wakes up, she doesn't cry. She just opens her eyes, looks around and plays alone. It's easy to raise her (P 11, line 114).

Comforting

The participants learned and practiced how to comfort their babies. They learned the ways to soothe the baby such as taking the baby for a walk, feeding, holding, rocking, and bathing.

> The baby likes to take a bath very much. She takes a bath four times a day. She easily gets too warm and cries. There was one day, even though she was fed

> enough, she still cried. I soothed her, took her to go to for a walk, she still cried. Mom told me to bathe her. As soon as her body touched the water, she stopped crying. She likes warm water, not cold water (P 9, line 116).

Caring for a sick baby

When asked about the baby's health, they reported that their babies had fever after getting a vaccination or because of a cold, and that some babies had diarrhea. They sought help from significant others such as their mothers and from health care providers. They kept an eye on the sick baby and followed the suggestions of the nurses.

> Only once she [the baby] got a fever because mom covered her with thick blanket so she would not get cold, but she began to have a fever. I pulled the blanket off, but mom covered her again. So she had a fever. That's the only time she got sick. The nurse took off all her clothes, rub her body with warm water until the fever was gone (P 11/I 3, line 149).

> When he got a vaccination, he cried so much and had a fever. He also caught a cold from me on that day. When I recovered from a cold, he still had it. So we took turns having a cold. When he had a cold, he couldn't breathe well, he cried and needed me to carry him all the time (P 12/I 3, line 148)… I rubbed his body when he had a fever. I didn't buy a fever medication for him because he is too young unless the doctor gives it. After he got his 2 month shots, a nurse told me to use a wet towel with warm water to pat on his body if he got a fever. It helped bring his fever down and I should try to keep him clean, especially the shot area, otherwise he would get an abscess (line 150).

Observing and promoting development

Many participants observed child development in terms of physical appearance, emotional and social development. For instance, the baby gained weight quickly, had an eye contact with them, cooed, looked around, smiled, turned the body, and recognized their voice. They stated:

> She likes to look at me. She can recognize my voice. When I let her stay in a stroller, she always looks at me. Her eyes follow me here and there. Whoever carries her, she will not sleep except with me. She will be quiet and sleep. Now she can suck a lot of milk (P 11/I 3, line 229)… Her neck is strong now, she can raise her head up from a prone position. She can recognize who is dad or mom.

> When she watches me, she will smile. She could suck much more milk and grow quickly. Now her weight is over 6 kg (line 235).

> I turned on the T.V. for him and he stared at it. I noticed that his eyes could follow the objects that were moving around him and he was so sensitive to the bright light of the TV pictures (P 12/I 3, line 139)… His ears are very sensitive to noises, his eyes like to follow a flash light, now he tries to turn his body from side to side. He almost makes it to a prone position. When others carry him and he hears my voice, he will make a noise and smile. He coos and his neck is strong now (line 142).

The participants were aware of the baby's development. They tried to promote the child's development by talking to the baby, raising the baby with a good mood, hugging, and playing with the baby. In addition, they hung a balloon on the cradle or bought a CD or toys for their babies.

> I bought her gifts such as CD with ABC songs. I turn on the CD for her to listen. One day she'll be smart (P 13/I 3, line 26)… I want to buy toys for her, to stimulate her development (line 115).

> Mom told me to talk to the baby frequently. This helps her have a good mood (P 9/I 3, line 159).

One participant learned how to promote child development by watching television.

> If I can't sleep, I will watch TV. I watch a TV program "Love your children," it teaches that a mother should read books to her child. This will encourage the child to like reading. The child will be smart (P 18, line 80).

<u>Punishing the baby</u>

Many new mothers got frustrated when their babies cried non-stop. The old Thai ways of disciplining a crying bay is to slap the baby. However, this is discouraged as awareness child abuse issues have grown (Yothinchuchawan, 2008). Therefore, the new generation does not hit the baby as much as the old generation. Most participants tried to

be patient with the baby's crying. They tried to stop the babies' crying by using several ways such as soothing, rocking, and holding, etc. Most never punished the babies.

> I never punish him. If he cries a lot, I would talk to him like "*please don't cry"* I sooth him. I don't dare to beat him. I am afraid that he will get hurt (P 2, I 3, line 221).

> I get angry easily, but for the baby, I will count 1-10. I try to calm down and tell myself that she is just a baby. She can't talk. I must accept her. My parents never beat me. So how can I beat my baby? I dare not to punish her. Even a dog loves its baby, who I am, I must love her more (P 11, line 209).

Only one participant reported that she had punished her baby once by pinching the buttock, yelling, and letting the baby cry alone without doing anything. However, she reported that she did only one time.[7]

Some of the mothers fed their babies solid food too early. Some started to feed their babies with pureed rice and banana within the first month or second month, usually told by their significant others to do this. Many did not agree with the elder's practices, however, they thought they needed to follow the advice because of their redemption from the earlier mistake. There were different challenges that the participants faced on their journey.

> My baby is now over two months, he can eat pureed rice twice a day. Grandma said *"Let him eat pureed rice and he will grow big"* (P 18/I 3, line 80)… I think the teen mom needs to learn more about how to take care of a baby, learn about

[7]The participant who punished her crying babies by pinching the baby's buttocks, yelling, or letting the baby cry alone stated she only did this once early in her adjustment to the infant The interaction with the infant was inappropriate. As a nurse, after interviewing this participant, the researcher had taught her strategies to appropriately take care of a non-stop baby and suggested services she could ask for help and advice in taking care of the baby.

> the solid foods, and how to prepare them. I only listen to grandma and follow her advice. I don't know about healthy food. I don't understand why my child can eat pureed rice when my friend's child can't. I want to know this kind of things (line 155).

In conclusion, the participants reported low self confidence to do some basic newborn care during the early postpartum period, for example breastfeeding, holding, bathing, caring for a sick baby, and promoting development. However, most participants reported they were learning the skills of taking care of the babies as they were doing them. They needed more advice, techniques, and knowledge about raising the babies in each age group appropriately. However, the services that would fill this gap were not available to these adolescent mothers.

Following a Traditional Belief (*Yu fire*), She *Must* Do It Despite Her Unwillingness

Traditional belief dictates practices in lifestyles of people in the community, especially in the rural area where people strictly follow the practices that are passed on from generation to generation. They are ingrained in their living and decision making. *"Yu fire"* is one of the traditional Thai beliefs that postpartum women must practice in order to promote their health (Thai Cultural Encyclopedia, 1996). *"Yu fire"* is a practice during the first month postpartum, in which the new mothers must be near heat. The heat *" fire"* is believed to promote uterine involution and the flowing of lochia.

In this study, the participants who did not have a cesarean section complied with the *"Yu fire"*. The methods of being near the heat (*Yu fire)* were varied. Some participants lay near the fire. Some placed a hot water bottle on their abdomen. Some would only take an herbal warm bath. The practices of *"Yu fire"* are different in each region of Thailand. However, the *"Yu fire"* is based on the principle that heat would help with recovery from the hard time during labor processes, to promote healing, and to be healthy in the future.

The significant others, especially elder persons in the family, prepared the equipment and herbs needed for the *"Yu fire"*. All family members had different duties during the processes. For example, a grandmother prepared the herbs to put into the water for bathing. The husband kept adding the charcoal into the stove. The participant's father provided firewood. The mother prepared some clothing for the new mother and the baby.

The practices of *Yu fire* literally meant lying near the fire. In addition to lying near the fire, the new mother was limited to eating certain food, ways of dressing, and other practices. In this study, the results showed that the duration of the *Yu fire* period varied from family to family and community to community. It was also different in each part of Thailand. Not only was it different in duration, the details of each practice were also different. For example, some families did not allow postpartum women to consume papaya because it might cause jaundice to a baby. Some families prepared banana flower soup to promote lactation. The new mother would drink herbal tea that was specially prepared in order to promote the flow of lochia. In this study, *Yu fire* was reported to start as soon as giving birth to a baby and the length of this practice varied from 7 to 30 days. Those who underwent an operation reported that they did not practice this because it was forbidden. The people in the community believe that the women who have a wound on their abdomens are forbidden to practice *Yu fire*, particularly lying near fire, because it causes postpartum hemorrhage and wound infection. Lesson learned about complications from *Yu fire* practices with women who underwent an operation in the past is continuously passed on to the present.

Except for two participants who underwent operations, all participants experienced *Yu fire* in various practices. Some participants adhered to the old tradition,

whereas some were flexible in the practices. The majority of the practices included using heat (lie near fire, used hot packs, or *yu fireshood*), covering the whole body from neck to toes to keep their body warm, limiting place to stay after birth, drinking an herbal solution before or after meal, consuming specific food and avoiding the prohibited food, washing body and hair with herbals, and abstaining from sexual activity during this period. *Yu fireshood* referred to one of the practices during *Yu fire* period to keep the body warm to promote the involution of uterus and the flow of lochia. The processes include lighting 4 bars of herbal charcoal and putting them inside a box then wrapping it around postpartum women's belly twice or more a day; each time it lasted around an hour or until the heat was gone. Those who did not practice *Yu fire* believed that they might experience adverse effects in the long term like a mental disorder, easily getting sick, could not tolerate heat or cool weather.

During *Yu fire* period, the participants expressed feeling stressed because of the limitation of the activities. They were encouraged to adhere to the *Yu fire* practice despite their unwillingness. Moreover, they felt like they had to obey their parents or guardians' teachings because they wanted to seek redemption from their early mistake of being pregnant as well as to be forgiven by the parents or guardians. In addition, they viewed the practices as being beneficial for their health. The practices helped them to recognize what their mothers had gone through for them. They appreciated that their mothers had to sacrifice for their children by being patient and tolerating the limitation and difficulties during the *Yu fire* period. As a result, they followed the tradition with the help and care from their families.

Detailed Activities During *Yu fire* Period

Detailed activities during the processes included care takers during *Yu fire* period, specific and prohibited food consumption, limitation of place and lying near the fire or *Yu fireshood*, dressing styles, drinking an herbal solution, taking an herbal bath and washing hair.

Care takers during *Yu fire* period. The most common care takers during *Yu fire* period were the participants' mother. For those who did not have mothers, elder persons such as grandparents, helped with the processes.

> My mom took care of my meals. I ate fish, kind of not spicy food. I had to stay only in my room. She closed all windows and a door, and didn't allow the wind to get into the room. At first grandpa would light a charcoal for me, but I asked him not to. I felt too warm. Grandpa checked on the baby very frequently. He told me to have an herbal bath. He prepared it for me. Its color was red. He boiled it for me (P 9/I 3, line 89).

> Mom was with me all the time, helped bathe the baby, prepared food for us, washed clothes, prepared boiled water for me to drink and was insistent about being "*Yu fire*". She helped with everything for a whole month (P 11/I 3, line 77).

Food during *Yu fire* period. During the *Yu fire* period, the participants were provided specific food by their significant others, especially their mothers or elder persons in the family. Simultaneously, they had to avoid prohibited food. The concept behind the food that they could eat is from the traditional belief that certain food is better in healing the body and better for lactation. Prohibited food, such as spicy food, was believed to be harmful to the new mother and the baby. The care takers would prepare food for the participants that helped with the recovery from giving birth and for healthy body in the future. Frequent food provided to promote lactation was banana flower soup, whereas spicy food and sticky rice were prohibited.

> At first, I had no breast milk. My boyfriend's mom boiled salted water for me to drink instead of water. After that I had so much milk that it shot out until my clothes and bra were soaked with breast milk (P 12/I 3, line 67)… After birth, I couldn't eat regular food like other people and couldn't eat with them. I ate separately. I could eat only pork, vegetable soup, and rice. I wanted to eat many things like them. My boyfriend fries fish and pork for me every day. I said to him *"I eat so much that my face is going to be like a pig and a fish"* [laughs]. So he cooked vegetable soup for me, but not spicy. It's prohibited. I also had to eat banana flower soup that increased my breast milk. So after birth, almost every kind of the food I used to eat was not allowed. Now I can eat more, but not everything at once. I have to add back one at a time and observe the baby's condition. If he is OK and nothing's wrong. It means I can eat that kind of food (line 85).

Limitation of place and lying near the fire or *Yu fireshood.* The participants and their babies had to stay near the fire. The participants might put a hot water pack on the abdomen or *Yu fireshood*, and stayed only in the room. They were not allowed to go outside or to have sexual intercourse with their boyfriends during this period.

> I and the baby had to be in a warm place. In the first month I had to stay only in my room. I could not step outside to touch the ground. My mom prepared a hot water bag for me all the time. I placed it on my belly. When it became cold, she would change it for me (P 9/I 3, line 89).

> She [mother] lit charcoal on a stove outside until the charcoal was red. She got it back inside my room. She kept on adding charcoal to make the room warm all the time for the whole month. I couldn't do anything except breastfeed, take care of the baby, change the diaper clothes. I could not go out of the room. Every visitor had to get into the room. Besides, I had to use the hot packs too. These helped the lochia to come out well. But what bothered me was that I couldn't sleep near my boyfriend for over a whole month. The baby slept between us. I slept near the charcoal burner (P 11/I 3, line 80).

> She [grandmother] gave me an herbal charcoal set and a cloth belt. She showed me how to *"yu fireshood"* by lighting 4 bars of the herbal charcoal and put them inside a box. Then she wrapped it around my belly twice a day. Each time, it lasted around an hour. Then I did this by myself for 5 days. She said it helped the uterus to reduce to its size quickly (P 18/I 3, line 83).

Dressing styles during *Yu fire* period. The participants had to dress by covering their whole body from neck to toe in order to keep their body warm. They were covered

up from the wind. The belief was that if they were exposed to the wind, they might get sick. Wrapping up their body was to keep the body warm and to prevent them from getting sick.

> I had to wear a long sleeved coat, hand gloves, socks, long sack. I felt so warm (P 9/I 3, line 89).
>
> Mom had me wear socks, hand gloves, and a hat. I covered my whole body, never let it touch sunshine or wind. I was sweating the whole day (P 11/I 3, line 80).

Drinking herbal medicine. The participants were provided with an herbal medication to promote uterine involution. They had to drink it before or after meals despite disliking the smell and the taste.

> Mom gave me some liquid medication to help my uterus dry up faster. I had to drink it 3 times a day after meals. I have finished six bottles already. I hate it. It smells so bad (P 9/I 3, line 89).
>
> I took medicine that helped promote the flow of lochia. The herbal drug was prepared by blending it with water. I drank it instead of water for 9-10 days. It helped my lochia flow. This drug was made by a quack who collected many herbs, mixed them together, dried, and pounded them. Its taste wasn't good and smelt bad (P 12/I 3 line 79).

Taking a bath and washing hair during *Yu fire* period. The participants had to bathe with warm water. They were not allowed to scrub their bodies with soap or wash their hair. They were allowed to wash their hair after the *Yu fire* period.

> When I took a bath, I had to use warm water, no soap was allowed to be applied to my body. The first time I washed my head was after completing the *Yu fire* period, I had to use a kaffir lime then squeeze it so that the liquid flowed down on my head and washed my hair. Mom did it all for me (P 11/I 3, line 80).
>
> I didn't do anything during a hospital stay of 10 days. I couldn't have my hair washed, couldn't scrub my skin, didn't apply soap because it might affect my tendons in the long run. I took a bath only once a day in the evening (P 12/I 3, line 73).

Opinions About *Yu fire*

The participants expressed their feelings about the *Yu fire* practices after they had accomplished the *Yu fire* process. The opinions about *Yu fire* were both positive and negative. The participants responded to the questions such as "How did you feel about *Yu fire*? or "How did you feel about the limitation of activities or food?."

Many participants felt lonely, frustrated, or bad because of the limitation to stay only in the room and to eat only certain food. They felt good when their friends were allowed to visit them in the room. However, they accepted the processes and followed the practices because they thought it was beneficial for their health.

> So lonely! At first I felt bad. But later on, I decided to accept it because that's what other new mothers do in the village. Mom said if I didn't follow the practice, it would not be good for me. I might be weak, and get sick easier. I was glad that my friends came to visit me in my room. Mom allowed them to talk to me in the room (P 9/I 3, line 103)… I would like to eat like others but mom told me to be patient. That's OK. I could eat everything she cooked. It's useful for me. And I didn't eat what was prohibited in order to be healthy (line 146).

One participant felt frustrated that she could not sleep near her boyfriend. She cried a lot, but could not complain. She felt like she had a terrible infectious disease comparing it with having AIDS while she was practicing *Yu fire*. In addition, she was afraid that the baby would inhale too much smoke from the charcoal burner. This particular participant's mother strictly followed the tradition, therefore, the participant had to follow the practices.

> In fact, when I was sweating in that room, I was afraid that my baby would inhale too much smoke from the charcoal and I wanted my baby to be out of that room. But my mom said the newborn should be kept warm so that she would not be sick. My mom did take the baby out to take care of her but returned to the room when it was time to breast feed. I felt I was left alone in the room like an AIDS patient (P 11/I 3, line 102)… I really felt so frustrated. I cried a lot. I could not complain. She [mother] said it's good for my health. In fact, I think we [participant and boy friend] could sleep together without having sex. But mom

> believed in the tradition and didn't allow us. She said that my body smelt like lochia discharge. But I and my boyfriend didn't smell anything. I also felt funny of my ankle-length skirt for the first time and through a whole month. I had lost weight. Now I am 47 kg. I lost weights so fast, 13 kg during a month of being near the charcoal burner. After that I gained 1 kg., up to 48 kg (line 193).

Another participant expressed that she felt lucky because she had to do the *Yu fire* only for 5 days. Her grandma could not afford the herbal charcoal set. She felt hardship during the practice because of the discomfort from the heat. In addition, she felt restricted and uncomfortable. However, she had to do it because she wanted to be healthy.

> If possible, I wanted to quit it since the first day. That's terribly hot (P 18/I 3, line 83)… I felt restricted and uncomfortable. But if I disobeyed, I would have surely been scolded. Every mom does this in order to be healthy. I had to do it (line 86).

Strategies Used to Reduce Stresses During *Yu fire*

The *Yu fire* practices were very difficult for the participants. They tried to adhere to the practices, despite, feeling frustrated, tortured, and restricted. The ways that helped them cope during this time were crying and distraction. The activities that they did to distract themselves during the *Yu fire* included watching TV, listening to music, and chatting. In addition, they tried to focus on positive thinking about the benefits of *Yu fire* for their health. This category is named "Faith of positive consequences of *Yu fire.*" Their faith helped to relieve their stress during the *Yu fire*. Example quotations follow:

> [During *Yu fire* period] I was glad that my friends came to visit me in my room. My mom allowed them to talk to me in the room. They said the baby looks like my husband more than me. If no one visited me, I would watch TV., listen to music. My mom was always with me (P 9/I 3, line 105).

> Sometimes when I cried, I felt better. Or I called my boyfriend. He encouraged me. Sometimes I watched TV or talked with friends. I felt so bad when I had to be alone. Anyway I didn't want to disobey the elder adults or do things against their belief. Otherwise, they would complain more and might talk badly behind my back to others that I did wrong things that were against the custom. So I must be patient for the good of myself and my parents (P 11/I 3, line 105).

Most participants were not enthusiastic about the *Yu fire* practices, and they followed the tradition with ambivalence. They tried to obey their elders for their redemption. They wanted to do it for their health. As a result, they all finished the *Yu fire* period with the support from their significant others. One participant got burned from the *Yu fireshood,* as she stated:

> Then I did this [*Yu fireshood*] by myself for 5 days. She [grandma] said it helped the uterus to reduce to its size quickly (help promote an involution of the uterus). But you know it burnt my belly (showed her right side belly which had a burnt area with a diameter around 4 cm.). A friend of mine was burnt like me too. While I did this, I had to be careful. I carry the baby while nursing. It might burn his skin (P 18, line 83).

Realizing the Meaning of the Word "Mother"

The feelings of being a mother-to-be, enacting maternal roles, and the experience of *Yu fire* of the adolescent mothers made them realize the meaning of "mother." The path from being pregnant to a new mother was an emotional journey. They learned the difficulties that a woman goes through before become a mother. They learned the unconditional love, devotion, and good intentions that a mother has for the baby. As a result, they reported that they were more understanding of their mothers after having a baby. They also reported that they loved and appreciated their mothers more. Some participants who had never shown their affection ended up telling their mothers that they loved them. They showed their love and appreciation by hugging, kissing, saying words like *"I love you mom"*, or *Grab tao. Grab tao* is a way Thai people pay respect to another person. *Grab* means to pay respect. *Tao* means feet. When the person pays respect to another person by their feet, it shows great respect. The more they loved their babies, the better they understood their mothers and the more they understood the word "mother." Now when they put themselves in their mothers' shoes, they knew their

mothers loved them and how their mothers confronted a difficult time during labor processes.

> I understand being a mom, a mother wants to protect her children. She doesn't want anybody to criticize them. I have my own baby, I realize the mother's feelings (P 1/I 3, line 318).

When asking the participants "What is the meaning of the word "mother" when are you a real mother?" The participants said:

> Oh! It's such a great thing. It's everything. Mother is everything. Mother has to raise her baby, keep eyes on the baby all times. I thought of my mom when I gave birth. When I raise my baby. Some people said that when you experience labor pains, you would think of your mom. It's true. Particularly, I am raising my baby by myself. When mom visited me at the hospital, I cried, I *Grab tao* her. I realized how it was, how painful to it was to give birth. She was very glad that I thought about her. I understood the mothers' feelings for the baby. I really understand this word (P 4/I 3, line 168).

Another example of the meaning of being a mother to the adolescent mom is as follows:

> The more I raise my baby, the more I realize how difficult a time my mom must have had with me. I understand her very much. When I did something wrong, I disappointed her so much. While I was giving birth, I also thought that my mom must have felt like me. My mom also had gone through the *Yu fire* period, how difficult, how warm, how worried, how lonely, she also went through it. This made me love her very much. I can't live without her. She always worries about me and extends her love to my baby. Now I dare to say to mom that I love her so much. In the past I could not say this. When mom heard me say that, she looked surprised. She couldn't say a word. She looked like she was going to cry. I told her that I love her. Now I realize the bad things I did and disappointed her. On that day, I watched a TV program *"Women to women"* They encouraged every child to say *"I love mom"* to his or her mother. So I did. I said many words to her and asked her to forgive me for everything I did wrong. Mom said with a trembling voice that she also loves me, but she could not say anymore words. Just said, *"That's all right"*. I knew she was so touched (P 11/I 3, line 186).

In summary, the word "mother" became meaningful to the participants. It meant unconditional love. The participants realized the devotion that their mothers did for them

and what they had gone through for their babies. The participants appreciated their mothers and expressed their appreciation more.

Creating the Web of Family Connection: the Consequence of Having a New Baby

Because the pregnancies were unintended, the participants and their families had gone through many difficulties and tension. What happened after the baby was born was a different story. The babies, despite being unintended, were welcomed. The baby's arrival in some respectful alleviated some of the tension in the family. The baby helped ameliorate the feelings of disappointment and stress. Many participants mentioned that the baby had created the web of family connection *(Sai yai rak nai krob kua).* The relationship that the participants built with different people became stronger. The baby helped maintain the participants' status and relationships with others in their community.

After the baby was born, many of the family members became closer as they watched the baby grow. Family members talked about the baby's development, concerns about their well being, loved them, and took care of them. As the baby was growing, their relationships were growing stronger. The web of family connection became stronger as well. As the participants said:

> Since the baby was born, the home atmosphere has been more colorful. Everybody talks about the baby together. This new family member is very cute. She brings people happiness and joy. I feel like I talk more with my boyfriend's family. I got used to this place, I don't feel uncomfortable now. I'm happier (P 3/I 3, line 147)

> I say it's much better. Several people come to play with my baby. When dad and mom are moody from other things, they change when they're with her. They smile and play with her. My baby makes everybody at home come closer, especially, my mom and I. She [mom] takes very good care of us, so does my dad. My younger brother, too. He goes to work with my husband. He stopped playing around. He earns money everyday, comes home to play with his niece, talks to her (P 9/I 3, line 230)… The baby makes everybody in the family come closer together (line 279).

Not only did the baby bring joy and happiness to the family, the baby also brings the love and connection between the adolescent mothers and the grandparents of the baby. The neighbors and the community became more forgiving. Because of the baby, the participants felt more accepted by the people surrounding them.

> My dad loves his granddaughter so much. He's so kind. Usually my dad does not hold the baby. But he did it for the first few days. He kissed her, and held her. The whole house was so happy. My mom was never far away. She watched closely. She helped me do everything. I felt bad when I saw she got tired. She walks all the time. While my boyfriend goes to school and my dad goes to work, my mom has to do everything for me and the baby. She is pretty old and tired (P 11/I 3, line 112)… I think the baby creates a connection between my boyfriend and I (line 290).

Some participants did not get along with other family members, but having the baby helped the situation. The baby almost became like a mediator between the adolescent mothers and others.

> His [boyfriend's] mom is nice to me now. She talks with me more. It's about the baby. During pregnancy, we hardly talked although we stayed in the same house. I think the baby helped me get closer to his mom. Particularly, his dad is really good to me and the baby. He's crazy about the baby. I could say that my baby helped connect relationship among family members. We talked about him a lot each day. My husband's brother likes to play with him. If I take the baby to visit my mom at Lab lae, they [boyfriend's family] call me to come back home quickly because they miss the baby. My boyfriend tries to please me so much since the baby's born. He doesn't dare to do bad things because he is afraid that I and the baby might run away from him. He loves the baby so much and can't stay without us, so does his family (P 16, I 3, line 240).

In sum, the babies in this study were reported to bring strong connections within the family, like a web (*Sai yai*). Having gone through the *Yu Fire* and adjustment to being a new mother, the participants felt the joy of having the baby. They saw that the babies helped solve some of the conflicts and repaired the damages of the unintended pregnancy. The baby played an important role to create the web of family connection.

Setting Goals and Having Hope for the New Baby

All participants and their babies continued to depend on their parents or guardians. They needed help with money, accommodation, food, and support. They set their future plans and had hopes for the new baby. Some wanted to help themselves and not to depend on their parents or guardians. Because the participants were adolescents, they thought of their future as well as the baby's. They thought of going to school or going to work. They thought about childcare and how the baby would have good opportunities in the future.

The participants had to plan for the baby care. Some stated that they would keep raising the babies until the babies stopped breastfeeding. After that, they planned to look for a job. Some returned to study at the Non Formal Educational Center (NFEC) because the school offered a flexible curriculum for anybody. The schedule at NFEC is flexible in the courses and the times. Figure 4.11 illustrates adolescent mothers' goals after birth.

One participant decided not to continue their studies and planned to work when their babies grew up.

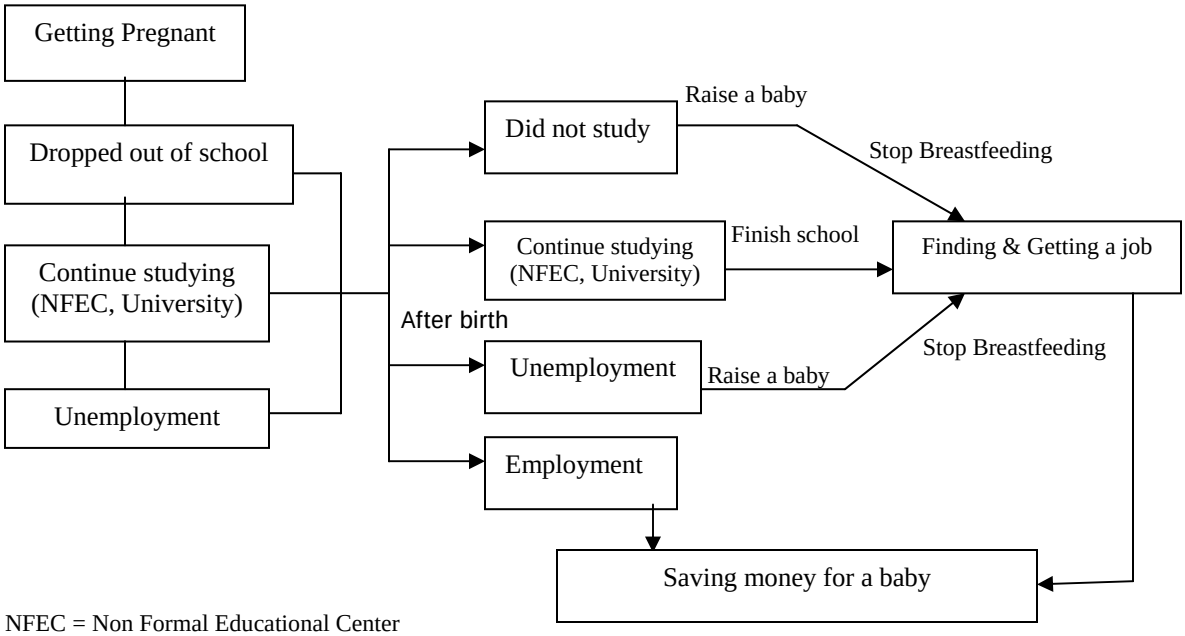
> I think when she [the baby] grows up, I will work in Bangkok at a factory. Friends of mine have worked there. They make good money and send money back home (P 9/I 3, line 205)… Nowadays, my husband has a stable job and regular income. Before he runs out of work, our child should grow up a lot. Then I will look for a job. I am too lazy to go to school. I will not return to school. I want to work around here or work in Bangkok at a factory (line 333).

Another participant decided to go to school. She planed to take the baby to a day care center during the daytime. She did not want to depend on her parents any longer. She and her boyfriend wanted to work and earned their own money. She stated:

> I think my boyfriend will complete his study. He has a job. My child will be 3 years old. I will take her to a child care center in the daytime. In the evening, her grandma will take her home. I want to work and earn my own money. I don't

> want to depend on my parents any longer. I don't want to put a burden on them. Even though my parents give money to us, we are not proud of ourselves. When I finish high school, I will study at Rajabhut University. My boyfriend will work not far away. We agree to live together, not to be separated because it's not good. It isn't a family (P 11/I 3, line 306).

Figure 4.11: Adolescent mothers' goals after birth



NFEC = Non Formal Educational Center

One participant decided to put her education on hold until her baby goes to school.

> So I decided to raise him until he can stop breastfeeding. It should be about a year then I'll leave him with my sister or my aunt (P 12/I 3, line 220)… I used to think of going to school. But now I will keep on raising the baby first until he goes to school. My boyfriend told me not to work now, just keep on taking care of the child. He can take care both of us. If the child goes to school, I will have time to continue a non formal education and finish grade 12. That's my plan (line 250).

Besides setting goals in their lives, these young mothers also had hope for their babies. They hoped to see their babies growing up to be good people, be healthy, have high education, and have a good job. In addition, they hoped that their babies only find good things in their lives. Example quotations are as follows:

> I want my baby to be a good kid, smart, and have a good job (P 1/I 3, line 95)… I want the baby to be good and smart. That way he or she will have a nice job, high salary and will never get into trouble (line 134).
>
> My boyfriend would like to have another child. It's OK, but I told him to wait until this child studies in grade 5 or 6 first. I want to see him grow up, become a good boy, help his parents work. That's what I think (P 18/I 3, line 158).

No matter how they set goals or had hope for the new baby, the participants still needed help from other people. For example, they needed other people to help either while they went to school or to work. They needed help with tuition, household expenses, and accommodation. Without any help from others, they could not reach their goals. The Thai government has some programs that would help them to find a job. There are some private organizations that need labor and will train people on the job. However, these job training programs are not very accessible to these young people. They lacked information on how to access these programs. As one participant stated:

> I have been thinking about it [future], I have to raise the baby until he grows up and then find a job. But I don't know where I can find it. I've never worked before. I have no ideas. I think about that again. I quit school when I got pregnant. I don't want to go to school again because I have to raise the baby. I've talked with my boyfriend that I'll ask mom to raise the baby. Then I'm going to find a job. I will wait until he stops breastfeeding and I'll go to work (P 14/I 3, line 240).

In summary, although the participants were young when they became mothers, they could set goals and have hope for their babies.

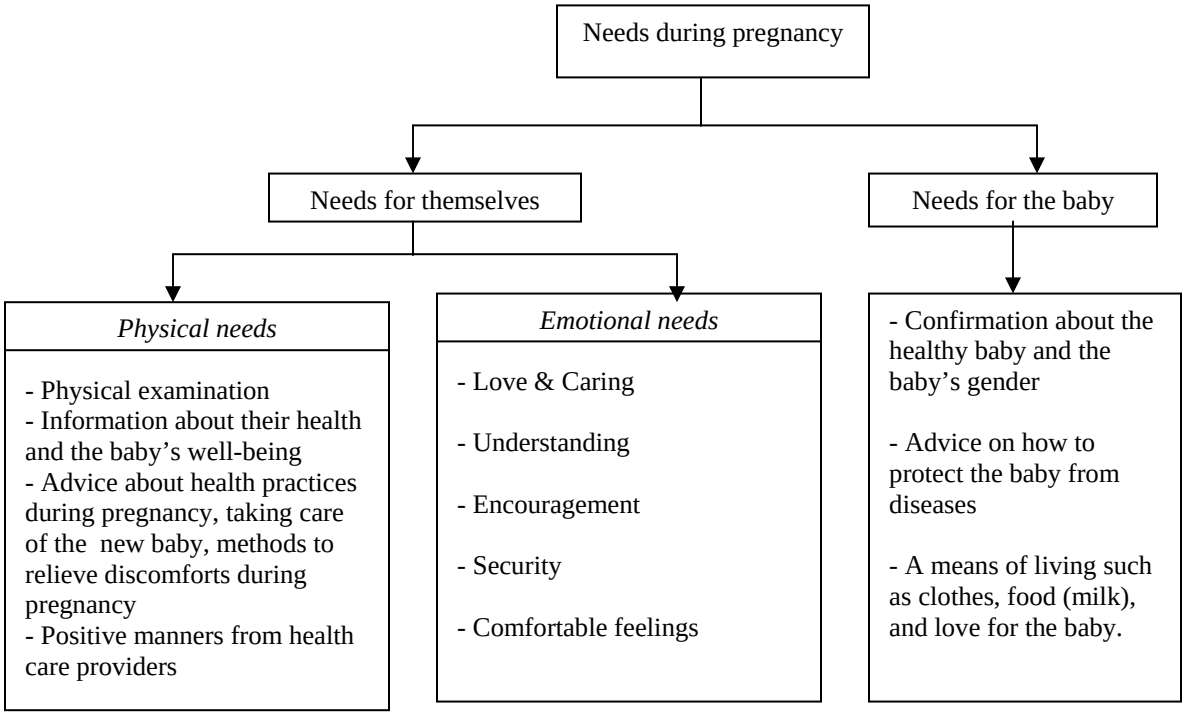
Part 8: Adolescents' Needs from Pregnancy to the Postpartum Period

This part focuses on the participants' needs during pregnancy and the postpartum period. It is important in understanding the needs of the pregnant adolescents and what they needed during pregnancy and the postpartum period because the needs were different at the different times. In addition, each participant had different needs depending on their circumstances.

Needs During Pregnancy

Pregnant adolescents reported their needs during pregnancy, including needs for themselves and needs for the baby. Needs for themselves could be divided into physical and emotional needs. Figure 4.12 portrays needs during pregnancy and each need is discussed as follows:

Figure 4.12: Needs during pregnancy



Needs for Themselves

Physical needs. Their physical needs were related to maintaining a healthy pregnancy. They wanted to know how to take care of themselves. The needs included information about their health or a baby's well-being when attending prenatal visits, advice about health practices during pregnancy, knowledge about how to relieve discomforts during pregnancy, how to take care of the baby, good services from the health care providers, and health insurance for themselves.

> I want them to teach me more about healthy practices during pregnancy, like what are the proper positions of lying down that can reduce pain around my hip (P 2/I 1, line 141).
>
> I want them to take good care of me, to please me more, talk to me nicely. I want them to teach me fun stuff, not too serious. I want to know what healthy food to eat, and how to raise a baby (P 4/I 1, line 127).
>
> Mostly, doctors speak fast. I don't understand what they say. I want them to explain slowly, step by step (P 6/I 1, line 129).
>
> I would like them to give me some advice… how to take care of myself, what to eat, and how to use a birth control (P 7/I 1, line 161)… After giving birth, I would like everybody to help me take care of the baby (line 230).
>
> I want them to follow up frequently because I'm too young. There may be something wrong that happens to me. After they do an examination, I want them to tell me every time about how the baby is. I want them to tell me more details. I want to know whether the baby is healthy (P 8/I 1, line 158).

Emotional needs. Emotional needs were discussed by one participant who was a student and kept going with her education while being pregnant. She voiced that she needed understanding, forgiveness, encouragement from others. These would make her feel comfortable and happy as she said:

> I think my mistake [a pregnancy] was forgiven. I think I have people who understand me. A thing that a pregnant woman wants is encouragement. Money is not as important as understanding. No matter how much money people have, without caring for each other, it couldn't bring them happiness. Money is not everything for me. I feel comfortable and happy because of encouragement and understanding from people surrounding me. I realized that being pregnant while studying should not happen, but when I got pregnant and every person forgave me, it helped encourage me. I got a chance from everybody. I think if mom didn't forgive me, not love me anymore, not love my baby, how miserable it would have been (P 17/I 2, line 356).

Needs for the Baby

The participants worried about the baby. They wanted to make sure that the baby would have everything. The participants might be limited in providing for their babies because they did not work. The needs for baby included clothes, food (milk) for the baby,

and love. They also needed information how to protect their babies from diseases. In addition, some participants who had attempted an abortion were concerned about the baby's health. They expressed their concerns of congenital anomalies that could happen to their babies. They requested the doctors to do an ultrasound to check on the baby. Some wanted an ultrasound to see the baby's gender.

Example quotations are as follows:

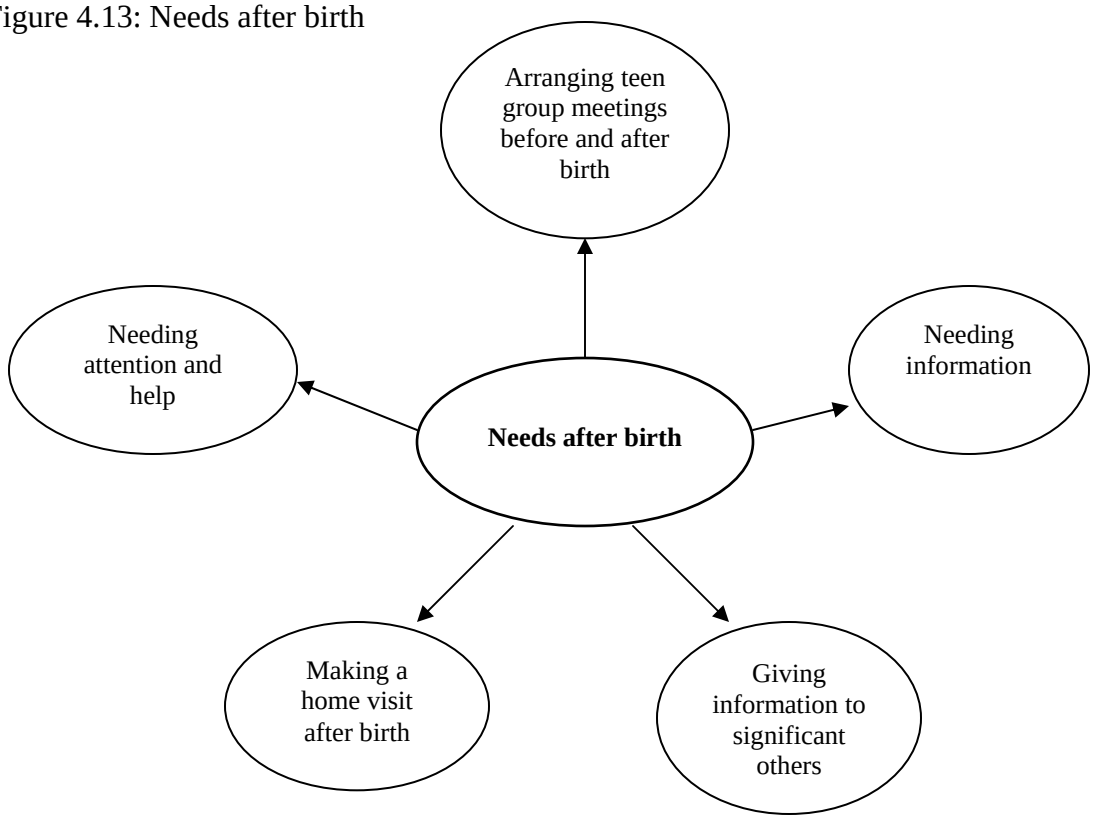
> I want to do an ultrasound of the baby. I want to know if it's normal or crippled (P 4/I 1, line 77)… If I have social security, I will feel more comfortable (line 95)… I want to know the baby's gender. I want a doctor to do a test (ultrasound) and tell me what gender of my baby is (line 124).

> I want them to tell me how to prevent infant jaundice. I'm afraid that my baby would have jaundice. My boyfriend's friend also had a baby. She was anemic like me. Both she and her husband are carriers of anemia like me. She had a premature birth. Her baby was in an incubator. I'm worried that my baby will be like that, so I want them to tell me how to protect my baby from jaundice (P 6/I 1, line 129).

Needs During Postpartum Period

Because of their age, maturity and readiness, there are substantial difference between adolescent mothers and adult mothers. The participants expressed that they wanted more attention and help from others, including parents and health care providers than adult mothers. Most had low self-confidence and felt lots of fear about taking care of their baby while staying in the hospital. They expressed their needs during the postpartum period which included more attention and help compared to adult mothers, teaching and demonstrating child care after delivering, demonstrating basic care for a new baby before delivering, giving information about how to promote child development, giving information to significant others, arranging adolescent group meeting before and after birth, and making a home visit after birth. Figure 4.13 summarizes needs after birth and each need is discussed below.

Figure 4.13: Needs after birth



Needing Attention and Help

The participants said that as an adolescent mother, they wanted more help and knowledge. They said:

> I think a young girl like me wants more help than the older women. The older women know how to raise a baby, but I know nothing. I want them [health care Providers] to teach me, to tell me. I have never raised a baby before. I'm afraid I may drop the baby. I was afraid of breastfeeding, carrying her. When the baby was sick, I didn't know what to do. I cried and cried. Without mom's help, I could do nothing (P 9/I 3, line 296).

> I think a teen mom wants to know how to raise a baby very much because we don't know how to promote a baby's development. Another thing, I would like to have them [nurses] teach teenagers about these kinds of things (P 11/I 3, line 322).

Needing Information

Most participants needed information before and after birth. The information included teaching and demonstrating basic care for a new baby before and after birth, and giving information about how to promote child development.

Teaching and demonstrating basic care for a new baby before and after birth

One participant thought that if she was taught how to take care of the baby while she was pregnant, it might help. As she said:

> I think teen mothers want to be taught about how to raise the baby, get training in bathing a baby, how to carry, how to change diapers, also how to breastfeed, how to cleanse the cord, etc. If I were trained before giving birth, that would have helped a lot. I don't have adults in my house, I stay with the baby. My aunt and sister come to visit me only when they're not working. I can learn from them (P 12/I 3, line 226).

Another participant was not brave enough to ask for help or information from the health care providers because she was afraid of being criticized by them. She wanted the nurses to teach and demonstrate child care after giving birth. She said:

> I want them to teach me how to hold a baby, how to breastfeed, to be near me, to make suggestions. I don't dare to ask them. I'm afraid of being blamed that I can't do anything. On the day after the delivery I was told to breastfeed, but I was afraid of carrying or dropping her (P 8/I 3, line 304).

This same participant told more stories about her lack of knowledge and fears about taking care of the baby. She reported her condition after birth made her not ready to learn new things. She stated:

> Day 2 at the hospital, I was still so tired by giving birth. I couldn't remember what she [a nurse] taught me. In fact, I wanted to practice doing many things at the hospital before leaving (line 309).

Some participants needed information about how to take care of a baby in regards to when to feed solid foods, thorough details about the baby such as blood group, size at birth, and appointment for vaccinations. They said:

> I want them to teach me how to raise a baby to be healthy because he is growing everyday. I want to know what healthy food I should provide for him. I want them to teach me how to provide the first meal for my baby, explain it to me, and show me so I can do it by myself when I'm alone (P 1/I 3, line 491).

> I want them to write more information about my baby like her blood group, her size at birth, the appointment date for vaccinations. I didn't know where I have to go; the clinic or the health center to get information (P 13/I 3, line 124).

> I only listen to grandma and follow her advice. I don't know about good food. I don't understand why my child can eat puree rice whereas my friend's child can't. I want to know these kinds of things (P 18/I 3, line 155).

Giving information about how to promote child development

One participant thought that adolescent mothers wanted more information about how to promote child development. She mentioned:

> I don't know how to do it [promote child development]. But what I do with her everyday is talking to her, raise her to have a good mood, hug her, tease her like this (P 11/I 3, line 241)… I think a teen mom wants to know how to raise a baby very much because we don't know how to promote a baby's development. Another thing, I would like to have them teach teenagers about these kinds of things (line 322).

Arranging Adolescent Group Meetings Before and After Birth

Many participants also voiced their needs from health care providers in terms of providing a group forum for adolescents who are pregnant or new mothers to support each other. They thought that they could share and learn things from people who were in the same situation or the same age. Subsequently, during a group meeting they would have a chance to share their experiences of pregnancy and motherhood with each other.

> Sometimes I want to meet teens who are pregnant or have a baby. I want to have friends the same age. I had no friends my same age. Everybody here is older than

> me. Sometimes they talk about some thing I could not understand. I could not follow their thoughts. If I had some friends the same age, I would have talked to them, asked them how they raised their babies. So it will be good to have friends (P 11/I 3, line 322).

The participants also voiced their needs after birth that they wanted to see other adolescent mothers and share their experiences of raising the baby, as they said:

> I want to know very much that if other teen moms' babies were like mine, how they raised their babies. I want to meet many moms who are the same age as mine so we can talk and share our experiences of raising the babies. And I can compare if we do the same or different things. I even compared my baby who is breastfed with my friend's baby who is formula fed. I found that mine has better development than the friend's. Anyway, I want to see more teen moms, to talk with them so we can exchange our ideas (P 17/I 3, line 529).

Making a Home Visit After Birth

Two participants wanted the health care providers to make a home visit after birth. They stated:

> I want them to call me or visit me and the baby at home. I want an expert to see if I do the right things for the baby, to check if the baby is healthy. Sometimes I have questions about raising him. I don't know whom I can talk to. If they were here, I could have asked them. When I was in the hospital I didn't dare to ask them because I wasn't familiar with them. If there is the same person who can come to see me and the baby, I would feel familiar with her. I can ask what I want to know (P 1/I 3, line 477).

> I want them [health care providers] to visit me and the baby after birth. Two or three months after birth is OK. I want them to tell me if I am doing the right things for my baby (P 17/ I 3, line 527).

Giving Information to Significant Others

Health care providers could be mediators in providing information between the adolescent mother and family members. Some mothers-in-law might have different ways to take care of the baby, the health care providers could help reduce the conflicts between the adolescent mother and the mother-in-law about raising the baby. As one participant described:

> I had my mother-in-law take care of the baby while I was studying during the day. I found that our ways and ideas of taking care of the baby are quite different. I follow what I read from new handbooks and magazines, but my mother-in-law still follows the old ways. For example, she wanted to feed the baby with pureed rice and banana when he was a month old. I disagreed. I told her that it's too early for the baby. His stomach isn't ready for solid food. He may have a stomachache. I also told her that doctors and nurses suggested only to feed the baby with breast milk. They suggested starting solid food when the baby is six months. My mother-in-law said she had raised my boyfriend and her kids this way. They're OK, healthy, like this. She didn't listen to me. I thought to myself that it's useless to try to explain to her all these reasons. She always think that I'm young, lack experience and don't know anything about taking care of the baby (P 17/ I 3, line 536).

In sum, needs during pregnancy and after birth varied depending on each participant's circumstances. Health care providers are one of the social networks who should take the role of a facilitator to provide services that meet their needs during pregnancy and foster them as new mothers.

Summary

This study has described the experiences of the adolescent mothers during their journey from an unintended pregnancy to mature motherhood. "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood" was identified as the basic social psychological process for adolescents who decided to carry an unintended pregnancy. The process was shaped within the contexts of family, life styles and values, traditions, religion, education, gender roles, and law. The life journey began with "surrender (*Yom jum non*) to an unintended pregnancy" and which reflected the causal conditions. It started in the chronological order of events during pregnancy. "Preparation to become a new mother" comprised the action/interaction strategies used to cope with changes during pregnancy. "Support from their close circle is like nourishment for their soul *(Yad nam tip chalom jai*) and which gets them through difficult time (*Tee*

peung yam yak)," were the intervening conditions that helped facilitate and balance the strategies used to cope with changes during pregnancy on the journey to motherhood. The journey ended with "Adolescent mom: I can do this mission." which described the consequences of the use of different strategies and the support from people surrounding them. Needs and sources of support during pregnancy and transition to motherhood were identified and informed health care providers in services that meet their needs. Consequently, these young people will have a healthy pregnancy as well as the ability to enact a maternal role effectively.

CHAPTER FIVE

DISCUSSION

In this final chapter, findings are discussed in relationship to research questions, selected theories, and previous research. Strengths, limitations, and implications are addressed in the subsequent section. This chapter finishes with a conclusion.

In this study, the findings have addressed the study questions of "What is the experience of being pregnant and becoming a mother for Thai adolescents?", "What are the positive and negative influences on pregnancy and becoming a mother for Thai adolescents?", and "How do Thai adolescents manage their experiences and challenges during pregnancy and childbearing year?" The Thai adolescents reported that they had experienced both good and bad events in their lives from being pregnant to being a new mother. A life journey of these young people, *Kwa ja ru diang sa*, was the basic social psychological process in the study which referred to a maturation process from innocent teen to motherhood. The term "*Kwa ja ru diang sa*" captured the suffering in these young peoples' lives from the sociocultural mistake of the unintended pregnancy. The maturity process (*Kwa ja ru diang sa)* to surmount their suffering because of the violation of the social norms and culture could stimulate understanding from others. The researcher hopes that these results can be used as an example of a life journey for any adolescent. The path on this life journey was not very smooth. This name, *Kwa ja ru diang sa,* could act as a representation of the young mothers' voices to remind society that they also had the potential to enact a role as a mother with the encouragement and understanding of the people surrounding them. *Kwa ja ru diang sa* started with surrender to an unintended pregnancy, preparation to become a new mother, support from their close circle is like

nourishment for their soul *(Yad nam tip chalom jai*) which gets them through a difficult time (*Tee peung yam yak*), and ended with the ultimate outcome adolescent mom: "I can do this mission." Other findings are discussed in relation to research questions as follows.

What is the Experience of Being Pregnant and Becoming a Mother for Thai Adolescents?

The findings have addressed that the experiences started when the participants discovered that they became pregnant unintentionally. They noticed from changes in their bodies first and then sought confirmation of the pregnancy by either using a home pregnancy test or going to the hospital or clinic. When they first found out that they were pregnant, most participants had negative feelings such as feelings of fear and unreadiness. They also expressed feelings of loneliness, worrying about their financial status, and were easily irritated. This finding is supported by the study of Stenberg and Blinn (1993) which found that the pregnant adolescents showed negative responses to their bodies and mind such as feelings of being fat, ugly, lonely, edgy, and moody.

The responses to pregnancy of these participants were similar to the early adolescent's responses to the tasks of each trimester identified by Wieland Ladewig, London, and Davidson (2006). They sequentially identified the responses from the first trimester to the third trimester. During the first trimester, the pregnant adolescents respond to the developmental task in different ways depending on each circumstance. The pregnancies of these young girls were mostly unplanned and responses to the pregnancy were negative. As a result, most of them ignored seeking confirmation of being pregnant. In addition, those who did not want to reveal the pregnancy refused to believe that they became pregnant despite, the noticeable changes they experienced.

Many were afraid that the revelation of pregnancy to their families or others might create distress for them. In the second trimester, many of the adolescents continued to conceal the pregnancy by wearing a tightened outfit or doing activities as usual.

Likewise, during the first and second trimester, the participants in this study responded to the pregnancy in three ways including concealment, secretly getting an abortion, and disclosure. They concealed the pregnancy by doing their routine activities as usual, wearing tightened clothing to camouflage themselves, and telling lies. Nearly half of them attempted an abortion. Some participants made the decision on their own, whereas other participants were compelled by significant others like parents, boyfriends, or relatives. Decisions to attempt abortion were due to feelings of fear, unreadiness, and disapproval from significant others. These findings are supported by the study of Andrews and Boyle (2003) which found that African American adolescents decided not to become mothers and sought an elective abortion because their partners denied to be a father of their babies. Another study conducted by Hess (2007) also found that lack of financial and partner support were the reasons why the women in rural, South Gabon, Africa selected an abortion as a solution method for their unplanned pregnancy. The participants in this study chose an unsafe abortions, for example jumping from a high place or having an illegal person to do an abortion by pressing and squeezing an abdomen. This finding is supported by Sedgh, Henshaw, Singh, Ahman, and Shah (2008) who reported that in 2003, 48% of the 42 million abortions were conducted illegally and unsafely. Most unsafe abortions were done in the developing countries in response to an unintended and undesired pregnancy. However, the participants finally disclosed the

pregnancy in the second trimester due to the appearance of noticeable changes in their bodies or failure of the abortion attempt.

The findings in this study of the third trimester of being pregnant had similarities and differences to the theory proposed by Wieland Ladewig, London, and Davidson (2006). They stated in the third trimester, pregnant women realize that a fetus is separate from themselves and they plan to welcome a new family member by providing baby things, places, a name, and other things. Additionally, they prepare themselves to give birth. During this period, they are anxious about the labor and birth processes and worry about their babies' health, therefore they seek knowledge and advice from many sources. Some pregnant adolescents wanted to finalize the pregnancy by counting the days until delivering the baby. Others never prepared themselves for the labor and birth processes. Consequently, they may have been stressed than other pregnant women about labor and birth. Some had nightmares or some did not prepare anything for the birth. Finally, a few thought that the baby was an enemy who brought about discomfort during pregnancy.

In the present study, during the third trimester, the participants' responses to the pregnancy were similar to the theory mentioned above in some aspects, for example, when the pregnancy was near the due date, the participants reported that they counted the days until delivery the baby and some had nightmares. They also worried about the birth process. On the other hand, the responses were different in the aspects of preparing themselves for the labor and birth process and preparing stuff for the baby. It was found that the participants in the study actively sought knowledge and assistance about the labor and birth processes as well as well prepared things for the coming baby when they came

to terms with the unintended pregnancy. In addition, they did not perceive that the baby as an enemy who brought discomfort to them.

When the participants revealed the pregnancy to others such as parents, boyfriends, relatives, and friends, these people initially responded to the pregnancy in two different ways; unavoidable acceptance or rejection. However, it was found that in the end, all participants had some acceptance from important people. It was found that the participants' families were upset about the pregnancy and played a crucial role in the decision about maintaining the pregnancy. The participants decided to stay pregnant or attempted an abortion based on their significant others' desires. These findings are similar to the study of Farber (1991) which found that families of all races and social classes were disappointed about their daughters' pregnancy and the pregnant adolescents could not have decision-making about pregnancy on their own, but depended on their families.

The participants who failed in their abortion attempt and decided to stay pregnant came to terms with an unintended pregnancy. They faced changes during pregnancy which brought about negative influence on their lives. However, gaining support from the important people surrounding them played an important role as a positive influence in their lives. These were thoroughly discussed in findings in relation to the research question "What are the positive and negative influences on pregnancy and becoming a mother for Thai adolescents?"

During motherhood, the participants' experiences of being a new mother were both similar and different from the seven steps for women to accomplish the maternal tasks of early postpartum identified by Mercer (1981). The first step is to 'reconcile the

actual childbirth experience with her prenatal fantasies of birth.' The participants in this study perceived the labor and birth processes either in a positive or negative way. Like most people, they tended to think that they could pass these processes rather easier. However, when they experienced more pain or complications during the processes that were not like their expectations, the negative feelings of the processes predominated. It was hard for them to reconcile the actual childbirth experience with their prenatal fantasies of birth in order to move on to other maternal tasks. The second step is to 'reconcile pre-birth fantasies of the baby with actual infant characteristics.' The participants compared the baby's characteristics with those they fantasized during pregnancy. If the baby's characteristics matched their desires, the participants took less time for this step and could move to other tasks.

The third step is to 'reconcile her body image after birth with her expectations.' Like other women, the participants wanted to recover from the physical discomfort after the labor and birth processes as soon as possible and become as normal as they used to be. The participants in this study experienced a recovery and healing time process quickly. This may be because of their youth as in other studies (May & Mahlmeister, 1994). Nevertheless, the participants were more concerned about their body image and wanted their appearances to be the same after giving birth as quickly as possible. They observed their weight closely and felt satisfied when it was reduced to what it was before pregnancy. Most participants viewed themselves after birth positively and none of them reported limiting food intake in order to reduce their weight. The fourth step is to 'observe the baby's normal bodily functions.' The participants began the attachment process with their babies in this step. Those who had personal experiences taking care of

children could do this step easily. They observed the babies' bodily functions through feeding, sucking, burping, crying or excreting. However, the participants who never had any experiences about nurturing a baby had a hard time, more stress and were more dependent on significant others, especially their mothers or elder women in the family.

The fifth step is to 'perform mothering tasks, like other new mothers.' The participants learned and practiced taking care of their babies. For example, they learned how to bathe, to breastfeed, to cleanse an umbilical stump, to change diapers, and to hold a baby to burp. However, many participants in this study had low self-confidence and feelings of fear about taking care of their babies, particularly, if it was their first time. They were more dependent on their mothers or elder women in the family. Some learned and practiced each mothering duty by trial and error and experienced that it was a difficult time in their lives. This finding is supported by the study of Sommer et al. (1993) which found that adolescent mothers experienced more stress in parenting roles when compared to adult mothers. Some were not allowed to take care of the baby alone because their mothers thought that they were too young and could not do it properly. However, like other mothers, they needed to be able to take care of the baby and to be accepted by others to accomplish this task.

The sixth step is to 'redefine partner roles.' Like other couples, the participants and their boyfriends developed their relationship as partners and parental roles to serve the needs of the new family members. They took their responsibilities as parents and adapted to changes because of the birth of the baby. Their new roles were composed of caring and nurturing the demands of a new baby who needed to be taken care of 24 hours a day. The fathers in the study tended to be responsible for financial support more than

taking care of the baby, and the participants faced radical changes after the baby was born. The participants reported some feelings of loneliness during this period. They also had some conflicts about how to enact a maternal role following the developmental task of early postpartum as well as to create independence following the developmental task of adolescence. For example, they needed advice from their mothers about taking care of the baby whereas they also want to establish their independence from them.

In the seventh step, to 'resume other responsibilities, after recovering from the delivery process,' the participants learned how to handle the role changes as a mother and as a wife. For example, they adjusted their activities to fit to the baby's needs and they took care of their boyfriends, respectively. All participants set their goals and had hope for their babies. In sum, the participants in this study had both good and bad experiences of being pregnant and becoming a mother. Their developmental tasks during pregnancy and motherhood were either similar to or different from the previous theory and others' studies as mentioned above. Each participant had different experiences depending on each circumstance. Positive and negative influences on pregnancy and becoming a mother played a crucial role on their experiences.

What are the Positive and Negative Influences on Pregnancy and Becoming a Mother for Thai Adolescents?

When the participants came to terms with the unintended pregnancy, they confronted both positive and negative experiences in their journey to becoming a mother. During pregnancy, if they received appropriate support from the people surrounding them, they accepted to the pregnancy quickly and could enact roles as a new mother. Support was the positive influence on pregnancy and becoming a mother. On the other

hand, when they came to terms with an unintended pregnancy, they faced changes that brought about a difficult time in their lives until after the birth. Adolescents struggled with life changes when they were pregnant and becoming a mother compared to adult women because they had fewer skills and life experiences to help them to cope with such challenges (Montgomery, 2003). As a result, it can be said that changes during pregnancy and after birth had both positive and negative influences on the participants.

Support from their close circle was like nourishment for their soul *(Yad nam tip chalom jai)* and helped get them through the difficult times *(Tee peung yam yak)*. These were intervening conditions of this study. It was the positive influence on pregnancy and becoming a mother for the participants. The participants felt they would not have survived without the support from the people surrounding them. The findings were consistent with findings from many studies in the literature which demonstrate that the concept of social support playes a crucial role in pregnant adolescents adjusting to motherhood (Logdon et al., 2006; Mercer, 2006; Perrin & McDermott, 1997; Roye & Balk, 1996; Secco & Moffatt, 1994; & Stiles, 2005). The experiences of pregnancy and motherhood of the participants were mainly influenced by their families. The most frequent supporters for the participants in this study from pregnancy to postpartum were their mothers and boyfriends. Other studies of pregnant adolescents also found that mothers and boyfriends were the most supportive persons during pregnancy and postpartum as well (Burke & Liston, 1994; Chen, Telleen, & Chen, 1995, Sriumporn, 2000; Oxley & Weekes, 1997).

Many participants who decided to reveal their pregnancy as soon as possible to their families and received good support from their parents or boyfriends attended the

prenatal clinic early. This finding is similar to the study of Lee and Grubbs (1995) which found that the pregnant adolescents who had adequate family support and did not fear disclosure of the pregnancy to the parents and came to prenatal visits earlier than those who delayed attending a prenatal care. The family in this study was of great importance as a source of all types of support, including emotional, physical, financial, material, and informational. The participants gained such support during pregnancy and through the postpartum period. Each family member provided support differently. For example participants' mothers provided extreme support in the aspects of emotional, physical, and informational support; whereas the boyfriend or the father more provided material and financial support. This is because a Thai family expects men and women to enact roles in different ways; the male roles are determined to work for financial support in the family, whereas the female roles include taking care of family members, looking after the home, and managing family expenses (Suriyasarn, 1993).

Friends were reported by the participants in this study as source of support in the aspects of emotional support more than other types of support. This is because the friends were still students and had limited knowledge about issues of pregnancy as well as lacking experiences of raising a baby. This is consistent with the study of Stevenson et al. (1999) which found that friends were less helpful about pregnancy and motherhood for adolescents because they had few experiences and lack of knowledge about needs of pregnancy and parenting. It was found that the neighbors had great influence on the participants' decision-making as well as providing support during pregnancy and during the postpartum period for the participants. Although the neighbors responded negatively to the pregnancy, they forgave the participants and provided support in terms of material,

emotional, and informational support. Some participants whose mothers passed away or did not live with their mothers sought knowledge and advice about pregnancy, labor and birth processes, and caring for the baby from the neighbors who had experience of these events. This finding is congruent with the study of Pungbangkadee (2007) which found that adolescent mothers who did not reside with their families obtained knowledge about maternal roles from elder neighbors who had child care experiences.

Health care providers, particularly nurses were still frequently reported as the support persons by the participants who provided services for them and the baby from pregnancy until the postpartum period. The nurses could provide support covering four dimensions of nursing care such as curing, prevention, promotion, and recovering. Their support actions included assessing, teaching, advising, counseling, demonstrating, and so on. Hupcey and Morse (1997) found that professional support persons provided professionally supportive actions such as teaching, role modeling, encouraging, and counseling. The participants mentioned less support in the aspects of emotional, material, and financial support from the health care providers during pregnancy and the postpartum period. This may be because the participants received those supports adequately from their mothers and boyfriends, therefore they did not request these supports from the health care providers. In addition, they reported that the nurses seemed very busy with their workload. Many pregnant women still waited for assessment, therefore, they did not want to bother the nurses although they wanted nurses to give some advice related to their concerns about pregnancy. Furthermore, some participants were not brave enough or not familiar with the health care providers to ask for these kinds of support. This may be because in Thai society, respect for the elderly and authority such as health care

providers is held as core values. As a result, communication is typically one way, from the elder or authority figure to the younger person, who is socially in a lower respect position (Suriyasarn, 1993). This value can be used to explain why the participants were not brave enough to ask for help from the health care providers whom they thought of as elder and in authority.

The participants reported positive behavioral changes to protect themselves and the baby from harm according to support received from the significant others. Many studies have shown that support impacted on positive health practices during pregnancy. Sriumporn (2000) found that social support was the first predictor that could explain pregnant adolescents' self care behavior ($P<.001$). Likewise, Puttapitukpol (2001) found that social support had a significantly direct positive effect on health responsibility in pregnant adolescents. Furthermore, the participants also stated that emotional support from people surrounding them helped reduce stress during pregnancy and after birth. The finding is consistent with the study of Nirattharadorn et al. (2005) which found that social support had a significantly negative direct influence on depression, both in the antepartum and postpartum period. There is empirical evidence that social support plays an important role to buffer the stress and to exert positive outcomes of pregnancy and motherhood.

After the participants came to terms with the unintended pregnancy, they faced changes during pregnancy. Changes during pregnancy were reported in four aspects. They included changes in physical (body) and psychological (mind) because of the pregnancy, changes in their roles, for example, from a student to a housewife, or from a daughter to a becoming mother, changes in residency because of moving out to stay with

their boyfriends' family or on their own, and changes in the interactions of people surrounding them after getting pregnancy. When they gave birth, they faced changes that included changes in their daily life after birth, sleep patterns, relationship with others, expenses, and body and mind.

All changes were negative influences on pregnancy and becoming a mother for the participants. Although the physiologic changes are normal to pregnant and postpartum women, they can impact negatively on pregnant adolescents and adolescent mothers (May & Mahlmeister, 1994). The participants experienced discomforts during pregnancy and postpartum period such as backache, fatigue, nausea, vomiting, and sleep disturbances. Changes in skin darkening, weight gain during pregnancy, or breast engorgement after birth had negative effects on the participants' self esteem. The participants also reported changes in mind during pregnancy and after birth, for example they got easily irritated because of the hormonal changes during pregnancy. They felt isolated from friends when they had to drop out of school after getting pregnant or they felt lonely, sad, or unhappy when they had to stay only in one room during the *Yu fire* period after birth. These role changes from a student to a pregnant adolescent or a housewife to an adolescent mother brought about role strain among these young people. It can be explained that the participants tried to make themselves good housewives or good mothers as expected by others, however, when they perceived that they could not enact their roles appropriately when they got pregnant or became a new mother, they experienced role strain, role stress, and role conflict, respectively (Klein & White, 2002). Such situations can lead to feelings of having difficulty to the participants.

The participants also reported negative responses from people surrounding them. These people said that they were too young to get pregnant or they were still a student and did not follow the tradition of the community by having an unmarried pregnancy. This was congruent with May and Mahlmeister (1994) who stated that the unmarried pregnant adolescents had a difficult time in transition to adulthood since they were isolated from friends and were rejected from society during pregnancy and after birth. After getting married, many participants moved to stay with their boyfriends' family. They felt it was difficult, uncomfortable, and they were unhappy in the new place. They had to adjust themselves to be accepted by other family members. In addition, some had to change their routine daily lives such as sleeping or eating patterns during the postpartum period. They reported negative feelings were included limited or prohibited food intake during the *Yu fire* period or they had not enough sleep due to the demands of taking care of their babies 24 hours a day. Furthermore, they had less time with their boyfriends after birth and had to spend a lot of money for their babies. They also reported worry, low self-confidence, and concerns during early parenting, especially when the baby got sick and also a lack of knowledge to promote child development. These were congruent with Causby, Nixon, and Bright (1991) who stated that adolescent mothers have less knowledge about children and their developmental processes.

Besides support and changes during pregnancy and the postpartum period, socio-cultural contexts, namely family, lifestyles and values, traditions, religion, education, gender roles, and the law played a vital role in positive and negative influences on pregnancy and becoming a new mother for Thai adolescents. Some socio-cultural contexts could lead to both negative and positive influences. For example, religion was a

negative influence when the participants feared sin to attempt an abortion despite their unwillingness to keep the baby. However, it was a positive influence when their beliefs in Buddhist principles helped them cope properly with changes during pregnancy and after birth. Another example of both negative and positive sides of socio-cultural contexts is about the law. Law was a negative influence when the participant wanted to get rid of the baby because it is illegal to attempt an abortion. However, law was a positive influence making their boyfriends take responsibility to be a father of the baby, otherwise they might be put in jail for a penalty. Negative responses from family members to the pregnancy influenced the participants, but support gained from them during pregnancy and after birth was positive. The traditions associated with being pregnant outside of wedlock were a negative influence to the participants in the opinions of the society. Yet the tradition of organizing a wedding party became a positive influence for many participants since it indicated that the people accepted them. Furthermore, the male dominant relationship was a negative influence on the participants because they had few chances to make a decision by themselves. Lifestyles and values were negative influences on the participants because they were pregnant or lived together with their boyfriends before marriage. Education was a positive influence on the participants both during pregnancy and after birth because the government provides a flexible curriculum to fit their needs and a time for them to continue studies. In sum, socio-cultural contexts could be positive or negative influences on pregnancy and becoming a new mother for Thai adolescent depending on each circumstance. Negative influences brought about challenges to the participants' lives. During pregnancy and motherhood, they responded

to the changes in several ways. Strategies used to cope with all changes are discussed as follows.

How do Thai Adolescents Manage Their Experiences and Challenges during Pregnancy and the First Childbearing Year?

No matter whether the participants appraised the pregnancy as difficult or normal, they were stressed during pregnancy and the first year of motherhood due to unexpected changes in their lives. May and Mahlmeister (1994) stated that the adolescent mothers confronted the conflict of two developmental tasks, one is a developmental task of adolescence and the other is a developmental task of motherhood. They have to accomplish two significant tasks at the same time that lead to a lot of stress in their lives. They try many ways to reduce the stress, such as using coping behaviors. Likewise, the participants in this study also prepared to become a mother by using many strategies to cope with changes during pregnancy until after birth, depending on their situations. During pregnancy, the participants used several strategies, including relying on Buddhist principles, *Gu naa*: having a traditional wedding ceremony, seeking assistance, seeking knowledge from various sources, seeking redemption from their early mistake, and building relationships with others. In addition, during the postpartum period, many strategies used to reduce stress included adjusting their activities and time to fit into the baby's needs, seeking entertainment, having others take care of the baby when getting moody, sharing the experience of raising a baby, maintaining relationships, seeking assistance and knowledge, and not expecting help to raise the baby from their boyfriends.

When the participants used the concept of *tum jai* (accept the truth) or *aria ja gerd mun gor tong gerd* (what ever will be, will be) as taught by the Buddha, they had

sati (mindfulness) to handle their problems. During their difficult time, the participants sought help from other persons. For example, they talked with their friends and the friends cheered them up so they felt better, or they consulted health care providers about the changes in their body. Their stress reduced when they received support from these people. These two strategies are similar to the coping strategies in the study of Frydenberg and Lewis (1991) which found that female high school students used more emotion-focused strategies for coping, such as wishful thinking or daydreaming and seeking social support. Seeking support in the study of Myors, Johnsons, and Langdon (2001) referred to "talked the problem over with family and friends" and "talked the problem over with someone who had been in a similar situation" (p. 28). They also found that emotion-focused or the optimistic coping style were most frequently used by pregnant adolescents and this strategy was the most effective coping style for these young people, followed by a confrontive coping style (problem-focused). Examples of the optimistic coping style were "tried to think positively", "tried to see the good side of the situation", "told myself not to worry because everything would work out fine" (p. 28). Other examples of a confrontive coping style were "tried to look at the problem objectively and see all sides" and "tried to handle things one step at a time" (p. 28).

During the *Yu fire* period, many participants suffered from limitation in activities, including food intake and dressing style; They coped positively by thinking about the advantages of *Yu fire* for their health (Faith of positive consequences of *Yu fire*). This helped relieve their tension. When the participants were asked what made them feel better during this period, their answers were crying and doing some activities to forget the stress such as watching TV, listening to songs, and chatting. These strategies are similar to the

answer of pregnant adolescents in the study by Myors, Johnsons, and Langdon (2001) which found that these young people cited the coping methods to reduce their stress included “sit in my room listening to music,” “go for a walk or do some gardening or hobby,” and “broke out in tears while saying ‘this can’t be happening to me” (p. 29).

Another strategy used to reduce stress was *Gu naa*: having a traditional wedding ceremony. By doing this, the participants felt more accepted by the community. It helped to maintain the family’s status. Since Thai society determines that people belong to a group; if they practice following the tradition and norm, they could remain in the community (Meesil, 2006). The participants in the study tried to seek knowledge from various sources about pregnancy and after birth, such as changes in skin during pregnancy, health practices during pregnancy and after birth, ways to reduce weight after birth, and so on. When they gained knowledge, they reported that it reduced their stress. Since adolescents have few experiences about being pregnant and motherhood, fear of the unknown led to stress. One way of stress reduction was seeking knowledge (Ladewig, London, & Davidson, 2006). In short, the participants in the study had a variety of strategies to cope with changes during pregnancy and becoming a mother. All strategies used varied depending on each participant’s circumstances.

New Findings of the Study

This study recruited adolescent girls in the rural area that had been overlooked by most previous studies related to adolescent pregnancy conducted in Thailand. Several new findings were found in this study: First, it was found that marriage was an important event for the participants in the rural area. The families followed the tradition by organizing a wedding ceremony for the participants in order to be accepted by the

community. This showed that in the rural area, the traditions are still implanted in the lifestyles of the people. The people strictly practice following the traditions from generation to generation. Whoever does not follow the tradition, for example getting pregnant before marrying, will have a difficult life or cannot remain in that community. Besides marriage, the participants also followed another traditional practice, *Yu fire*, after birth. This new finding was not mentioned in other previous studies conducted with adolescents in the urban area of Thailand. The practice was followed by most participants in order to be healthy and to recover from the labor and birth. Although many participants felt uncomfortable during the processes of *Yu fire*, they understood the reasons why they had to practice it and accepted as part of the tradition of becoming a mother.

Second, the beliefs in the Buddha's teachings were embedded in the practices of the participants in the rural area. When they confronted difficulties during pregnancy and motherhood, the participants brought the Buddha's teachings into their strategies to cope with changes. For example, they prayed before bedtime, made a merit, or went to a temple. They believed the practices helped them relieve their tension and led them to peaceful mind. This finding was different from the previous studies which found that most Thai adolescents rarely practiced or participated in religious activities (Rajabhat Chiang Mai Poll, 2007; & Suandusit Poll, 2003).

Third, the participants had more opportunities to continue their educational studies compared to their own counterparts in the past since the government enacted the policy that allows the pregnant adolescents to study in the formal school, as well as provided a more flexible curriculum in the Non Formal Educational Center for all people (Government gazette, 1999; & Thaipost, 2006). Consequently, this could provide an

educational chance for pregnant adolescents or adolescent mothers. Fourth, the word "mother" became meaningful to the participants. Most participants realized the devotion and the unconditional love that their mothers had for them and what they had gone through for their babies. They understood and loved their mothers more when they became a mother.

Fifth, nearly half of the pregnant adolescents in this study attempted an abortion due to unintended pregnancy. They decided to attempt abortion secretly or were compelled by others, despite that all of them were Buddhists who believed that killing life is sin. Many participants chose unsafe abortion methods such as taking a blood-expelling drug, jumping from a high place or having an illegal person to do an abortion by pressing and squeezing an abdomen. When they failed an abortion attempt, they continued the pregnancy with anxiety about the baby's health. They expressed worry that they damaged their babies and what would happen if the child developed problems later. Finally, the unintended pregnancy was initially responded to by people surrounding the participants with unavoidable acceptance and rejection. However, it was found that in the end, it was accepted. When time passed by, the people better understood them and forgave them for the mistake they had made. They received continuous support during pregnancy until motherhood from these people. Without this support, the participants delivered that they and their babies would not have survived.

Strengths of Study

Constructivist grounded theory used as a methodological approach in this study added strength to the study. Therefore, the participants and the researcher had interactions and built relationships with each other. The participants cooperated in the study and data

and analysis were partially created through this social process. The researcher used a reflexive process to provide a way to critically examine her personal interface with the participants and data. Hence, a solid and useful theory was generated from the study.

In addition, the rigor of the study was enhanced by following the participants during pregnancy until early motherhood. Consequently, the researcher collected data with the same participants at different points in time and could see the ongoing processes of developmental parts of their lives both in developmental tasks of pregnancy and the early postpartum period, and in developmental processes during adolescence. For example, these young people had gradually developed maturity as well as had more responsibility after giving birth and becoming a mother. All of them had the basic instinct of mothers-to-be and were able to enact roles as a mother with the support from people surrounding them. Their potential for becoming a mother varied depending on each circumstance and specific socio-cultural contexts. The findings could fill the gaps in knowledge about pregnant adolescents and adolescent mothers in the rural Thailand. All findings could be employed as baseline data for enacting policies and have implications for nursing practice that meet the needs of these adolescents in the near future.

Limitations of the Study

Sample selection was limited by the homogeneity of participants who attended the prenatal clinic at Uttaradit Hospital. Most participants were poor and lived in the Uttaradit Province, northern region of Thailand. All of them had a father for their babies and gained a lot of support as perceived from their viewpoints. The pregnant adolescents who were in the middle class or had a rich family, had few supports or had no father for their babies did not come to a prenatal visit at Uttaradit Hospital. Those who were rich

went to the private clinic. Therefore, the findings may not be applicable and transferable beyond this group. In addition, the researcher interviewed the same participants multiple times from pregnancy until postpartum and made a visit at the hospital after birth. The participants had more opportunities to voice their needs and to express their feelings compared to those who did not participate in the study. These interactions might provide additional support unintentionally. As a result, it might have impacted on the experiences of these young people.

Another limitation was about long term consequences of a new baby. In this study, many participants reported the baby created a connection among family members. However, the study was conducted only 8-12 weeks postpartum, it was not clear if the baby was still creating the connection in the family in the long run. Finally, this study included those who continued the pregnancy. It is unknown how many pregnant adolescents were successful an abortion attempt and what their experiences were. These issues should be taken into account for the future research to follow this group of people in a long term study.

Implications of this Research

The goal of grounded theory is to generate a substantive theory. The findings can provide powerful implications for policy, nursing practices, and future research.

Implications for Policy Development

Health care policy can benefit from employing this study's findings. At the level of health care provider, there needs to be more in-depth assessment for the young women from pregnancy until motherhood. At a national level, the findings can be used as baseline data to raise awareness for health policymakers to enact a policy that meets the

needs of these young people. Since nearly half of the pregnant adolescents in the study attempted an abortion due to unintended pregnancy, these issues should be taken into consideration. Funding and staffing initiatives for clinical services and research studies to prevent unintended pregnancy, promote a healthy pregnancy, and postpartum period for the adolescents need to be structured and maintained with recognition that it is a comprehensive, long-term process.

For example, the hospitals should have policies that provide services for this particular group. A prenatal care clinic should organize a special unit for pregnant adolescents and adolescent mothers such as "*Cholom Mae Wai Roon*" (Adolescent Mom Club). Health education programs, from pregnancy until the postpartum period must be launched and arranged systematically for pregnant adolescents. The hospitals should adjust the previous protocol to allow the pregnant mothers to stay longer in a postpartum ward after giving birth in order to confirm that the adolescent mothers have enough knowledge and skills to raise their babies. The hospital needs the budget and staff to provide a hotline center for pregnant adolescents or adolescent mothers to consult about any concerns 24 hours a day. In addition, the hospitals have policies to encourage the health care providers to conduct research continuously among these young people with full of support in the aspects of funding and resources.

Implications for Nursing Practice

This study provides several directions for health care providers. It provides special lenses for health care providers to gain better understanding of the participants' experiences of being pregnant and becoming a mother and to tailor their care specifically to their needs. Without understanding the adolescents' experiences of being pregnant and

becoming a mother, health care providers will launch programs or caring that are ineffective and costly to the health care system and the adolescents. The health care providers can provide nursing practices to meet the needs of these young people during antepartum and postpartum periods. Since the needs of the adolescents during both periods are different and continuous, they will be discussed sequentially as follows.

Nursing Practices during the Antepartum Period

When the pregnant adolescents attend the prenatal clinic for the first time, the nurses should create a first impression by providing a friendly atmosphere, a warm welcome, and build relationships with these young people. Since most adolescent pregnancy is unintended, an abortion may have been attempted, but failed before attending the prenatal clinic. Consequently, the nurses should carefully assess both physical and psychological conditions of the adolescents. However, the nurses should be aware of the difficulties in assessing mental health problems in pregnant adolescents the first time they meet. In addition, the nurses should assess the level of developmental tasks of adolescence of each person simultaneously with the developmental tasks of pregnancy. The nurses should be aware that chronological age does not predict a maturity level. Some adolescents whose age is younger may behave in a more mature manner than their own counterparts. Furthermore, they also have different ways to seek knowledge about pregnancy, depending on their styles. For example, some like reading, whereas others like listening or watching. Some may access the Internet to seek knowledge.

To provide information to these young people, nurses should consider their preferred sources. For example, some pregnant adolescents prefer to see pictures, or some want the nurses to explain clearly and slowly with simple words in a relaxed atmosphere

in prenatal classes. Therefore, the nurses should provide them with additional resources of knowledge including pictures, videotapes, films, games, pamphlets, or websites related to pregnancy and health practices. Additionally, the nurses should be aware of the social values in relation to elders or authority figures. The pregnant adolescents may not ask nurses any questions related to pregnancy because of this value. As a result, the nurses should initiate discussion by asking about adolescent concerns or give a chance for these girls to ask questions. For example, during physical examination, the nurses should ask them "do you have any questions or concerns about your health or the baby?" or during the health educational group with adult pregnant women, the nurses may give them a paper to write down the questions instead of telling them to ask questions openly. This could make them feel comfortable. In addition, the nurses can relieve their concerns about the baby by encouraging them to see the fetus outline, fetal movement, or the fetal heart beat while having an ultrasound or allowing them to listen to the fetal heart sounds via a fetal monitor. By doing this, it could help confirm the reality of the baby to the pregnant adolescents.

Since the pregnant adolescents face many changes that cause them to suffer during pregnancy, the nurses should assess closely about the changes happening in their lives at each visit such as changes in body and mind, roles, residence, and responses to the pregnancy from people surrounding them in order to provide proper nursing care in each situation. The nurses should assess more about how adolescents view their body image during pregnancy because adolescence is the period of concern about the appearance of the body, weight gain or skin darkening occurring due to the pregnancy. These changes may lead them to negative health practices or mental problems. For

example they may limit food intake to control weight or they may have become depressed. While doing an assessment, the nurses should approach them with understanding, be non-judgmental, and actively respond to their requests because the adolescents state that they need more attention and understanding compared to adult pregnant women.

Family plays a vital role in supporting the pregnant adolescents to pass this milestone, hence, the nurses should assess the relationship between the pregnant adolescents and other family members, especially their mothers and boyfriends whom they report frequently as the most helpful persons. The nurses could assess each pregnant adolescent in the amount of, type of, and continuity of support gained from her family. Every effort should be made to maintain a good relationship among these people. If they are in severe conflict, the nurses should refer them to the appropriate services. When the pregnant adolescents come to the prenatal care clinic with their family members, the nurse should encourage them to participate in the activities provided by the clinic services such as health education.

Furthermore, the nurses can facilitate group meetings for these young persons periodically until after birth such as an adolescent pregnancy group. The findings from a randomized controlled trial of group prenatal care conducted with pregnant women aged 14-20 years in the U.S. appeared that a group prenatal care contributes to the pregnant women in terms of decreasing rate of preterm birth, increasing prenatal knowledge, enhancing more readiness for giving birth, satisfying with prenatal care, and initiating breastfeeding (Ickovics, et al., 2007). Based on the research findings, the group meeting can create opportunities to discuss all kinds of issues related to adolescent lives,

especially pregnancy. These can help them to make new friends, share their opinions with the persons who are in the same situations, and support each other. Group meetings help reduce the gap between adult pregnant women and adolescents as well as reduce feelings of loneliness and isolation. The nurses can act as facilitators who encourage activities of the group and provide sources of knowledge or additional help if needed during the group meeting. In addition, the nurses should arrange a session to include the adolescents and their mothers to give them an opportunity to do activities together. This can help enhance a good relationship between them.

In order to prepare the pregnant adolescents to become a new mother, the nurses should assess their child care experiences and enhance their basic baby care skills during the third trimester by teaching and demonstrating for them how to do each skill, especially, breast feeding, holding, and bathing. These young girls should have a chance to practice caring for newborns as much as they can and return demonstrations for each skill to be evaluated by the nurses as to whether they have enough skill to care for the baby. In addition, during the third trimester, the nurses should assess their health belief about *Yu fire* after birth such as what practices they do, what activities they limit, or what kinds of food and herbal solutions they take. The nurses should remind them to be careful of *Yu fireshood* in order to protect them from burning their skin or have them check whether the herbal solution is mixed with alcohol since it could pass through their breast milk that could affect their baby's health. It would be more of a benefit to the pregnant adolescents if the nurses have an opportunity to discuss this issue with the pregnant adolescents' mothers or elder persons in the family who will take care about the practices during this period.

Nursing Practices during the Postpartum Period

During the early postpartum period, the adolescent mothers voice that they and their babies need more attention from the nurses compared to the adult mothers. They need the nurses to take care of them and the babies closely, particularly the first time they hold or breastfeed the baby. Furthermore, the nurse should assess adolescent mothers' early postpartum developmental tasks individually. Although the adolescent mothers recover from the labor and birth processes quickly, they are not ready to learn new things within a couple days after birth. For example, they could not concentrate on the topics taught by the nurses and their perceptions about basic baby care skills or health practices after birth. As a result, their mothers or other significant others may provide initial care for them. The nurses should assess if these people provide appropriate care for the baby and encourage these people to participate in the parenting class. However, before discharging them from the hospital, the nurses should assess whether the adolescent mothers have enough knowledge and skills to take care of the baby.

A home visit should be made periodically after birth by the same health care provider team in order to serve the needs of the adolescent mothers. They requested that the same persons take care of them because they feel comfortable asking questions. During the home visit, the nurses should assess the adolescent mothers' skills of caring for the baby and provide information and knowledge that they need. The team should make a home visit within a week after birth to see if adolescent mothers can take proper care of their baby such as bathing, breastfeeding, and so on. No matter if they depend on their mothers or other family members to take care of the baby during the early postpartum, the nurses should provide additional information, knowledge, and sources of

knowledge for adolescents. During the visit, the nurses may teach and demonstrate the skills that adolescents lack or assess if they can take care of a sick baby appropriately or how they respond to a non-stop baby crying. Child development and solid food should be discussed between the nurses and the adolescent mothers or the significant others. It was found that six participants in the study never used any birth control and fourteen used it irregularly while having sexual intercourse. Lack of knowledge and a misunderstanding about birth control can lead to repeat pregnancy (Tangmunkongvorakul & Bhuttarowas, 2004). Consequently, the nurses should provide adolescents with information about birth control and encourage them to use appropriate contraceptive methods.

Although domestic violence and child abuse were not found in the study, the nurses should be aware of these issues since there was evidence that the adolescent mothers are at greater risks of experiencing domestic violence and of their babies experiencing child abuse (Thompson, Powell, Patterson, & Ellerbee, 1995; Wieland Ladewig, London, & Davidson, 2006). To protect the adolescents from domestic violence, the nurses should assess the relationship between the adolescents and the family members, ask them whether they are abused either in body or mind, and provide them with information about sources of assistance if such situations occur to them. Furthermore, to protect the babies from child abuse, the nurses should carefully observe and assess how the adolescent mothers respond to fussy babies. The nurses have to be vigilant and have a plan to support a new mother. They should suggest appropriate techniques for the adolescent mothers to respond to those babies. When the nurses suspect that the child is abused, they should report immediately to a person who is responsible for the child's safety.

The nurses should arrange an adolescent mother group for the brand new adolescent mothers to participate in and meet each other, particularly, it will be effective if the group involves experienced adolescent mothers. Therefore, they have an opportunity to share their experiences about taking care of a baby with others who are the same age. Having friends who are in the same situation to talk with helps reduce the feeling of loneliness and stress, creates the sense of belonging, and enhances self-confidence to take a role as a new mother. In addition, the nurses should provide them with the various resources and information to help them reach each personal goal such as education programs, employment and training, or day care centers, etc.

Finally, the nurses can launch a program to fit to the needs of the adolescents from early pregnancy to motherhood. The program should include knowledge of pregnancy, health practices during pregnancy, childbirth classes, breastfeeding classes, parenting classes, home visits, and knowledge of child development. The program should be evaluated and developed continuously.

In summary, during pregnancy and motherhood, when the adolescents demonstrate that they have positive health practices, the nurses should respond immediately with reinforcement and encouragement. The nurses must show their understanding and confirm that the nurses will be on their side in order to build rapport and establish trustworthiness with the adolescent mothers. Since for Thai society, younger persons have to show respect to their elders or authority by listening, being obedient, following suggestions, and refraining from arguments, these practices impact on adolescent girls' self-confidence to take a role as a new mother. As a result, the nurses should be open-minded to listen to adolescent voices as well as not to prematurely judge

that these young people were only “kids raising kids.” The nurses should treat them as adults and let them learn and practice maternal duties as much as they can so they can enact their role as a new mother appropriately. In addition, the nurses should encourage them to participate in religious activities in order to relieve their stress and have a peaceful mind.

Implications for Nursing Research

The findings from this study provide basic knowledge of the experiences of being pregnant and becoming a mother of Thai adolescents. The next step should be theory testing. The developed theory can be used as an explanatory model for an intervention study. There is a need to develop a program for adolescent girls during pregnancy until motherhood. Such a program will contribute to the adolescents, their offspring, family, and society at large. Examples of research questions about the program include “what are the postpartum outcomes for pregnant adolescents who participate in a health education program for adolescent pregnancy” and “what is the level of satisfaction for pregnant adolescents who participate in a health education program for adolescent pregnancy?.”

Additional research is needed to follow these young mothers and the babies in terms of mental health and developmental process. The findings can be used to understand developmental processes and mental health of adolescents and their babies in the long run and bring about nursing interventions that correspond to these issues effectively. Example research questions are “what is the experience of adolescent mothers of a preschool child?” and “what is the level of stress of adolescent mothers of a school-age child?”

It is advisable in future research to study the experiences of Thai adolescents of becoming a father and of becoming a grandmother of the adolescents' baby, since the boyfriends and the mothers of the adolescent girls play important roles as helpful supporters. Possible questions are "what is the experience of becoming a father of the adolescent girls' baby?, and "what is the experience of becoming a grandmother of an adolescents' baby?" Such research holds potential for making contributions to knowledge about the experiences as a father or a grandmother. Knowledge gained from these types of inquiry may improve the approach of health care providers in developing effective nursing care among these people.

Conclusion

The goal of this grounded theory study was to understand experiences of pregnancy and becoming a new mother in Thai adolescents who decided to carry an unintended pregnancy. The participants included 20 pregnant Thai adolescents who were pregnant for the first time. The ages of the participants varied from 14 to 19 with a mean of 16.4 years old. Most of them were in the middle adolescent phase 15-17 years. All were Thai, Buddhists, and grew up in the rural areas of the Northern region of Thailand. The majority finished high school and more than half dropped out of school when they became pregnant. Most of them were of low socioeconomic status and depended on their family. Eighteen participants were interviewed twice during pregnancy and one after birth. Two participants were only interviewed twice due to delivery prior to the second interview. The majority of the participant's children were of normal birth weight (≥2,500 grams) with a mean gestational age at birth of 38.6 weeks. Most mothers had a normal delivery. All of the babies were healthy during the time of the third interview. The age of

participants' boyfriends ranged from 17 to 29 with a mean of 21.7 years. All of them were Thai and Buddhists. The majority of them finished junior high school and were employed.

A substantive theory was generated to demonstrate the basic social psychological process of "*Kwa ja ru diang sa*: A life journey of Thai adolescents from unintended pregnancy to motherhood." Their life journey started when they realized the pregnancy, then they assigned, and appraised their pregnancy and the early postpartum period. During pregnancy and the transition to motherhood, they developed and maintained relationships with other people, and identified needs and sources of support. They developed strategies to cope with pregnancy and becoming a new mother during their challenging time, with the support from people surrounding them.
Adolescent learned from these experiences that pregnancy and parenting was a maturation process from innocent adolescent to motherhood.

The study addressed causal conditions, action/interaction strategies, intervening conditions, and consequences under the socio-cultural contexts including family, life styles and values, traditions, religion, education, gender roles, and the law. The findings from this study provide directions for future nursing interventions, policy, and research on adolescents and their significant others.

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APPENDICES

Appendix A

CHR Approval (U.S. and Thailand)

COMMITTEE ON HUMAN RESEARCH
OFFICE OF RESEARCH, Box 0962
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
www.research.ucsf.edu/chr/Apply/chrApprovalCond.asp
chr@ucsf.edu
(415) 476-1814

CHR APPROVAL LETTER

TO: Holly Powell Kennedy, Ph.D.
Box 0606

Wanwadee Neamsakul, Doct. Student
Box 0606,

RE: Unintended Thai Adolescent Pregnancy: A Grounded Theory Study

The Committee on Human Research (CHR) has reviewed and approved this application to involve humans as research subjects. This included a review of all documents attached to the original copy of this letter.

Specifically, the review included but was not limited to the following documents:
Minor (English & Thai) Consent Form, Dated 2/13/07
Main (English & Thai) Consent Form, Dated 2/13/07
English & Thai Information Sheet, Dated 2/13/07

The CHR is the Institutional Review Board (IRB) for UCSF and its affiliates. UCSF holds Office of Human Research Protections Federalwide Assurance number FWA00000068. See the CHR website for a list of other applicable FWA's.

APPROVAL NUMBER: H12251-27300-04. This number is a UCSF CHR number and should be used on all correspondence, consent forms and patient charts as appropriate.

APPROVAL DATE: January 18, 2008 **EXPIRATION DATE:** January 18, 2009 **Expedited Review**

GENERAL CONDITIONS OF APPROVAL: Please refer to www.research.ucsf.edu/chr/Apply/chrApprovalCond.asp for a description of the general conditions of CHR approval. In particular, the study must be renewed by the expiration date if work is to continue. Also, prior CHR approval is required before implementing any changes in the consent documents or any changes in the protocol unless those changes are required urgently for the safety of the subjects.

HIPAA "Privacy Rule" (45CFR164): This study does not involve access to, or creation or disclosure of Protected Health Information (PHI).

Sincerely,

Alan P. Venook, MD
Chair, Committee on Human Research

cc:

No. 133/2006

Certificate of Approval

Name of Ethics Committee : Research Ethics Committee 3 , Faculty of Medicine , Chiang Mai University
Address of Ethics Committee : 110 Intavaroros Rd., Amphoe Muang, Chiang Mai, Thailand 50200

Principal Investigator : Holly P. Kennedy
Family Health Care Nursing, S/N, University of California, San Francisco, United State of America

Protocol title: Unintended Thai Adolescent Pregnancy: A Grounded Theory Study

Documents filed	Document reference
Research protocol	- Dated 4 June 2006
Informed consent document /Patient information sheet	- None
Curriculum vitae of Principal Investigator	- Present
Advertisements (none)	- None
Other	- None

Opinion of the Ethics Committee/Institutional Review Board
____√____ Approval
_____ Conditional approval (specify in space below)

DECISION: By expedited review process

Date of Review : June 30 , 2007 Expiration Date: May 5 , 2008

This Ethics Committee is organized and operates according to principles of good clinical practice and relevant international ethical guidelines, applicable laws, and regulations.

Signed: ..... **Panja Kulapongs, M.D.**
(Chairperson, Faculty of Medicine)

Signed: ..... **Niwes Nantachit, M.D.**
(Dean, Faculty of Medicine)

GENERAL CONDITIONS OF APPROVAL:

Please refer to www.med.cmu.ac.th/research/ethics/inv_sop_announce.pdf, article 13. In particular, approval of this study must be renewed at least one month before the expiration date if work is to continue. Prior Research Ethics Committee approval is required before implementing any changes in the consent documents or protocol unless those changes are required urgently for the safely of subjects.

Faculty of Medicine
Chiang Mai University
Chiang Mai 50200, THAILAND
Tel. 66-53-221122 Fax: 66-53-217144

๖ February, 2008

Subject: Response to Request for Extension of Time for Research

To: (Miss) Wanwadee Niamsakul

In your letter of 17 January 2008 you requested an extension of time for research on the project "Unintended Thai adolescent pregnancy: a grounded theory study".

Previously you requested an extension of the period 1 July 2006 – 30 June 2007 to the period 30 June 2007 – 5 May 2008. The above request is for an extension of the period 30 June 2007 – 5 May 2008 to the period 30 June 2007 – 30 November 2008.

The Committee on Research Ethics of the Faculty of Medicine has considered the above request and decided to approve your request for an extension to the period 30 June 2007 -- 30 November 2008 for this research.

You are hereby notified of this.

Sincerely yours,

Niwes Nantachit

Niwes Nantachit, MD
Dean
Faculty of Medicine
Chiang Mai University
Chiang Mai, THAILAND

Appendix B

Study Information Sheet (English and Thai)

Appendix B

UNINTENDED THAI ADOLESCENT PREGNANCY:
A GROUNDED THEORY STUDY

Study information sheet

At the prenatal clinic, Uttaradit Hospital, there is a study going on that is trying to find out what it is like to be a pregnant adolescent. The study is conducted by Ms. Wanwadee Neamsakul, RN with the support of Boonkerd Chawengsri, MD, the director of Uttatradit Hospital. Ms. Neamsakul is a doctoral student at University of California at San Francisco in the U.S. I am telling you about the study because you have come to the prenatal clinic at Uttaradit Hospital and I think you would be able to give Ms. Neamsakul a really good idea about what it is like.

Here is what would happen if you decide to participate in the study.

- You would be asked about the experiences of being a pregnant adolescent and a mother, what it is like, and things that changed in your life since you got pregnant and became a mother. Ms. Neamsakul will also ask you how you deal with changes in your life and what kind of things you need now that you are pregnant and as a mother. That conversation would be digitally voice recorded, but only Ms. Neamsakul and her research team will know what you said.
- You need to talk to her three times. The first time will be around the 6th month of pregnancy. The second time around the 8th month of pregnancy, and the last time will be 2-3 months after birth. She will visit you at the hospital when you delivered a baby, but you will not be interviewed at that time and she will make an appointment for the third interview. Each interview takes 30-60 minutes. But if you agree, she might also ask if she could talk with you more, but that is up to you.
- Any thing that you tell Ms. Neamsakul will be kept between the two of you with two exceptions:
    - ❖ If you tell her that you are thinking of hurting yourself or someone else, she will need to tell us at the prenatal clinic, Uttaradit Hospital so that you get the help and services that you need.
    - ❖ If you tell her that you have been abused, she will also tell us at the prenatal clinic, Uttaradit Hospital so that we can make sure you get help with that.

If you think you might be willing to be in the study you can:

- o Return this sheet to Ms. Neamsakul with your signature, meet her now or contact her by phone or email later (see contact information below).
- o Let me give her your name and telephone number. She will call you to set up a time to talk.

If you decide to participate in the study, Ms. Neamsakul will pay 500 Baht in cash at the completion of all interviews and will give you a baby gift that costs 200 Baht when she visits you at the hospital after birth.

If you participate or not, it will not affect your care at the prenatal clinic, Uttaradit Hospital in any way. It is completely up to you.

What do you think?

☐ She can call me

My name_____

Number to call me at _____or_____

Email address_____

☐ She can meet me now.

☐ I will call her.

☐ I will email her.

☐ No thanks.

CONTACT INFORMATION

If you have questions at any time about the study participation or the procedure, please contact Ms. Neamsakul at 1-415-239-4272 (US), 055-412-782 (Home) or 086-927-3995 (Cell phone) (Thailand), or wanwadee_p@yahoo.com

Study Information sheet (Translation)

การตั้งครรภ์โดยไม่ได้ตั้งใจในวัยรุ่นไทย: การศึกษาโดยใช้ทฤษฎีรากฐาน

คำชี้แจงการศึกษาวิจัย

ที่แผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ ได้มีการศึกษาวิจัยเกี่ยวกับประสบการณ์การตั้งครรภ์ในวัยรุ่น โดยมี นส. วรรณวดี เนียมสกุล พยาบาลวิชาชีพเป็นผู้ดำเนินการวิจัย และได้รับการสนับสนุนจาก นพ.บุญเกิด เชวงศรี ผู้อำนวยการโรงพยาบาลอุตรดิตถ์ นส. วรรณวดี (ผู้วิจัย) เป็นนิสิตปริญญาเอก มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก ประเทศสหรัฐอเมริกา เราต้องการชี้แจงการศึกษาวิจัยในครั้งนี้เพราะ ท่านมารับบริการฝากครรภ์ที่แผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ และอาจมีคุณสมบัติตรงกับความต้องการของการศึกษาวิจัยนี้

เมื่อท่านตัดสินใจเข้าร่วมวิจัย ท่านจะผ่านขั้นตอนต่างๆ ดังต่อไปนี้

- ท่านจะได้รับการสัมภาษณ์จากผู้วิจัย เกี่ยวกับประสบการณ์การตั้งครรภ์และการเป็นมารดาวัยรุ่น มีอะไรเปลี่ยนแปลงไปบ้างเมื่อตั้งครรภ์และเป็นมารดา นอกจากนี้ผู้วิจัยจะซักถามว่าท่านมีวิธีการจัดการต่อการเปลี่ยนแปลงต่างๆในชีวิตของท่านอย่างไร มีสิ่งใดบ้างที่ท่านต้องการขณะตั้งครรภ์ ขณะสัมภาษณ์ผู้วิจัยจะทำการบันทึกเสียงตลอดการสัมภาษณ์ และมีเพียงผู้วิจัยและทีมวิจัยเท่านั้นที่จะรับทราบข้อมูลต่างๆจากการฟังในแฟ้มบันทึกเสียง นอกจากนี้ท่านจะได้รับการขออนุญาตจากผู้วิจัยในการถ่ายภาพตัวท่านและบุตร ซึ่งผู้วิจัยอาจนำมาประกอบการนำเสนอข้อมูลผลการศึกษาต่อสาธารณะ
- ผู้วิจัยจะสัมภาษณ์ท่านสามครั้ง ครั้งแรกเมื่อท่านตั้งครรภ์ประมาณหกเดือน ครั้งที่สองเมื่ออายุครรภ์ประมาณแปดเดือน และครั้งสุดท้ายภายหลังคลอดบุตรสองถึงสามเดือน ผู้วิจัยจะเยี่ยมท่านที่โรงพยาบาลหลังจากท่านคลอดบุตรแต่จะมิได้ทำการสัมภาษณ์ใดๆในครั้งนี้ โดยเธอจะนัดสัมภาษณ์ท่านในครั้งที่สามต่อไป การสัมภาษณ์แต่ละครั้งใช้เวลาประมาณ 30-60 นาที แต่ถ้าท่านยินดีให้ความร่วมมือ อาจมีการสัมภาษณ์เพิ่มเติม ทั้งนี้ขึ้นอยู่กับการตัดสินใจของท่าน
- ผู้วิจัยจะทบทวนรายงานประวัติสุขภาพของท่านที่ตึกหลังคลอด

ข้อมูลที่ได้จากการสัมภาษณ์จะถูกเก็บเป็นความลับระหว่างท่านกับผู้วิจัย ยกเว้น 2 กรณีดังนี้

- กรณีที่ท่านแจ้งว่าท่านมีความคิดที่จะทำร้ายตนเองหรือผู้อื่น ผู้วิจัยจำเป็นต้องแจ้งแก่หัวหน้าตึกแผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ เพื่อให้ท่านได้รับความช่วยเหลือหรือบริการที่จำเป็นแก่ท่าน

- กรณีที่ท่านแจ้งว่าท่านได้รับการทารุณกรรม ผู้วิจัยจำเป็นต้องแจ้งแก่หัวหน้าตึกแผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ เพื่อจะได้มั่นใจว่าท่านจะได้รับความช่วยเหลือในกรณีดังกล่าว

ถ้าท่านเต็มใจเข้าร่วมศึกษาวิจัยในครั้งนี้ ท่านสามารถ:

- ส่งแบบฟอร์มคำชี้แจงนี้ไปยัง คุณวรรณวดี พร้อมทั้งลงนาม หรือ อาจติดต่อไปยังเบอร์โทรศัพท์หรือ จดหมายอีเล็กโทรนิคส์ (ตามที่แนบมาท้ายคำชี้แจงนี้)
- อนุญาตให้ดิฉันได้แจ้งชื่อและเบอร์โทรศัพท์ของท่าน ทั้งนี้คุณวรรณวดี จะได้ติดต่อเพื่อนัดวันและเวลาในการพูดคุยกับท่าน

ถ้าท่านตัดสินใจเข้าร่วมศึกษาวิจัย คุณวรรณวดี จะจ่ายค่าตอบแทนเป็นเงินสดแก่ท่านเป็นจำนวน 100 บาทภายหลังสิ้นสุดการสัมภาษณ์ในแต่ละครั้ง และท่านจะได้รับของขวัญสำหรับเด็กแรกเกิดเป็นมูลค่า 200 บาทเมื่อท่านคลอดบุตร

ไม่ว่าท่านจะตัดสินใจเข้าร่วมศึกษาวิจัยหรือไม่ก็ตาม จะไม่มีผลกระทบใดๆต่อการดูแลรักษาท่าน ที่แผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ ทั้งหมดนี้ขึ้นอยู่กับการตัดสินใจของท่าน
ท่านตัดสินใจอย่างไร?

☐ คุณวรรณวดี สามารถติดต่อทางโทรศัพท์มาที่ฉันได้

ฉันชื่อ_____

เบอร์โทร_____หรือ _____

Email address_____

☐ คุณวรรณวดีสามารถพบฉันได้เลยในขณะนี้

☐ ฉันจะติดต่อไปยังคุณวรรณวดี เอง

☐ ฉันตัดสินใจไม่เข้าร่วมการศึกษาครั้งนี้ ขอขอบคุณในคำเชิญ

ข้อมูลสำหรับติดต่อกลับ

กรณีที่ท่านมีคำถามใดๆก็ตามเกี่ยวกับการเข้าร่วมศึกษาวิจัยหรือขั้นตอนต่างๆ ท่านสามารถติดต่อคุณวรรณวดี ได้ที่เบอร์โทร 1-415-239-4272 (ประเทศอเมริกา) หรือ 055-412-782 (บ้าน) 086-927-3995 (มือถือ)(ประเทศไทย) หรือ wanwadee_p@yahoo.com

Appendix C

Screening Instrument (English and Thai)

Appendix C

Screening Instrument

At the first contact with the researcher, either in persons or by telephone, the potential participants will be screened to determine eligibility by these provided questions.

1. How old are you now?
2. Do you plan for this pregnancy?
3. Are you pregnant with your first child?
4. How long have you been pregnant?
5. Do you attend a prenatal care clinic at Uttaradit Hospital?
6. Do you have any health problems? If so, please tell me about your health problems.
7. Are you willing to participate in all three interviews?

Screening instrument (Translation)

แบบคัดกรองคุณสมบัติผู้เข้าร่วมวิจัย

ภายหลังจากได้พบผู้วัจัยครั้งแรกทั้งโดยส่วนตัวหรือทางโทรศัพท์ ผู้เข้าร่วมวิจัยที่อาจมีคุณสมบัติตรงตามที่กำหนดจะถูกคัดกรองเพื่อประเมินคุณสมบัติดังกล่าวจากคำถามดังต่อไปนี้

1. ขณะนี้คุณอายุเท่าไหร่?
2. บุตรในท้องเป็นลูกคนแรกหรือไม่?
3. คุณได้วางแผนการท้องครั้งนี้หรือไม่?
4. คุณตั้งท้องมานานกี่เดือนแล้ว?
5. คุณมาฝากครรภ์ที่แผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์หรือไม่?
6. คุณมีปัญหาด้านสุขภาพหรือไม่ ถ้ามีโปรดระบุว่ามีปัญหาอย่างไร?
7. คุณยินดีที่จะได้รับการสัมภาษณ์ทั้งสามครั้งหรือไม่?

Appendix D

Consent Form for Participants Aged 14-18 Years Old

(English and Thai)

Appendix D

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Study Title: Unintended Thai adolescent pregnancy: A grounded theory study
What is this study about?

This study is about the experiences of being pregnant and becoming a mother of Thai adolescents who decide to carry an unintended pregnancy. Wanwadee Neamsakul, RN, a doctoral student in the Department of Family Health Care Nursing at University of California, San Francisco, and Holly P. Kennedy, CNM, PhD, FACNM, Associate Professor are conducting a study. Ms. Neamsakul will explain this study to you.

This study includes only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

You are being asked to participate in this study because you are a pregnant adolescent at the prenatal clinic at Uttaradit Hospital.

What will happen to you if you are in this study?

If you agree to be in the study, the following procedures will occur:

- You will be interviewed by the researcher at the place you feel comfortable and the interview will be conducted privately. You will be asked about the experiences of being pregnant and becoming a mother, when you first found out that you were pregnant, what it is like, and things that changed in your life.

- The researcher will also ask you how you deal with changes in your life, what kind of things you need now that you are pregnant and become a mother. The researcher will make a sound recording of your conversation. She may also take some notes during the conversation. After the interview, study records and digitally voice recorded interviews will be kept in a locked file at all times during the study, and only the researcher will have access to the data. After completing this study, the digitally voice recorded interviews and digitally recorded files will be destroyed and transcripts of interviews will be kept in a locked file by the researcher. You will be identified by a number on all study records to protect your privacy.

- The researcher will interview you three times, the first time will be around the 6th month of pregnancy. The second time around the 8th month of pregnancy, and the last time will be 2-3 months after birth. She will visit you at the hospital when you delivered a baby, but you will not be interviewed at that time and she will make an appointment for the third interview. But if you agree, she might also ask if she could talk with you again, but that is up to you. Each interview takes 30-60 minutes.

- If you agree, she may contact you yearly up to five years to talk with you about experiences for future research.

Will any parts of the study hurt?

- No, some questions, however, may make you feel uncomfortable when talking about your pregnancy. You may choose not to answer any question you do not wish to answer or to withdrawal from the study at any time.

- The interview is time consuming and may be boring, but you can stop at any time.

Will you get better if you are in this study?

There will be no direct benefit to you from participating in this study other than you will have an opportunity to speak about your feelings and experiences. However, the information that you provide may help health professionals better understand pregnant adolescents and adolescent mothers. This may help them to provide better care for pregnant adolescents and adolescent mothers.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Any information resulting from the study will be handled as confidentially as possible with two exceptions:

- If you tell the researcher that you are thinking of hurting yourself or someone else, she will need to tell the head nurse at the prenatal clinic, Uttaradit Hospital so that you get the help and services that you need.
- If you tell the researcher that you have been abused, she will also tell the head nurse at the prenatal clinic, Uttaradit Hospital so that we can make sure you get help with that.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include:

- UCSF's Committee on Human Research
- Research Ethics Committee, Faculty of Medicine, Chiang Mai University

What are the costs of taking part in this study?

There will be no cost to you as a result of taking part in this study.

Will I be paid for taking part in this study?

In return for your time and effort, you will be paid 500 Baht for all interviews and you will receive a baby gift worth 200 Baht when the researcher visits you at the hospital after birth. If you do not complete the interview, you will not be paid. You will be paid in cash immediately after you complete all interviews.

What if you have questions?

You can ask the researcher about any question or concern you have about this study. Contact the researcher, Wanwadee Neamsakul, RN, at 1-415-239-4272 (in San Francisoco) or 055-412-782 (in Thailand) or you can talk to the Head nurse, Bhargamas Srisuwanarat, RN, at 055-411-164. You can also ask your parents to ask questions for you. You may call the Research Ethics Committee, Faculty of Medicine at Chiang Mai University at 053-945-279. You may also call Dr. Holly Kennedy at the University of California, San Francisco at 1-415-476-0335.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher. If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the **Committee on Human Research (CHR)**, UCSF's Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at **1-415-476-1814**, 8 am to 5 pm (Pacific Standard Time), Monday through Friday. Or you may write to: Committee on Human

Research, Box 0962, University of California, San Francisco (UCSF), San Francisco, CA 94143.

What are your choices?

Taking part in this study is your choice. You may choose either to take part or not to take part in this study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way. You will not lose any of your regular benefits, and you can still get your care from the prenatal clinic at Uttaradit Hospital the way you usually do.

If you don't want to be in this study, just tell us.

If you want to be in this study, just tell us.
The researcher will give you a copy of this form to keep.

****

SIGNATURE OF PERSON CONDUCTING CONSENT DISCUSSION
I have explained the study to _____(*print name of child here*) in language he/she can understand, and the child has agreed to be in the study.

_____ _____
Signature of Person Conducting Consent Discussion Date

_____
Name of Person Conducting Consent Discussion (*print*)

_____ _____
Participant's Signature for assent Date

"The person being considered for this study is legally unable to consent for herself because she is a minor. By signing this form, you are giving permission for your child or ward to participate in the study"

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

Consent Form for Participants Aged 14-18 years Old (Translation)

มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก

การยินยอมเข้าร่วมศึกษาวิจัย

(แบบฟอร์มคำยินยอมสำหรับผู้เข้าร่วมวิจัยอายุ 14-18 ปี)

หัวข้อวิจัย การตั้งครรภ์โดยไม่ได้ตั้งใจในวัยรุ่นไทย: การศึกษาโดยใช้ทฤษฎีรากฐาน

การศึกษาวิจัยนี้เกี่ยวกับเรื่องอะไร?

การศึกษาวิจัยนี้เป็นเรื่องเกี่ยวกับประสบการณ์ในการตั้งครรภ์และการเป็นมารดาของวัยรุ่นไทย ซึ่งตัดสินใจดำเนินการตั้งครรภ์โดยไม่ได้ตั้งใจต่อจนครบกำหนด ผู้ทำการศึกษาวิจัยครั้งนี้ได้แก่ คุณวรรณวดี เนียมสกุล พยาบาลวิชาชีพ และนิสิตปริญญาเอก ภาควิชาการพยาบาลครอบครัว และ รศ. ดร.ฮอลลี่ เคนเนดี้ มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก โดย คุณวรรณวดี จะเป็นผู้อธิบายขั้นตอนการศึกษาวิจัยแก่ท่าน

การศึกษาครั้งนี้จะดำเนินการเฉพาะผู้ที่สมัครใจเท่านั้น กรุณาไตร่ตรองอย่างรอบคอบก่อนตัดสินใจเข้าร่วมการวิจัย โดยท่านอาจขอคำปรึกษาจากครอบครัวหรือผู้ที่ท่านให้ความไว้วางใจ ถ้ามีข้อสงสัยประการใดท่านสามารถซักถามผู้วิจัยได้ทันที

ท่านได้รับเลือกเข้าร่วมในการศึกษาวิจัยครั้งนี้เนื่องจากท่านเป็นหญิงตั้งครรภ์ในวัยรุ่นที่มารับบริการฝากครรภ์ที่โรงพยาบาลอุตรดิตถ์

จะมีอะไรเกิดขึ้นแก่ท่านเมื่อเข้าร่วมศึกษาวิจัยในครั้งนี้?

เมื่อท่านตัดสินใจเข้าร่วมวิจัย ท่านจะผ่านขั้นตอนต่างๆ ดังต่อไปนี้

- ท่านจะได้รับการสัมภาษณ์จากผู้วิจัย ในสถานที่ที่ท่านเลือกและรู้สึกสบายใจ การสัมภาษณ์จะขดำเนินการเป็นความลับ และซักถามเกี่ยวกับประสบการณ์การตั้งครรภ์ในวัยรุ่นและการเป็นมารดาอาทิเช่น เมื่อทราบว่าตั้งครรภ์ครั้งแรกท่านรู้สึกอย่างไร และมีอะไรเปลี่ยนแปลงไปบ้างในชีวิตของท่าน นอกจากนี้ท่านจะได้รับการขออนุญาตจากผู้วิจัยในการถ่ายภาพตัวท่านและบุตร ซึ่งผู้วิจัยอาจนำมาประกอบการนำเสนอข้อมูลผลการศึกษาต่อสาธารณะ
- ผู้วิจัยจะซักถามว่าท่านมีวิธีการจัดการต่อการเปลี่ยนแปลงต่างๆในชีวิตของท่านอย่างไร มีสิ่งใดบ้างที่ท่านต้องการขณะตั้งครรภ์และเป็นมารดา ขณะสัมภาษณ์ผู้วิจัยจะทำการบันทึกเสียงตลอดการสัมภาษณ์ และจดบันทึกในขณะสัมภาษณ์ ภายหลังสิ้นสุดการสัมภาษณ์แฟ้ม

บันทึกเสียงจะถูกเก็บไว้เป็นอย่างดี และมีเพียงผู้วิจัยเท่านั้นที่จะรับทราบข้อมูลต่างๆ ภายหลังสิ้นสุดการศึกษาแฟ้มบันทึกเสียงและแฟ้มบันทึกข้อความการสัมภาษณ์จะถูกทำลาย สำหรับข้อมูลต่างๆจะเก็บเป็นความลับและจะไม่ระบุชื่อของท่านแต่จะบันทึกเป็นรหัสหมายเลขทั้งนี้เพื่อปกป้องความเป็นส่วนตัวของท่าน

- ผู้วิจัยจะสัมภาษณ์ท่านสามครั้ง ครั้งแรกเมื่อท่านตั้งครรภ์ประมาณหกเดือน ครั้งที่สองเมื่ออายุครรภ์ประมาณแปดเดือน และครั้งสุดท้ายภายหลังคลอดบุตรสองถึงสามเดือน ผู้วิจัยจะเยี่ยมท่านที่โรงพยาบาลหลังจากท่านคลอดบุตรแต่จะมิได้ทำการสัมภาษณ์ใดๆในครั้งนี้ โดยเธอจะนัดสัมภาษณ์ท่านในครั้งที่สามต่อไป แต่ถ้าท่านยินดีให้ความร่วมมือ อาจมีการสัมภาษณ์เพิ่มเติมอีกทั้งนี้ขึ้นอยู่กับการตัดสินใจของท่าน การสัมภาษณ์แต่ละครั้งใช้เวลาประมาณ 30-60 นาที
- ผู้วิจัยจะทบทวนรายงานประวัติสุขภาพของท่านที่ตึกหลังคลอด
- ถ้าท่านยินดี ผู้วิจัยอาจจะติดต่อกับท่านเป็นระยะทุกหนึ่งปีเป็นเวลาห้าปีเพื่อพูดคุยเกี่ยวกับประสบการณ์ต่างๆที่เกิดขึ้น ซึ่งเป็นการศึกษาวิจัยอย่างต่อเนื่องต่อไป

การศึกษาครั้งนี้มีผลเสียหรือไม่?

- ไม่มี แต่ในบางคำถามอาจทำให้ท่านรู้สึกไม่สบายใจที่จะตอบคำถามเกี่ยวกับการตั้งครรภ์ ท่านสามารถเลือกที่จะไม่ตอบคำถามดังกล่าว หรือถอนตัวจากการเข้าร่วมศึกษาวิจัยได้ทุกเวลา
- การสัมภาษณ์จำเป็นต้องใช้เวลาบ้างซึ่งอาจทำให้ท่านรู้สึกเบื่อ แต่ท่านสามารถที่จะหยุดให้สัมภาษณ์ได้ตลอดเวลา

ท่านจะรู้สึกดีขึ้นหรือไม่ในการเข้าร่วมศึกษาวิจัย?

ในการศึกษาครั้งนี้ไม่มีผลประโยชน์โดยตรงกับตัวท่าน แต่ท่านจะได้รับโอกาสในการพูดคุยแสดงความคิดเห็นและประสบการณ์ต่างๆของตัวท่านเอง อย่างไรก็ตามข้อมูลที่ได้รับจากท่านจะเป็นประโยชน์ต่อเจ้าหน้าที่สุขภาพในการเข้าใจความรู้สึกความต้องการต่างๆ ของวัยรุ่นในขณะตั้งครรภ์เพื่อนำมาวางแผนให้การดูแลรักษาอย่างมีประสิทธิภาพต่อไป

ข้อมูลเกี่ยวกับตัวฉันจะเป็นความลับหรือไม่?

ผู้วิจัยขอรับรองว่าข้อมูลต่างที่ได้รับจากท่านจะถูกเก็บเป็นความลับ อย่างไรก็ตามเราไม่สามารถรับประกันความเป็นส่วนตัวได้ทั้งหมด ข้อมูลส่วนตัวอาจจำเป็นต้องเปิดเผยถ้าเป็นไปตามความต้องการ

ด้านกฎหมาย กรณีที่ข้อมูลในการศึกษาถูกตีพิมพ์หรือเผยแพร่ในที่ประชุม จะไม่มีการใช้ชื่อสกุลและข้อมูลส่วนตัวของท่าน

ข้อมูลที่ได้จากการสัมภาษณ์จะถูกเก็บเป็นความลับ ยกเว้น 2 กรณีดังนี้

- กรณีที่ท่านแจ้งว่าท่านมีความคิดที่จะทำร้ายตนเองหรือผู้อื่น ผู้วิจัยจำเป็นต้องแจ้งแก่หัวหน้าตึกแผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ เพื่อให้ท่านได้รับความช่วยเหลือหรือบริการที่จำเป็นแก่ท่าน
- กรณีที่ท่านแจ้งว่าท่านได้รับการทารุณกรรม ผู้วิจัยจำเป็นต้องแจ้งแก่หัวหน้าตึกแผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ เพื่อจะได้มั่นใจได้ว่าท่านจะได้รับความช่วยเหลือในกรณีดังกล่าว

องค์กรที่จะรับทราบข้อมูลและทำสำเนาข้อมูล ประกันคุณภาพ และวิเคราะห์ข้อมูลของท่านได้แก่

- คณะกรรมการพิทักษ์สิทธิ์มนุษยชนในการวิจัย แห่งมหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก
- คณะกรรมการจริยธรรมการวิจัย คณะแพทยศาสตร์ มหาวิทยาลัยเชียงใหม่

มีค่าใช้จ่ายในการศึกษาวิจัยเท่าใด?

ในการศึกษาวิจัยครั้งนี้ท่านไม่ต้องเสียค่าใช้จ่ายใดๆทั้งสิ้น

ฉันจะได้รับเงินในการเข้าร่วมศึกษาวิจัยครั้งนี้หรือไม่?

เนื่องจากท่านได้เสียสละเวลาส่วนตัวอันมีค่าในการเข้าร่วมวิจัยนี้ ท่านจะได้รับค่าตอบแทนเป็นเงินสดทันทีจำนวน 100 บาทต่อการสัมภาษณ์ 1 ครั้งและท่านจะได้รับของขวัญสำหรับเด็กแรกเกิดเป็นมูลค่า 200 บาทเมื่อท่านคลอดบุตร ในกรณีที่ท่านไม่สามารถให้การสัมภาษณ์จนเสร็จสมบูรณ์ได้ ท่านจะไม่ได้รับค่าตอบแทนใดๆทั้งสิ้น

ถ้าท่านมีคำถามจะทำอย่างไร?

กรณีที่ท่านมีข้อคำถามใดๆก็ตาม ท่านสามารถซักถามผู้วิจัยได้ทันที โดยติดต่อได้ที่ คุณวรรณวดี ที่เบอร์โทร 055- 412-782 ประเทศไทย หรือ 1-415-239-4272 ประเทศสหรัฐอเมริกา หรือติดต่อ คุณผกามาศ ศรีสุวรรณรัตน์ เบอร์โทร 055-411-064 ต่อแผนกฝากครรภ์ หรือท่านอาจติดต่อคณะกรรมการจริยธรรมการวิจัย คณะแพทยศาสตร์ มหาวิทยาลัยเชียงใหม่ เบอร์โทร 053-945-279 นอกจากนี้ท่านอาจติดต่อ รศ. ดร. ฮอลลี่ เคนเนดี้ เบอร์โทร 1-415-476-0335 ประเทศสหรัฐอเมริกา

กรณีที่ท่านมีข้อสงสัยหรือข้อคำถามใดๆก็ตาม ให้ซักถามจากผู้วิจัยเป็นลำดับแรก หรือไม่ว่าด้วยเหตุผลใดก็ตามท่านสามารถติดต่อคณะกรรมการพิทักษ์สิทธิ์มนุษยชนในการวิจัยแห่งมหาวิทยาลัยแคลิฟอร์เนีย ซาน
ฟรานซิสโก ที่ 1-415-476-1814 เวลา 8.00-17.00 น. วันจันทร์ ถึงวันศุกร์ (เวลามาตรฐานแปซิฟิค) หรือเขียนจดหมายส่งไปยัง Committee on Human Research, Box 0962, University of California San Francisco, CA 94143

ท่านมีทางเลือกอื่นใดหรือไม่?

การเข้าร่วมศึกษาวิจัยครั้งนี้ขึ้นอยู่กับการตัดสินใจของท่าน ท่านอาจตัดสินใจเข้าร่วมศึกษาวิจัยหรือไม่เข้าร่วมศึกษาวิจัยก็ได้ กรณีที่ท่านตัดสินใจเข้าร่วมศึกษาวิจัย ท่านสามารถที่จะถอนตัวจากการเข้าร่วมศึกษาวิจัยได้ตลอดเวลา ไม่ว่าท่านจะตัดสินใจอย่างไรก็ตาม ท่านจะไม่มีความผิดใดๆ ท่านจะไม่สูญเสียผลประโยชน์ใดๆที่พึงจะได้รับและ ท่านยังคงได้รับการดูแลตามหลักมาตรฐานการรักษาพยาบาลดังเดิม ที่แผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์

ถ้าท่านตัดสินใจไม่เข้าร่วมศึกษาวิจัย กรุณาแจ้งให้เจ้าหน้าที่ทราบ

ถ้าท่านตัดสินใจเข้าร่วมศึกษาวิจัย กรุณาแจ้งให้เจ้าหน้าที่ทราบ ท่านจะได้รับสำเนาฉบับนี้เก็บไว้เป็นหลักฐาน

ลายเซ็นของผู้ที่อธิบายเอกสารยินยอมการเข้าร่วมศึกษาวิจัย

ข้าพเจ้าได้อธิบายการศึกษาวิจัยแก่.....(เขียนชื่อผู้เข้าร่วมวิจัย) ในภาษาที่ง่ายต่อการเข้าใจ และเด็กวัยรุ่นท่านนี้เห็นด้วยที่จะเข้าร่วมการวิจัย

_____	_____
ลายเซ็นผู้อธิบายเอกสารยินยอมการเข้าร่วมศึกษาวิจัย	วัน เดือน ปี
_____	_____
ชื่อสกุลของผู้อธิบายเอกสารยินยอมการเข้าร่วมศึกษาวิจัย (ตัวบรรจง)	วัน เดือน ปี
_____	_____
ลายเซ็นของผู้ให้ความยินยอมเข้าร่วมศึกษาวิจัย	วัน เดือน ปี

“ ตามกฎหมาย ผู้เข้าร่วมศึกษาวิจัยครั้งนี้ไม่สามารถเซ็นลงนามยินยอมเข้าร่วมการศึกษาได้ด้วยตนเองเนื่องจากเป็นผู้เยาว์ การลงนามในเอกสารนี้ถือว่าท่านได้ยินยอมให้บุตรหรือเด็กในปกครองของท่านเข้าร่วมศึกษาวิจัยนี้”

_____	_____
ลายเซ็น บิดามารดา และ/หรือผู้ปกครอง	วัน เดือน ปี
_____	_____
ลายเซ็นพยาน	วัน เดือน ปี

Appendix E

Consent Form for Participants Aged 19 Years Olds

(English and Thai)

Appendix E

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Study Title: Unintended Thai adolescent pregnancy: A grounded theory study

This is a research study about the experiences of being pregnant and becoming a mother of Thai adolescents who decide to carry an unintended pregnancy.

Wanwadee Neamsakul, RN, a doctoral student in the Department of Family Health Care Nursing at University of California, San Francisco, and Holly P. Kennedy, CNM, PhD, Associate Professor are conducting a study. Ms. Neamsakul will explain this study to you.

This study includes only people who choose to take part. Please take your time to make your decision about participating, and discuss your decision with your family or friends if you wish. If you have any questions, you may ask the researchers.

You are being asked to take part in this study because you are a pregnant adolescent at the prenatal clinic at Uttaradit Hospital.

Why is this study being done?

The purpose of this study is to understand the experiences of pregnancy and becoming a mother of Thai adolescents who decide to carry an unintended pregnancy.

How many people will take part in this study?

About 20-30 people will take part in this study. They will be interviewed 3 times.

What will happen if I take part in this research study?

If you agree, the following procedures will occur:

- You will be interviewed by the researcher at the place you feel comfortable and the interview will be conducted privately. You will be asked about the experiences of being a pregnant adolescent and becoming a mother, when you first found out that you were pregnant, what it is like, and things that changed in your life.

- The researcher will also ask you how you deal with changes in your life, what kind of things you need now that you are pregnant and become a mother. The researcher will make a digitally voice recording of your conversation. She may also take some notes during the conversation. After the interview, study records and digitally voice recorded interviews will be kept in locked files at all times

during the study and only the researcher will have access to the data. After completing this study, the digitally voice recorded interviews and the digitally voice recorded files will be destroyed and the transcripts will be kept in a locked file by the researcher. You will be identified by a number on all study records to protect your privacy.

- The researcher will interview you three times, the first time will be around the 6th month of pregnancy. The second time around the 8th month of pregnancy, and the last time will be 2-3 months after birth. She will visit you at the hospital when you delivered a baby, but you will not be interviewed at that time and she will make an appointment for the third interview. But if you agree, she might also ask you if she could talk with her again, but that is up to you. Each interview takes 30-60 minutes.

- If you agree, she may contact you yearly up to five years to talk with you about your experiences for future research.

How long will I be in the study?

Participation in the study will take approximately 30-60 minutes for each interview.

Can I stop being in the study?

Yes. You can decide to stop at any time. Just tell the study researcher or staff person right away if you wish to stop being in the study.

Also, the researcher may stop you from taking part in this study at any time if he or she believes it is in your best interest.

What side effects or risks can I expect from being in the study?

- The interview is time consuming and may be boring, but you can stop at any time.

- Some of the questions may make you feel uncomfortable or upset, you may choose not to answer any question you do not wish to answer or withdrawal from the study at any time.

Are there benefits to taking part in the study?

There will be no direct benefit to you from participating in this study. However, the information that you provide may help health professionals better understand pregnant adolescents and adolescent mothers. Therefore, they can provide care that meets pregnant adolescents and adolescent mothers' needs.

What other choices do I have if I do not take part in this study?

You are free to choose not to participate in the study. If you decide not to take part in this study, there will be no penalty to you. You will not lose any of your regular benefits, and you can still get your care from the prenatal clinic at Uttaradit Hospital the way you usually do.

Will information about me be kept private?

We will do our best to make sure that the personal information gathered for this study is kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

Any information resulting from the study will be handled as confidentially as possible with two exceptions:

- If you tell the researcher that you are thinking of hurting yourself or someone else, she will need to tell the head nurse at the prenatal clinic, Uttaradit Hospital so that you get the help and services that you need.
- If you tell the researcher that you have been abused, she will also tell the head nurse at the prenatal clinic, Uttaradit Hospital so that we can make sure you get help with that.

Organizations that may look at and/or copy your research records for research, quality assurance, and data analysis include:

- UCSF's Committee on Human Research
- Research Ethics Committee, Faculty of Medicine, Chiang Mai University

What are the costs of taking part in this study?

There will be no cost to you as a result of taking part in this study.

Will I be paid for taking part in this study?

In return for your time and effort, you will be paid 500 Baht for all interviews and you will receive a baby gift worth 200 Baht when the researcher visits you after birth. If you do not complete all interviews, you will not be paid. You will be paid in cash immediately after you complete all interviews.

What are my rights if I take part in this study?

Taking part in this study is your choice. You may choose either to take part or not to take part in the study. If you decide to take part in this study, you may leave the study at any time. No matter what decision you make, there will be no penalty to you in any way.

You will not lose any of your regular benefits, and you can still get your care from the prenatal clinic at Uttaradit Hospital the way you usually do.

Who can answer my questions about the study?

You can talk to the researcher about any question or concern you have about this study. Contact the researcher, Wanwadee Neamsakul, RN, at 1-415-239-4272 (in San Francisco) or 055-412-782 (in Thailand) or the Head nurse, Bhargamas Srisuwanarat, RN, at 055-411-164. You may call the Research Ethics Committee, Faculty of Medicine at Chiang Mai University at 053-945-279. You may also call Dr. Holly Kennedy at the University of California, San Francisco at 1-415-476-0335.

If you have any questions, comments, or concerns about taking part in this study, first talk to the researcher (above). If for any reason you do not wish to do this, or you still have concerns after doing so, you may contact the office of the **University of California , San Francisco Committee on Human Research (CHR)**, Institutional Review Board (a group of people who review the research to protect your rights).

You can reach the CHR office at **1-415-476-1814**, 8 am to 5 pm (Pacific Standard Time), Monday through Friday. Or you may write to: Committee on Human Research, Box 0962, UCSF, San Francisco, CA 94143.

****

CONSENT

You have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to be in this study, or to withdraw from it at any point without penalty or loss of benefits to which you are otherwise entitled.

If you wish to participate in this study, you should sign below.

Date	Participant's Signature for Consent
Date	Person Obtaining Consent
Date	Signature of Witness

Consent Form for Participants Aged 19 years (Translation)

มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก

การยินยอมเข้าร่วมศึกษาวิจัย

(แบบฟอร์มคำยินยอมสำหรับผู้เข้าร่วมวิจัยอายุ 19 ปี)

หัวข้อวิจัย การตั้งครรภ์โดยไม่ได้ตั้งใจในวัยรุ่นไทย: การศึกษาโดยใช้ทฤษฎีรากฐาน

การศึกษาวิจัยนี้เป็นเรื่องเกี่ยวกับประสบการณ์ในการตั้งครรภ์และการเป็นมารดาของวัยรุ่นไทย ซึ่งตัดสินใจดำเนินการตั้งครรภ์โดยไม่ได้ตั้งใจต่อจนครบกำหนด ผู้ทำการศึกษาวิจัยครั้งนี้ได้แก่ คุณวรรณวดี เนียมสกุล พยาบาลวิชาชีพ และนิสิตปริญญาเอก ภาควิชาการพยาบาลครอบครัว และ รศ. ดร.ฮอลลี่ เคนเนดี้ มหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก โดย คุณวรรณวดี จะเป็นผู้อธิบายขั้นตอนการศึกษาวิจัยแก่ท่าน

การศึกษาครั้งนี้จะดำเนินการเฉพาะผู้ที่สมัครใจเท่านั้น กรุณาไตร่ตรองอย่างรอบคอบก่อนตัดสินใจเข้าร่วมการวิจัยโดยท่านอาจขอคำปรึกษาจากครอบครัวหรือผู้ที่ท่านให้ความไว้วางใจ ถ้ามีข้อสงสัยประการใดท่านสามารถซักถามผู้วิจัยได้ทันที

ท่านได้รับเลือกเข้าร่วมในการศึกษาครั้งนี้ เนื่องจากท่านเป็นหญิงตั้งครรภ์ในวัยรุ่นที่มารับบริการฝากครรภ์ที่โรงพยาบาลอุตรดิตถ์

เพราะเหตุใดจึงมีการศึกษาวิจัยครั้งนี้?

วัตถุประสงค์ในการดำเนินการวิจัยครั้งนี้ เพื่อที่จะให้เกิดความเข้าใจเกี่ยวกับประสบการณ์ในการตั้งครรภ์และการเป็นมารดาของวัยรุ่นไทย ซึ่งตัดสินใจดำเนินการตั้งครรภ์โดยไม่ได้ตั้งใจต่อจนครบกำหนด

การศึกษาครั้งนี้มีผู้เข้าร่วมศึกษาวิจัยจำนวนเท่าใด?

ประมาณ 20-30 คน ซึ่งแต่ละคนจะได้รับการสัมภาษณ์ 3 ครั้ง

จะมีอะไรเกิดขึ้นแก่ท่านเมื่อเข้าร่วมศึกษาวิจัยในครั้งนี้?

เมื่อท่านตัดสินใจเข้าร่วมวิจัย ท่านจะมีกิจกรรมดังต่อไปนี้

- ท่านจะได้รับการสัมภาษณ์จากผู้วิจัย ในสถานที่ที่ท่านเลือกและรู้สึกสบายใจ การสัมภาษณ์จะดำเนินการเป็นความลับ และซักถามเกี่ยวกับประสบการณ์การตั้งครรภ์และการเป็นมารดาในวัยรุ่น อาทิเช่น เมื่อทราบว่าตั้งครรภ์ครั้งแรกท่านรู้สึกอย่างไร และมีอะไรเปลี่ยนแปลงไปบ้างในชีวิตของท่าน นอกจากนี้ท่านจะได้รับการขออนุญาตจากผู้วิจัยในการถ่ายภาพตัวท่านและบุตร ซึ่งผู้วิจัยอาจนำมาประกอบการนำเสนอข้อมูลผลการศึกษาต่อสาธารณะ
- ผู้วิจัยจะซักถามว่าท่านมีวิธีการจัดการต่อการเปลี่ยนแปลงต่างๆในชีวิตของท่านอย่างไร มีสิ่งใดบ้างที่ท่านต้องการขณะตั้งครรภ์ ขณะสัมภาษณ์ผู้วิจัยจะทำการบันทึกเสียงตลอดการสัมภาษณ์ และจดบันทึกในขณะสัมภาษณ์ ภายหลังสิ้นสุดการสัมภาษณ์แฟ้มบันทึกเสียงจะถูกเก็บไว้เป็นอย่างดี และมีเพียงผู้วิจัยเท่านั้นที่จะรับทราบข้อมูลต่างๆ ภายหลังสิ้นสุดการศึกษาแฟ้มบันทึกเสียงและแฟ้มบันทึกข้อความการสัมภาษณ์จะถูกทำลาย สำหรับข้อมูลต่างๆที่บันทึกไว้จะเก็บเป็นความลับและจะไม่มีการบันทึกชื่อผู้ให้สัมภาษณ์แต่จะเรียกเป็นรหัสหมายเลขทั้งนี้เพื่อปกป้องความเป็นส่วนตัวของท่าน
- ผู้วิจัยจะสัมภาษณ์ท่านสามครั้ง ครั้งแรกเมื่อท่านตั้งครรภ์ประมาณหกเดือน ครั้งที่สองเมื่ออายุครรภ์ประมาณแปดเดือน และครั้งสุดท้ายภายหลังคลอดบุตรสองถึงสามเดือน ผู้วิจัยจะเยี่ยมท่านที่โรงพยาบาลหลังจากท่านคลอดบุตรแต่จะมิได้ทำการสัมภาษณ์ใดๆในครั้งนี้ โดยเธอจะนัดสัมภาษณ์ท่านในครั้งที่สามต่อไป แต่ถ้าท่านยินดีให้ความร่วมมือ อาจมีการสัมภาษณ์เพิ่มเติมอีกทั้งนี้ขึ้นอยู่กับการตัดสินใจของท่าน การสัมภาษณ์แต่ละครั้งใช้เวลาประมาณ 30-60 นาที
- ผู้วิจัยจะทบทวนรายงานประวัติสุขภาพของท่านที่ตึกหลังคลอด
- ถ้าท่านยินดี ผู้วิจัยอาจจะติดต่อกับท่านเป็นระยะทุกหนึ่งปีเป็นเวลาห้าปีเพื่อพูดคุยเกี่ยวกับประสบการณ์ต่างๆที่เกิดขึ้น ซึ่งเป็นการศึกษาวิจัยอย่างต่อเนื่องต่อไป

ฉันจะต้องเข้าร่วมการศึกษาวิจัยนานเท่าใด?

การเข้าร่วมวิจัยโดยการเป็นผู้ให้สัมภาษณ์ ครั้งละประมาณ 30-60 นาที

ฉันสามารถที่จะยุติการเข้าร่วมการศึกษาวิจัยได้หรือไม่?

ได้ ท่านสามารถยุติการเข้าร่วมในการศึกษาวิจัยเวลาใดก็ได้ โดยแจ้งให้ผู้วิจัยหรือเจ้าหน้าที่ทราบทันทีที่ท่านประสงค์จะยุติการเข้าร่วมในการศึกษาวิจัย

อะไรคือผลข้างเคียงหรือความเสี่ยงในการศึกษาครั้งนี้ที่จะเกิดแก่ฉัน?

- การสัมภาษณ์จำเป็นต้องใช้เวลาบ้างซึ่งอาจทำให้ท่านรู้สึกเบื่อ แต่ท่านสามารถที่จะยุติการให้สัมภาษณ์ได้ตลอดเวลา
- บางคำถามอาจทำให้ท่านรู้สึกไม่สบายใจหรือเสียใจที่จะตอบคำถามเกี่ยวกับการตั้งครรภ์ ท่านสามารถเลือกที่จะไม่ตอบคำถามดังกล่าว หรือถอนตัวจากการเข้าร่วมศึกษาวิจัยได้ทุกเวลา

มีผลประโยชน์ใดหรือไม่ในการเข้าร่วมศึกษาวิจัย?

ในการศึกษาครั้งนี้ไม่มีผลประโยชน์โดยตรงกับตัวท่านแต่ท่านจะได้รับโอกาสในการพูดคุยแสดงความคิดเห็นและประสบการณ์ต่างๆของตัวท่านเอง อย่างไรก็ตามข้อมูลที่ได้รับจากท่านจะเป็นประโยชน์ต่อเจ้าหน้าที่สุขภาพในการเข้าใจความรู้สึกความต้องการต่างๆของวัยรุ่นในขณะตั้งครรภ์เพื่อนำมาวางแผนให้การดูแลรักษาอย่างมีประสิทธิภาพต่อไป

ฉันจะเลือกไม่เข้าร่วมในการศึกษาครั้งนี้ได้หรือไม่?

ท่านมีอิสระในการตัดสินใจที่จะไม่เข้าร่วมศึกษาวิจัยครั้งนี้ กรณีที่ท่านตัดสินใจไม่เข้าร่วมศึกษาวิจัย จะไม่มีผลเสียใดๆเกิดขึ้นกับท่าน ท่านจะไม่สูญเสียผลประโยชน์ใดๆที่พึงจะได้รับและท่านยังคงได้รับการดูแลตามหลักมาตรฐานการรักษาพยาบาลดังเดิม ที่แผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์

ข้อมูลเกี่ยวกับตัวฉันจะถูกเก็บเป็นความลับหรือไม่?

ผู้วิจัยจะดำเนินการอย่างดีที่สุดเพื่อให้เกิดความมั่นใจว่าข้อมูลต่างๆที่ได้รับจากท่านจะถูกเก็บเป็นความลับ อย่างไรก็ตามเราไม่สามารถรับประกันได้ทั้งหมด ข้อมูลส่วนตัวอาจจำเป็นต้องเปิดเผยถ้าเป็นไปตามความต้องการด้านกฎหมาย กรณีที่ข้อมูลในการศึกษาถูกตีพิมพ์หรือนำเสนอในที่ประชุม จะไม่มีการใช้ชื่อสกุลและข้อมูลส่วนตัวของท่าน

ข้อมูลที่ได้จากการสัมภาษณ์จะถูกเก็บเป็นความลับ ยกเว้น 2 กรณีดังนี้

- กรณีที่ท่านแจ้งว่าท่านมีความคิดที่จะทำร้ายตนเองหรือผู้อื่น ผู้วิจัยจำเป็นต้องแจ้งแก่หัวหน้าตึกแผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ เพื่อให้ท่านได้รับความช่วยเหลือหรือบริการที่จำเป็นแก่ท่าน
- กรณีที่ท่านแจ้งว่าท่านได้รับการทารุณกรรม ผู้วิจัยจำเป็นต้องแจ้งแก่หัวหน้าตึกแผนกฝากครรภ์ โรงพยาบาลอุตรดิตถ์ เพื่อจะได้มั่นใจได้ว่าท่านจะได้รับความช่วยเหลือในกรณีดังกล่าว

องค์กรที่จะรับทราบข้อมูลและทำสำเนาข้อมูล ประกันคุณภาพ และวิเคราะห์ข้อมูลของท่านได้แก่

- คณะกรรมการพิทักษ์สิทธิ์มนุษยชนในการวิจัย แห่งมหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก
- คณะกรรมการจริยธรรมการวิจัย คณะแพทยศาสตร์ มหาวิทยาลัยเชียงใหม่

มีค่าใช้จ่ายในการเข้าร่วมศึกษาวิจัยครั้งนี้หรือไม่?
ในการศึกษาวิจัยครั้งนี้ท่านไม่ต้องเสียค่าใช้จ่ายใดๆทั้งสิ้น

ฉันจะได้รับเงินในการเข้าร่วมวิจัยครั้งนี้หรือไม่?
เนื่องจากท่านได้เสียสละเวลาส่วนตัวอันมีค่าในการเข้าร่วมวิจัยนี้ ท่านจะได้รับค่าตอบแทนเป็นเงินสดทันทีจำนวน 100 บาทต่อการสัมภาษณ์ 1 ครั้งและท่านจะได้รับของขวัญสำหรับเด็กแรกเกิดเป็นมูลค่า 200 บาทเมื่อท่านคลอดบุตร ในกรณีที่ท่านไม่สามารถให้การสัมภาษณ์จนเสร็จสมบูรณ์ได้ ท่านจะไม่ได้รับค่าตอบแทนใดๆทั้งสิ้น

ฉันมีสิทธิใดบ้างในการเข้าร่วมศึกษาวิจัยนี้?
การเข้าร่วมศึกษาวิจัยนี้ขึ้นอยู่กับการตัดสินใจของตัวท่านเอง ท่านอาจเลือกเข้าร่วมการวิจัยหรือไม่ก็ได้ กรณีที่ท่านตัดสินใจเข้าร่วมศึกษาวิจัยท่านสามารถจะถอนตัวออกจากการวิจัยได้ทุกเวลา หรือแม้ว่าท่านตัดสินใจไม่เข้าร่วมศึกษาวิจัยก็จะไม่มีผลเสียใดๆกับตัวท่าน ท่านยังคงได้รับการดูแลตามหลักมาตรฐานการพยาบาล จากแผนกฝากครรภ์โรงพยาบาลอุตรดิตถ์ดังเดิม
ใครจะเป็นผู้ตอบคำถามต่างๆเกี่ยวกับการวิจัยต่อท่าน?
กรณีที่ท่านมีข้อคำถามใดๆก็ตาม ท่านสามารถซักถามผู้วิจัยได้ทันที โดยติดต่อได้ที่ คุณวรรณวดี ที่เบอร์โทร 055- 412-782 ประเทศไทย หรือ 1-415-239-4272 ประเทศสหรัฐอเมริกา หรือติดต่อ คุณผกามาศ ศรีสุวรรณรัตน์ เบอร์โทร 055-411-064 ต่อแผนกฝากครรภ์ หรือท่านอาจติดต่อคณะกรรมการจริยธรรมการวิจัย คณะแพทยศาสตร์ มหาวิทยาลัยเชียงใหม่ เบอร์โทร 053-945-279นอกจากนี้ท่านอาจติดต่อ รศ. ดร. ฮอลลี่ เคนเนดี้ เบอร์โทร 1-415-476-0335 ประเทศสหรัฐอเมริกา

กรณีที่ท่านมีข้อสงสัย ความคิดเห็นหรือข้อคำถามใดๆก็ตาม ให้ซักถามจากผู้วิจัยเป็นลำดับแรก แต่ถ้าท่านไม่ต้องการถามผู้วิจัย ไม่ว่าเพราะเหตุผลใดก็ตาม ท่านสามารถติดต่อคณะกรรมการพิทักษ์สิทธิ์มนุษยชนในการวิจัยแห่งมหาวิทยาลัยแคลิฟอร์เนีย ซานฟรานซิสโก ที่ 1-415-476-1814 เวลา 8.00-

17.00 น. วันจันทร์ ถึงวันศุกร์ (เวลามาตรฐานแปซิฟิค) หรือเขียนจดหมายส่งไปยัง Committee on Human Research, Box 0962, University of California San Francisco, CA 94143

คำยินยอมในการเข้าร่วมศึกษาวิจัย

ท่านจะได้รับสำเนายินยอมเข้าร่วมการศึกษาวิจัยจำนวน 1 ชุด

การเข้าร่วมศึกษาวิจัยนี้ เป็นไปด้วยความสมัครใจ ท่านมีสิทธิที่จะปฏิเสธการเข้าร่วมวิจัย หรือถอนตัวออกจากการวิจัยได้ทุกเวลาโดยไม่มีความผิดหรือสูญเสียผลประโยชน์ใดๆที่ท่านจะได้รับ

ถ้าท่านประสงค์จะเข้าร่วมวิจัยนี้ กรุณาลงนามตามช่องว่างที่กำหนดด้านล่างนี้

_____	_____
วัน เดือน ปี	ลายเซ็นผู้ให้ความยินยอมเข้าร่วมศึกษาวิจัย
_____	_____
วัน เดือน ปี	ลายเซ็นผู้ได้รับความยินยอมจากผู้เข้าร่วมศึกษาวิจัย
_____	_____
วัน เดือน ปี	ลายเซ็นพยาน

Appendix F

Demographic Questionnaire (English and Thai)

Appendix F

Demographic Questionnaire

…….

Part I (For a record at the first interview)

Name……..**Last name**…….

Birth Date ……..**Month**……..**Year**……..**Age**……**years**

Marital Status O Single O Married O Divorced O Separated O Other

If married, Do you register for a marriage certificate? O Yes O No

Level of Education O No O Elementary school O Secondary school (grade 7-9)

O Secondary school (grade 10-12) O Vocational school O University (year)

Occupation……**Income**……**Baht**

If no income, who provide a financial support for you (please notify)……..

…….

Gestational Age……**weeks**

Number of attending prenatal care clinic……..**times**

Number of family members……..**persons**

Relationships with family members O Daughter O Wife O Siblings O Other (Please notify)…..……

Place of Residence O Parents O Other family members O Husband O Boyfriend

O Other (Please notify)……..

……..

Date/Month/Year of record

Part II (For a record at the third interview)

Delivery Date……**Month**……**Year**…….

Gestational Age at Birth…….**weeks**

Type of Delivery…….

Hour of Labor 1st stage……..**hours**……**minutes**

2nd stage…….**hours**……**minutes**

3rd Stage…….**hours**……**minutes**

Pain Medication…….

Complication during labor and postpartum O yes O No

If yes, please notify……..

NICU admission O yes O No

Fetal Birth Weight…….**grams**

Length of hospitalization after birth……**days**

Postpartum periods……..**weeks**

Infant Feeding O Breast Feeding O Formula O Combination

Breast Feeding O yes O No

If stopped breast feeding, please notify length of breast feeding…….**weeks**

……..

Date/Month/Year of record

Demographic Questionnaire (Translation)

แบบสัมภาษณ์ข้อมูลส่วนบุคคล

……

ส่วนที่ 1 (สำหรับบันทึกข้อมูลจากการสัมภาษณ์ครั้งแรก)

ชื่อ……. **สกุล**……

วัน เดือนปี เกิด…….... **อายุ**…… **ปี**

สถานภาพสมรส O โสด O คู่ O หย่า O แยกกันอยู่ O อื่นๆ

ถ้าสมรส ท่านจดทะเบียนสมรสหรือไม่ O จด O ไม่จด

ศาสนา O พุทธ O อิสลาม O คริสต์ O อื่นๆ (โปรดระบุ.....)

เชื้อชาติ O ไทย O จีน O ลาว O อื่นๆ (โปรดระบุ.....)

ระดับการศึกษา Oไม่ได้รับการศึกษา O ประถมศึกษา O มัธยมศึกษาตอนต้น

O มัธยมศึกษาตอนปลาย O อาชีวศึกษา O มหาวิทยาลัย ชั้นปีที่.....

คุณยังศึกษาอยู่หรือไม่ O ยังศึกษาอยู่ O ไม่ได้ศึกษาแล้ว, ถ้าไม่ได้ศึกษาได้ลาออกหรือหยุดเรียน เมื่อ.....

อาชีพ…… **รายได้**…… **บาท**

ถ้าไม่มีรายได้ ใครเป็นผู้ให้ความช่วยเหลือทางการเงิน โปรดระบุ.....

อายุครรภ์…….. **สัปดาห์**

จำนวนครั้งที่มาฝากครรภ์ที่แผนกฝากครรภ์…….. **ครั้ง**

จำนวนสมาชิกในครอบครัว…….**คน**

ความสัมพันธ์กับสมาชิกในครอบครัว O บุตรสาว O ภรรยา O พี่น้อง O อื่นๆ (ระบุ)

……

สถานที่พัก ขณะนี้พักอาศัยอยู่กับ O บิดามารดา O สมาชิกในครอบครัว O สามี O แฟน

O อื่นๆ (โปรดระบุ.....)

……

วัน เดือนปี ที่บันทึกข้อมูล

ส่วนที่สอง (สำหรับบันทึกเมื่อสัมภาษณ์ครั้งที่สาม)

วัน เดือน ปี ที่คลอดบุตร.....

อายุครร์เมื่อคลอด.....**สัปดาห์**

ชนิดของการคลอด.....

ระยะเวลาในการคลอด ระยะที่หนึ่ง.....ชั่วโมง.....นาที

ระยะที่สอง.....ชั่วโมง.....นาที

ระยะที่สาม .....ชั่วโมง.....นาที

ยาระงับปวดที่ได้รับ.....

ภาวะแทรกซ้อนขณะและหลังคลอด O มี O ไม่มี

ถ้ามี โปรดระบุ.....

ทารกได้รับการดูแลในหน่วยดูแลทารกวิกฤต O ได้รับ O ไม่ได้รับ

น้ำหนักทารกแรกเกิด.....**กรัม**

ระยะเวลาที่อยู่โรงพยาบาลหลังคลอด.....**วัน**

อายุครรภ์หลังคลอด.....**สัปดาห์** (ขณะสัมภาษณ์ครั้งนี้)

การเลี้ยงบุตร O นมแม่ O นมผสม O ทั้งนมแม่และนมผสม

การเลี้ยงบุตรด้วยนมแม่ O เลี้ยง O ไม่เลี้ยง, ถ้าหยุดให้นมแม่ โปรดระบุระยะเวลาที่ให้นมแม่.....สัปดาห์

คุณยกบุตรให้เป็นบุตรบุญธรรมแก่ใครหรือไม่ O ยก O ไม่ยก ถ้ายกให้เป็นบุตรบุญธรรม โปรดระบุสัมพันธภาพกับบุคคลดังกล่าว.....

……

วัน เดือนปี ที่บันทึกข้อมูล

Appendix G

Interview Guide (English and Thai)

Appendix G

INTERVIEW GUIDE

Question number 1-10 will be used at the first and second interview for pregnant adolescents.

The interview will be conducted in Uttaradit Province, Thailand and in the place that the participants prefer. Ms. Neamsakul will ask the permission to record the interview and write notes during the conversation.

Thank you very much for agreeing to talk with me. As I have mentioned, I would like to know about the experience of being a pregnant adolescent and what has happened to you since then?

1. Tell me about when you first realized you were pregnant?
   What were your feelings? How did you make decisions about pregnancy?

2. Please tell me about your experience of being pregnant.
- How do you think about yourself when you are pregnant?
- Tell me how other people think about you when you are pregnant.
- What has it been like to be your age and be pregnant?
- Tell me about your family's reactions to your pregnancy.
- What has it been like with your family since you became pregnant?

3. What has changed in your life since you got pregnant?
- How do you deal with these changes in your life?

4. Some pregnant adolescents tell me that it's tough being pregnant, but the others tell me that it's easy.
- What is it like for you?
- What is the best part about being pregnant?
- What has been hard for you?

5. Pregnant adolescents have said that they have some people who take care of them during their pregnancy.
- Who provide you supports? What does this person(s) do?
- Who has been the most helpful to you during your pregnancy?
- What type of support do you want and need?
- When you have a financial problem, who help you?
- Have you ever asked for help from friends during pregnancy? If so, tell me about their help.
- What kind of support/information do you need from the doctor/nurse?

6. Tell me about what you think it will be like to be a mother.
7. What do you think about your baby? What is your plan about the baby and

yourself after birth?
8. What kind of things do you need now that you are pregnant?
9. Is there anything I haven't asked about that you want to say?
10. Is there anything else that doctors/nurses should know to take better care of pregnant adolescents?

The second interview will start with "What has changed in your life since we last talked?"

Question number 11-16 will be used at the third interview with the same adolescents after birth 8-12 weeks.

11. Please tell me about the experience of being a mother.
- Tell me about your feeling when you first saw your baby.
- How do you think about yourself when you are a mother?
- Tell me how other people think about you when you are a mother.
- What has it been like to be your age and had a baby?
- What has changed in your life since you become a mother? How do you deal with these changes?
- Tell me about your family's reactions to yourself and the baby.
- What has it been like with your family since you became a mother?

12. When you look back to the past, how do you feel about your pregnancy now?

13. Some adolescent mothers tell me that it's tough being a mother, but the others tell me that it's easy.
- What is it like for you?
- What is the best part about being a mother?
- What has been hard for you as a mother?
- When you feel that you were confident to take care of a baby?

14. Pregnant adolescents have said that they have some people always take care of them after delivering a baby.
- Who provide you supports? What does this person(s) do?
- Who has been the most helpful to you after delivering a baby?
- What type of support do you want and need?
- When you have a financial problem, who help you?
- Have you ever asked for help from friends after delivering a baby? If so, tell me about their helps.
- What kind of support/information do you need from the doctors/nurses?

15. Is there anything I haven't asked about that you want to say?
16. Is there anything else that doctors/nurses should know to take better care of adolescent mothers?

Probes:

Could you tell me more about that?

Can you give me an example of that?
What does that mean to you?
How did that make you feel?

Interview Guide (Translation)

แบบสัมภาษณ์

คำถามที่ 1-9 ใช้สำหรับสัมภาษณ์วัยรุ่นขณะตั้งครรภ์ครั้งที่หนึ่งและสอง

การสัมภาษณ์จะดำเนินการในจังหวัดอุตรดิตถ์ ประเทศไทย ในสถานที่ที่ผู้เข้าร่วมวิจัยเลือก คุณเนียมสกุลจะขออนุญาตบันทึกเสียงการสัมภาษณ์และจดบันทึกขณะทำการสนทนา

ขอบคุณมากนะคะที่ให้ความร่วมมือในการพูดคุยในครั้งนี้

ตามที่ดิฉันได้กล่าวไว้ว่าดิฉันต้องการทราบเกี่ยวกับประสบการณ์ขณะตั้งครรภ์และสิ่งที่เกิดขึ้นภายหลังการตั้งครรภ์

1. คุณรู้สึกอย่างไรในตอนแรกเมื่อทราบว่าท้อง? คุณตัดสินใจอย่างไรเกี่ยวกับการท้องครั้งนี้?

2. ช่วยเล่าประสบการณ์ขณะท้องด้วยค่ะ
- คุณคิดอย่างไรเกี่ยวกับตัวเองเมื่อท้อง?
- ช่วยเล่าให้ฟังด้วยค่ะว่าคนอื่นๆ เช่น เพื่อนๆ แฟน หมอและพยาบาล ตลอดจนเพื่อนบ้าน คิดอย่างไรที่คุณท้อง?
- คิดว่าอายุเท่านี้แล้วท้องนี่เป็นอย่างไร?
- คนในครอบครัวมีปฏิกิริยาอย่างไรต่อท้องนี้? เช่น พ่อ แม่ พี่น้อง ปู่ย่าตายาย เป็นต้น
- ภายในครอบครัวเป็นอย่างไรเมื่อคุณท้อง?

3. มีการเปลี่ยนแปลงอะไรเกิดขึ้นบ้างเมื่อท้อง คุณมีวิธีการเผชิญหรือจัดการกับการเปลี่ยนแปลงในชีวิตเหล่านี้อย่างไร

4. วัยรุ่นท้องบางคนก็บอกว่ามีความยุ่งยากลำบากที่ท้อง บางคนก็บอกว่าง่าย ไม่ยุ่งยากอะไร
- สำหรับคุณคิดอย่างไร?
- อะไรคือสิ่งที่ดีที่สุดในการท้อง?
- อะไรคือส่วนที่ยุ่งยากหรือลำบากในการท้อง?

5. วัยรุ่นท้องบอกว่ามีคนคอยให้การช่วยเหลือสนับสนุนขณะที่ท้อง
- ใครคอยช่วยเหลือสนับสนุนคุณบ้าง? บุคคลเหล่านี้ช่วยเหลือสนับสนุนอะไร?
- ใครที่คอยให้ช่วยเหลือมากที่สุด?
- คุณต้องการความช่วยเหลือสนับสนุนอะไรบ้าง?
- เมื่อมีปัญหาการเงิน ใครให้ความช่วยเหลือ?
- คุณเคยขอความช่วยเหลือจากเพื่อนช่วงท้องหรือไม่ ถ้าเคย เขาช่วยเหลือคุณอย่างไร?
- คุณได้รับการดูแลและข้อมูลใดจากหมอและพยาบาลบ้าง?
- คุณคิดว่ามีอะไรอีกบ้างที่หมอและพยาบาลควรจะรู้เพื่อจะได้ดูแลวัยรุ่นท้องได้ดียิ่งขึ้น?

6. คุณคิดอย่างไรที่ตัวเองกำลังจะเป็นแม่คน
7. คุณคิดอย่างไรกับลูกในท้อง? คุณวางแผนเกี่ยวกับตัวเองและลูกหลังคลอดไว้อย่างไรบ้าง?
8. มีอะไรที่คุณอยากรู้เพิ่มเติมขณะท้องบ้าง?
9. มีอะไรที่ดิฉันยังไม่ได้ถามและคุณอยากพูดถึงหรือเพิ่มเติม

ในการสัมภาษณ์ครั้งที่สองจะเริ่มต้นด้วยคำถาม “หลังการพูดคุยในครั้งก่อน มีอะไรเปลี่ยนแปลงในชีวิตบ้างคะ?”

คำถามที่ 10-15 จะใช้ในการสัมภาษณ์ครั้งที่สาม กับวัยรุ่นตั้งครรภ์คนเดิมภายหลังคลอดบุตร 8-12 สัปดาห์

10. ช่วยเล่าประสบการณ์การเป็นแม่ด้วยค่ะ
- เมื่อเห็นลูกครั้งแรกคุณรู้สึกอย่างไร
- คุณคิดอย่างไรเกี่ยวกับตัวเองเมื่อเป็นแม่?
- ช่วยเล่าให้ฟังด้วยค่ะว่าคนอื่นๆ เช่น เพื่อนๆ แฟน หมอและพยาบาล ตลอดจนเพื่อนบ้าน คิดอย่างไรที่คุณเป็นแม่?
- คิดว่าอายุเท่านี้แล้วมีลูกนี่เป็นอย่างไร?
- มีการเปลี่ยนแปลงอะไรเกิดขึ้นบ้างเมื่อเป็นแม่ คุณมีวิธีการเผชิญหรือจัดการกับการเปลี่ยนแปลงในชีวิตเหล่านี้อย่างไร
- คนในครอบครัวมีปฏิกิริยาอย่างไรต่อคุณกับลูกอย่างไร? เช่น พ่อ แม่ พี่น้อง ปู่ย่าตายาย เป็นต้น
- ภายในครอบครัวเป็นอย่างไรเมื่อคุณเป็นแม่?
11. ถ้ามองย้อนหลังไปในช่วงก่อน ตอนนี้คุณรู้สึกเกี่ยวกับการท้องของตนเองอย่างไร?

12. แม่วัยรุ่นบางคนก็บอกว่าการเป็นแม่คนมีความยุ่งยากลำบาก บางคนก็บอกว่าง่าย ไม่ยุ่งยากอะไร
- สำหรับคุณคิดอย่างไร?
- อะไรคือสิ่งที่ดีที่สุดในการเป็นแม่?
- อะไรคือส่วนที่ยุ่งยากหรือลำบากในการเป็นแม่?
- เมื่อไรที่คุณมั่นใจในการดูแลลูก

13. วัยรุ่นบางคนบอกว่ามีคนคอยให้การช่วยเหลือสนับสนุนหลังคลอดลูก
- ใครคอยช่วยเหลือสนับสนุนคุณบ้าง? บุคคลเหล่านี้ช่วยเหลือสนับสนุนอะไร?
- ใครที่คอยให้ช่วยเหลือมากที่สุด?
- คุณต้องการความช่วยเหลือสนับสนุนอะไรบ้าง?
- เมื่อมีปัญหาการเงิน ใครให้ความช่วยเหลือ?
- คุณเคยขอความช่วยเหลือจากเพื่อนหลังคลอดลูกหรือไม่ ถ้าเคย เขาช่วยเหลือคุณอย่างไร?
- คุณต้องการการสนับสนุนและข้อมูลหลังคอลดใดจากหมอและพยาบาลบ้าง?

14. มีอะไรที่ดิฉันยังไม่ได้ถามและคุณอยากพูดถึงหรือเพิ่มเติมบ้าง?
15. คุณคิดว่ามีอะไรอีกบ้างที่หมอและพยาบาลควรจะรู้เพื่อจะได้ดูแลแม่วัยรุ่นได้ดียิ่งขึ้น?

คำถามเพิ่มเติมรายละเอียด
- คุณช่วยเล่าเพิ่มเติมเกี่ยวกับเรื่องนี้ด้วยคะ?
- ช่วยยกตัวอย่างด้วยค่ะ?
- สิ่งนี้มีความหมายอย่างไรคะ?
- สิ่งเหล่านี้มีผลต่อความรู้สึกของคุณอย่างไร?

Appendix H
Criminal Law
Offense Relating to Sexuality (English and Thai version)

"**Section 277**.- Whoever, has sexual intercourse with a girl not yet over fifteen years of age and not being his own wife, whether such girl shall consent or not, shall be punished with imprisonment of four to twenty years and fined of eight thousand to forty thousand Baht.

If the commission of the offense according to the first paragraph is committed against a girl not yet over thirteen years of age, the offender shall be punished with imprisonment of seven to twenty years and fined of fourteen thousand to forty thousand Baht, or imprisonment for life.

If commission of the offense according to the first or second paragraph is committed by participation of persons in the nature for destroying a girl and such girl is not consent, or by carrying the gun or explosive, or by using the arms, the offender shall be punished with imprisonment for life.

The offense as provided in the first paragraph, if the offender being the man commits against the girl over thirteen years but not yet over fifteen years of age with her consent and the Court grants such man and girl to marry together afterward, the offender shall not be punished for such offense. If the Court grants them to marry together during the offender be still inflicted with the punishment, the Court shall release such offender."

มาตรา 277 ผู้ใดกระทำชำเราเด็กหญิงอายุยังไม่เกินสิบห้าปี ซึ่ง มิใช่ภริยาของตน โดยเด็กหญิงนั้นจะยินยอมหรือไม่ก็ตาม ต้องระวางโทษจำคุก ตั้งแต่สี่ปีถึงยี่สิบปี และปรับตั้งแต่แปดพันบาทถึงสี่หมื่นบาท

ถ้าการกระทำความผิดตามวรรคแรกเป็นการกระทำแก่เด็กหญิงอายุ ยังไม่เกินสิบสามปี ต้องระวางโทษจำคุกตั้งแต่เจ็ดปีถึงยี่สิบปี่ และปรับตั้งแต่หนึ่งหมื่นสี่พันบาทถึงสี่หมื่นบาท หรือจำคุกตลอด

ชีวิต ถ้าการกระทำความผิดตามวรรคแรกหรือวรรคสองได้กระทำโดยร่วมกระทำความผิดด้วยกันอันมีลักษณะเป็นการโทรมเด็กหญิงและเด็กหญิงนั้นไม่ยินยอม หรือได้กระทำโดยมีอาวุธปืนหรือวัตถุระเบิดหรือโดยใช้อาวุธ ต้องระวางจำโทษจำคุกตลอดชีวิต

ความผิดตามที่บัญญัติในวรรคแรก ถ้าเป็นการกระทำที่ชายกระทำ กับเด็กหญิงอายุกว่าสิบสามปี แต่ยังไม่เกินสิบห้าปี โดยเด็กหญิงนั้นยินยอม และภายหลังศาลอนุญาตให้ชายและเด็กหญิงนั้นสมรสกันผู้กระทำผิดไม่ต้องรับโทษศาลอนุญาตให้สมรสในระหว่างที่ผู้กระทำผิดกำลังรับโทษในความผิดนั้นอยู่ ให้ศาลปล่อยผู้กระทำความผิดนั้นไป

“Section 278.- Whoever, committing an indecent act to the person out of fifteen years of age by threatening with any means, by doing any act of violence, by taking advantage of that person to be in the condition of inability to resist, or by causing that person to mistake him for the other person, shall be imprisoned not out of ten years or fined not out of twenty thousand Baht, or both.

มาตรา 278 ผู้ใดกระทำอนาจารแก่บุคคลอายุกว่าสิบห้าปีโดยขู่เข็ญด้วยประการใดๆ โดยใช้กำลังประทุษร้าย โดยบุคคลนั้นอยู่ในภาวะที่ไม่สามารถ ขัดขืนได้หรือโดยทำให้บุคคลนั้นเข้าใจผิดว่าตนเป็นบุคคลอื่น ต้องระวางโทษจำคุกไม่เกินสิบปี หรือปรับไม่เกินสองหมื่นบาท หรือทั้งจำทั้งปรับ

“Section 279.- Whoever, commits an indecent act on a child not yet over fifteen years of age, whether such child consent or not, shall be punished with imprisonment not exceeding ten years or fined not exceeding twenty thousand Baht, or both.

If the commission of the offense according to the first paragraph, the offender commits it by threatening by any means whatever, by doing any act of violence, by taking advantage of such child being in the condition of inability to resist, or by causing such child to mistake him for another person, the offender shall be punished with imprisonment not exceeding fifteen years or fined not exceeding thirty thousand Baht, or both.”

มาตรา 279 ผู้ใดกระทำอนาจารแก่เด็กอายุยังไม่เกินสิบห้าปี โดยเด็กนั้นจะยินยอมหรือไม่ก็ตาม ต้องระวางโทษจำคุกไม่เกินสิบปี หรือปรับไม่เกินสองหมื่นบาท หรือทั้งจำทั้งปรับ .....ถ้าการกระทำความผิดตามวรรคแรก ผู้กระทำได้กระทำโดยขู่เข็ญด้วยประการใดๆ โดยใช้กำลังประทุษร้าย โดยเด็กนั้นอยู่ในภาวะที่ไม่สามารถขัดขืนหรือโดยทำให้เด็กนั้นเข้าใจผิดคิดว่าเป็นบุคคลอื่น ต้องระวางโทษ จำคุกไม่เกินสิบห้าปี หรือปรับไม่เกินสามหมื่นบาท หรือทั้งจำทั้งปรับ

“Section 280.- If the commission of offence according to the Section 278 0r Section 279 causes:

(1) grievous bodily harm to the victim, the offender shall be punished with imprisonment of five years to twenty years and fined of ten thousand Baht;

(2) death to the victim, the offender shall be punished with death or imprisonment for life.”

มาตรา 280 ถ้าการกระทำความผิดตามมาตรา 278 หรือมาตรา 279 เป็นเหตุให้ผู้ถูกกระทำ
(1) รับอันตรายสาหัส ผู้กระทำต้องระวางโทษประหารชีวิตหรือจำคุก ตลอดชีวิต
(2) ถึงแก่ความตาม ผู้ผู้กระทำต้องระวางโทษประหารชีวิตหรือจำคุก ตลอดชีวิต
มาตรา 280 แก้ไขเพิ่มเติมโดยพระราชบัญญัติแก้ไขเพิ่มเติมประมวลกฎหมายอาญา (ฉบับที่ 5) พ.ศ. 2525

“Section 281.- The commission of offence according to the paragraph 1 of Section 276 and Section 278, if not to occur in the public, not to cause the grievous bodily harm or death to the victim, not commit against the person as specified in this Section, it shall be the compoundable offence.”

มาตรา 281 การกระทำความผิดตามมาตรา 276 วรรคแรก และมาตรา 278 นั้น .....ถ้ามิได้เกิดต่อหน้าธารกำนัล ไม่เป็นเหตุให้ผู้ถูกกระทำ รับอันตรายสาหัสหรือถึงแก่ความตาย....หรือมิได้เป็นการกระทำแก่บุคคลดังระบุไว้ในมาตรา 285 เป็นความผิดอันยอมความได้

“Section 282.- Whoever, in order to gratify the sexual desire of another person, procures, seduces or take away for indecent act the man or woman with his or her consent, shall be punished with imprisonment of one to ten years and fined of two thousand to twenty thousand Baht.

If the commission of the offence according to the first paragraph is occurred to the person over fifteen years but not yet over eighteen years of age, the offender shall be punished with imprisonment of three to fifteen years and fined of six thousand to thirty thousand Baht.

If the commission of the offence according to the first paragraph is occurred to the child not yet over fifteen years of age, the offender shall be punished with imprisonment of five to twenty years and fined of ten thousand to forty thousand Baht.

Whoever, in order to gratify the sexual desire of another person, obtains the person who is procured, seduced or taken away according to the first, second or third paragraph or supports in such commission of offence, shall be liable to the punishment as provided in the first, second or third paragraph, as the case may be.”

มาตรา 282 ผู้ใดเพื่อสนองความใคร่ของผู้อื่น เป็นธุระจัดหา ล่อไป หรือพาไปเพื่อการอนาจาร ซึ่งชายหรือหญิง ด้วยความยินยอม ต้องระวางโทษจำคุกตั้งแต่หนึ่งถึงสิบปี และปรับตั้งแต่หกพันบาทถึงสามหมื่นบาท

ถ้าการกระทำตามวรรคแรกเป็นการกระทำแก่บุคคลอายุไม่เกินสิบห้าปี ผู้กระทำต้องระวางโทษจำคุกตั้งแต่ห้าปีถึงยี่สิบปี และปรับตั้งแต่หนึ่งหมื่นบาทถึงสี่หมื่นบาท

ผู้ใดเพื่อสนองความใคร่ของผู้อื่น รับตัวบุคคลซึ่งมีผู้จัดหา ล่อไปหรือพาไปตามวรรคแรกหรือวรรคสอง หรือวรรคสาม หรือสนับสนุนการการะทำ ความผิดดังกล่าว ต้องระวางจำโทษตามที่บัญญัติไว้ในวรรคแรก วรรคสอง หรือวรรคสาม แล้วแต่กรณี

“Section 277” amended by Section 3 of the Act Amending the Criminal Code (No.8) B. E. 2530. (มาตรา 277 แก้ไขครั้งสุดท้ายโดย มาตรา 3 แห่ง พ.ร.บ. แก้ไขเพิ่มเติม ป.อาญา (ฉบับที่ 8) พ.ศ 2530)
“Section 278 and Section 279” amended by Section 4 of the Act Amending the Criminal Code (No.8) B. E. 2530. (มาตรา 278 และมาตรา 279 แก้ไขครั้งสุดท้ายโดย มาตรา 4 แห่ง พ.ร.บ. แก้ไขเพิ่มเติม ป.อาญา (ฉบับที่ 8) พ.ศ 2530)

“Section 280” amended by Section 3 of the Act Amending the Criminal Code (No.5) B. E. 2525. (มาตรา 280 แก้ไขครั้งสุดท้ายโดย มาตรา 3 แห่ง พ.ร.บ. แก้ไขเพิ่มเติม ป.อาญา (ฉบับที่ 5) พ.ศ 2525)

“Section 281” amended by the article 9 of the Decree (No. 11) of the National Executive Council in B. E. 2514. (มาตรา 281 แก้ไขครั้งสุดท้าย ฉบับที่ 9 โดย มาตรา 11 พระราชกฤษฎีกา พ.ศ. 2514)

“Section 282” amended by Section 4 of the Act Amending the Criminal Code (No.8) B. E. 2530. (มาตรา 282 แก้ไขครั้งสุดท้ายโดย มาตรา 4 แห่ง พ.ร.บ. แก้ไขเพิ่มเติม ป.อาญา (ฉบับที่ 8) พ.ศ 2530)

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