THE EFFECT OF NURSING CARE PROGRAM BASED ON SWANSON'S CARING THEORY ON GRIEF OF WOMEN WITH SPONTANEOUS ABORTION

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ABSTRACT

The present study was quasi-experimental research (Pretest-Posttest design with nonequivalent group) which examined the effects of a nursing care program that aimed to reduce the grief of women with spontaneous abortions. This program was based on Swanson's Caring Theory. The study sample consisted of 60 women who had had a spontaneous abortion and were admitted at Siriraj Hospital based on the inclusion criteria. The subjects were divided into control and experimental groups, 30 women in each group. The subjects in the control group received only routine nursing care, whereas those in the experimental group received the nursing care program based on Swanson's Caring Theory coupled with routine nursing care. Data were collected using a demographic characteristics questionnaire, a perinatal grief scale, and an anecdotal record. Data were then analyzed by means of descriptive statistics, Chi-square test, t-test, and Repeated-Measures ANOVA.

The findings of the study revealed that the mean scores of the experimental group concerning grief were significantly lower than those of the women in the control group who received only routine nursing care ($p < .001$). These scores were obtained before discharge and two-weeks after the end of the experiment. Also, the mean scores of grief of the subjects in the experimental group obtained before discharge and two-weeks after the end of the experiment examination were significantly lower than that obtained before the experiment ($p < .001$).

The findings of this study suggest that a nursing care program based on Swanson's Caring Theory could be provided to women with spontaneous abortions in order to help them through the grieving process freedom abnormal grief.

KEY WORDS: NURSING CARE PROGRAM / SWANSON'S CARING THEORY / GRIEF / WOMEN WITH SPONTANEOUS ABORTION

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ผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง

THE EFFECT OF NURSING CARE PROGRAM BASED ON SWANSON'S CARING THEORY ON GRIEF OF WOMEN WITH SPONTANEOUS ABORTION

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บทคัดย่อ

การศึกษาครั้งนี้เป็นการวิจัยกึ่งทดลองแบบศึกษาสองกลุ่มที่ไม่เท่ากันวัดก่อนและหลังการทดลอง เพื่อศึกษาผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง กลุ่มตัวอย่างเป็นผู้หญิงที่สูญเสียบุตรจากการแท้งเองซึ่งรับไว้รักษาในโรงพยาบาลศิริราช เลือกกลุ่มตัวอย่างจากผู้ที่มีคุณสมบัติตามเกณฑ์ที่กำหนด จำนวนทั้งหมด 60 ราย แบ่งเป็นกลุ่มควบคุม 30 ราย และกลุ่มทดลอง 30 ราย โดยกลุ่มควบคุมได้รับการพยาบาลตามปกติจากพยาบาลประจำการ กลุ่มทดลองได้รับโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันร่วมกับการพยาบาลตามปกติจากพยาบาลประจำการ เก็บรวบรวมข้อมูลโดยใช้แบบสอบถามข้อมูลส่วนบุคคล แบบวัดความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง แบบบันทึกข้อมูลในการพยาบาล วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณา การทดสอบไคสแควร์ ค่าทดสอบทีและการวิเคราะห์ความแปรปรวนแบบวัดซ้ำ

ผลการวิจัยพบว่ากลุ่มทดลองมีคะแนนเฉลี่ยของความเศร้าโศกก่อนกลับบ้านและเมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์ลดต่ำลงมากกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติที่ระดับ $p<.001$ และกลุ่มทดลองมีคะแนนเฉลี่ยของความเศร้าโศกก่อนกลับบ้านและเมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์ลดต่ำลงมากกว่าก่อนได้รับการโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันอย่างมีนัยสำคัญทางสถิติที่ระดับ $p<.001$

ผลการวิจัยครั้งนี้มีข้อเสนอว่าพยาบาลควรนำโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันไปใช้ในการดูแลหญิงที่สูญเสียบุตรจากการแท้งเอง เพื่อช่วยลดความเศร้าโศกและเพื่อช่วยให้ผ่านกระบวนการเศร้าโศกไปได้ด้วยดีโดยไม่เกิดความเศร้าโศกที่ผิดปกติ.

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CHAPTER I

INTRODUCTION

Background and Significance of the Study

Generally, pregnancy brings joy and happiness to parents and other members of the family. Pregnant women are nurtured and cared for to enable them to carry on the pregnancy until term. The condition in which the pregnancy is end before full term or before the fetus is able to live outside the womb is termed spontaneous abortion. In Thailand, the incidence of spontaneous abortion accounts for 10 to 15% of the total pregnancies (Kampitak, 1999). Spontaneous abortion is seen as a loss of hope or imagination (Chomsopha & Mongkol, 1993). It is also considered a loss of part of the woman's being as well as the relationship that has developed since the pregnancy started. In general, spontaneous abortion greatly affects not only the pregnant women but also their family members who tend to believe that they are the ones to blame (Gilbert & Harmon, 1993). Middleton and Quirk (1990) conducted a study and found that pregnant women who suffered from a spontaneous abortion were likely to blame themselves for the loss and to be stricken with grief.

Grief is individuals' reaction to losses. It is a natural process which results from the loss of loved persons or things or loss of expectation or imagination. It is individuals's feelings which are unknown to others. Women who have lost their fetuses may be stricken with grief to a varying extent, and they may have emotional responses to grief such as being startled and shocked, and such reactions may last for a short period, or they may last for days or months. They may have different expressions or symptoms, including crying, anger, insomnia, obsession with the lost fetus, irritability, loss of appetite, etc. If their grief is not understandingly taken care of or responded to, the women's health or well-being may be adversely affected. Generally, grief is difficult to eliminate without proper help (Leppert & Pahlka, 1984). Grief is very prominent during the initial period after the loss, and it can continue for months

before it begins to subside (Swanson, 1999). The extent of grief depends on significance of what is lost and psychological attachment to what is lost. Individuals who have experienced losses and are able to adjust themselves have more chances to cope with their loss better than those who have never had such experience (Ellis & Nowis, 1994). In addition, factors regarding personality and readiness, as well as sources of social support and family, have an affect on the level of severity of grief. If individuals receive assistance and moral support from family, friends, and society, their reaction should not be too serious, and they should be enabled to adjust themselves (Piriyakhunthorn, 2001). Grief varies in terms of severity and expression depending on a number of factors such as feelings toward the loss, experience with loss, personality, readiness, and social support. Individuals who have gone through the process of loss have more chance to adjust themselves. On the contrary, if they are unable to overcome their grief, they will have to suffer from grief for a long period of time, which can affect their psychosocial well-being. For instance, they may suffer from guilt and depression, and their relationship with their spouse may be affected. This can lead to anxiety about pregnancy and avoidance of various behaviors to prevent more spontaneous abortion (Cote-Arsenault & Mahlangu, 1998). Also, if there are certain obstacles that disrupt the grief process, there may be a prolonged reaction or excessive symptoms which become bad experiences that will worsen subsequent losses in individuals' life, eventually resulting in a mental problem. According to Neugebauer et al. (1997), the rate of mental problems after spontaneous abortion is 10.9%, especially when individuals are unable to overcome their pain from the loss (Piriyakhunthorn, 2001). Therefore, women suffering from a spontaneous abortion need appropriate care as soon as the grief sets in so as to enable them to successfully undergo their grieving process and adjust themselves to accept the loss, hence reducing the incidence of mental problems that may subsequently set in.

Nguycharoen (1998) investigated grief and needs for care of women with a spontaneous abortion and found that the level of grief of these women was at a rather high level while their overall needs for care were at a moderate level. When considering each aspect, it was found that women with a spontaneous abortion had the needs for knowledge on self-care, respect as individuals, and comfort and safety at a high level, while their needs for relationship, psychosocial support, and spiritual

empowerment were at a moderate level. Also, it was discovered that grief was positively related to needs for care with statistical significance. These findings were consistent with the findings of Tunlert (2001) which showed that women who lost their fetus had a rather high level of grief. In addition, a study on grief in women with a spontaneous abortion conducted by Promanart (2004) revealed that 5.3% of these women had a high level of grief, 37.9% had a moderate level of grief, and 56.8% had a low level of grief. For this reason, it is deemed necessary that women with a spontaneous abortion receive nursing care physically, psychologically, emotionally, socially, and spiritually to maintain their balance and enable them to deal with their grief. A review of related literature and research has shown that there are few studies on nursing care to reduce grief of women with a spontaneous abortion. For instance, Pengkasukantho (2004) investigated the effectiveness of an adaptive educative-supportive nursing program used with women with a spontaneous abortion and found that the level of grief before hospital discharge of women with a spontaneous abortion who received the adaptive educative-supportive nursing program was lower than that of the women with a spontaneous abortion who did not receive such program with statistical significance. In a foreign context, Leppert and Pahlka (1984) have reported that provision of consultation to women with a spontaneous abortion could lessen their grief, especially their guilt. Besides, consultation is found to be effective to reduce psychological effects including fear and anxiety in mothers and fathers who have experienced a loss of their child (Wallerstedt, Lilley, & Baldwin, 2003), to reduce the level of grief in those who have experienced losses (Payne, Jarrett, Wiles, & Fields, 2002), and to enable those who have received consultation to more effectively undergo the grieving process when compared to those who have not received such consultation (Brown, 1992).

Based on the aforementioned discussion, it could be seen that grief of women with a spontaneous abortion is a crisis that adversely affects their health. Thus, women with a spontaneous abortion need to receive immediate care and assistance to help them restore or maintain their health status. The aims of care provided to women with grief from a spontaneous abortion are to offer them the opportunity to relieve their feelings and to support them to help them eliminate their grief, accept the truth, and return to society as fast as possible (Mahasitiwat & Sanseeha,1998). This can be done

through the establishment of professional relationship which is trusting and reliable to lessen their grief, promote their hope, stimulate participation in activities to prevent obsession with the loss, and to promote a good relationship between the grieving women and their husband and other family members, all of which should help prevent excessive grief and help them carry on daily living activities. However, in practice, it has been found that at present the care and assistance provided to women with a spontaneous abortion tend to focus on physical care to ensure their safety and prevent hemorrhage, as well as to reduce duration of hospitalization. As such, women with a spontaneous abortion who do not suffer from any complications tend to be cared for during a brief hospital stay of one to two days only. The psychological care they receive, as a result, varies considerably depending on the personal experiences and skills of the nurses. Also, no specific care, such as consultation, is not provided in most cases, and the care provided is not comprehensive. Therefore, it can be said that no holistic nursing care is currently offered to women suffering from a spontaneous abortion, and the psychological care provided did not cover all patients with spontaneous abortion, hence a lack of truly holistic nursing care for these patients.

As previously discussed, psychosocial care, which includes spiritual empowerment and consultation, can help women with a spontaneous abortion lessen their grief. This is a direct response to the psychological needs of women with a spontaneous abortion. According to Swanson's Caring Theory (Swanson, 1991), which was selected by the researcher as a basis for the development and implementation of the nursing care program, care needs to be provided in five aspects as follows: maintaining belief, knowing, being with, doing for, and enabling. Simply put, Swanson's Caring Theory covers physical, psychological, emotional, social, and spiritual care. Therefore, it is considered a truly holistic nursing care which enabled women with spontaneous abortion understand the causes of the abortion, as well as the feelings of their own grief caused by their loss, and helped them search for ways to recover psychologically and for moral support from family members. This could enable women with spontaneous abortion to lessen various feelings caused by grief such as guilt and sense of worthlessness. It also supported women with spontaneous abortion by leading them to a belief that they were still able to become pregnant again after they had successfully adjusted their mental and psychological conditions, and

that they should seek for appropriate care from the healthcare team members as soon as they learned that they were pregnant again to ensure that they received advice on appropriate self-care. For this reason, the researcher was interested in studying the nursing guidelines to reduce grief of women with a spontaneous abortion based on the Caring Theory proposed by Swanson, which emphasizes holistic care involving interaction with the patients, appropriate release and expression of grief, self-understanding, understanding of the grieving process, and overcome the grief. When offering such care, women with a spontaneous abortion would receive physical care while they are still unable to help themselves and perform self-care while receiving emotional support from caregivers and family members to maintain their self-worth. It was anticipated that the nursing outcomes would help lessen grief of women with a spontaneous abortion and enable them to adjust themselves to the grief they are facing. Furthermore, it was expected that the findings of the present study would provide a guideline for nursing care practice to more effectively promote physical recovery, enhance adjustment, and reduce grief of women with a spontaneous abortion.

Research Question

Do women with a spontaneous abortion who receive a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care have less grief than women with a spontaneous abortion who receive only routine nursing care?

Purpose of the study

1. To compare the level of grief of women with spontaneous abortions who receive a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care and the level of grief of women with a spontaneous abortions who receive only routine nursing care before and after the experiment.

2. To compare the levels of grief of women with spontaneous abortions who receive a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care before and after the experiment.

Research Hypotheses

1. The mean scores of grief of women with spontaneous abortions who receive a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of women with a spontaneous abortions who receive only routine nursing care after the experiment.

2. The mean scores of grief of women with spontaneous abortions obtained after receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that obtained before receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care.

Conceptual Framework

Spontaneous abortion is an event that pregnant women do not expect or intend to have. It does not occur by choice, and it is not pregnant women's fault. Having a spontaneous abortion and being hospitalized are changes that affect the identity of women with a spontaneous abortion and their maternal role, so they are stricken with grief. As a result, care needs to be offered to enable pregnant women with a spontaneous abortion to appropriately recover from the loss, lessen their grief, and help them adjust themselves to maintain balance in life. In the present study, Swanson (1991) Caring Theory was employed as a conceptual framework of the study. The Caring Theory as proposed by Swanson is composed of five caring processes, the first of which emphasizes the caregiver while the other four of which focus on care provided to recipients of care. These five caring processes consist of the following: **Maintaining belief** is a thinking foundation of caregivers who are confident in the care recipients' ability to undergo difficult situations or changes and to meaningfully encounter future events. **Knowing** enables caregivers to make use of different knowledge and skills to understand the meaning of the situations by avoiding assumptions in advance. The caregivers are perceived as the center who need to understand the individualism of care recipients which in this study was spontaneous abortion. **Being with** refers to caregivers devotion of time and provision of emotional support by showing the care recipients that they are willing to stand by them and share their happiness as well as their pain. **Doing for** means caregivers perform different

activities which care recipients are unable to do for themselves such as ensuring physical comfort, responding to different needs, etc., by making full use of skills needed in carrying out activities. **Enabling** refers to caregivers's assistance to enable care recipients to successfully undergo a transitional and unfamiliar situation. Caregivers are knowledgeable persons who utilize their knowledge and skills to help others with an aim to increase the capability of the care recipients to enable them to perform self-care and recover what they are suffering from. Support provided by caregivers also includes information and explanation which enables care recipients to understand the problems and find solutions appropriate for each situation. In other words, this aims at making pregnant women with a spontaneous abortion understand the meaning of the problems, solve their problems, and perform appropriate self-care, hence eventually leading to well-being in life.

Swanson's Caring Theory (1991) is illustrated in Figure 1 below.

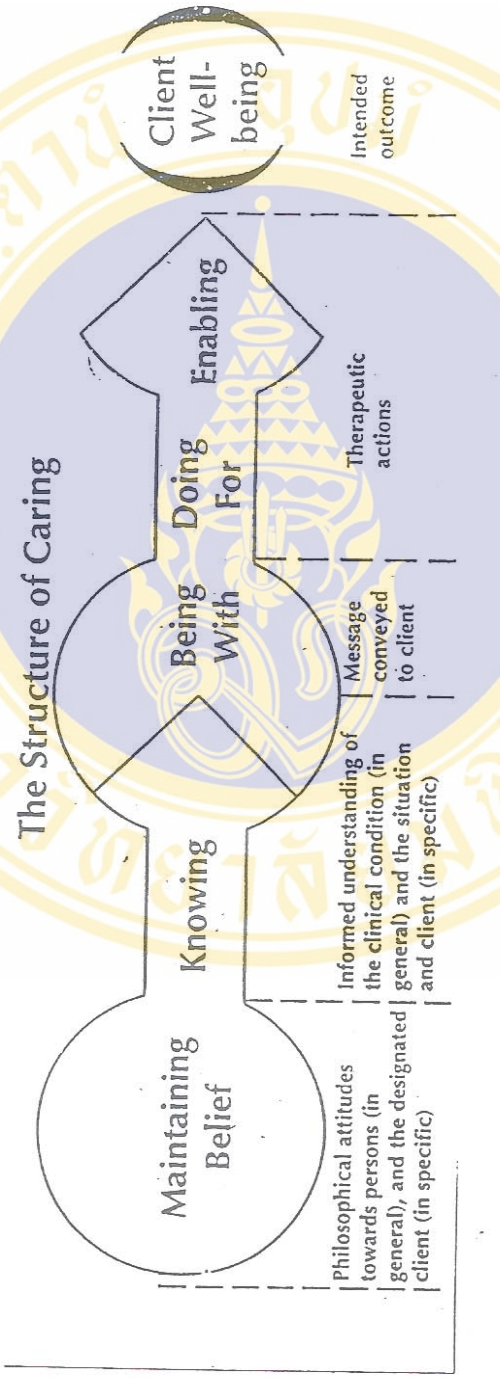

Figure 1: Swanson's Caring Theory (1991)

Five caring processes of Caring Theory proposed by Swanson (1991) were developed into a nursing care program which was divided into three phases—Phase 1: hospitalization, Phase 2: one week after hospital discharge, and Phase 3: two-weeks follow-up appointment. During each phase, nursing care provided to women with a spontaneous abortion was divided into three steps: initial nursing care, nursing care, and end of nursing care. It was anticipated that after the developed nursing care program was used, the grief of women with a spontaneous abortion would be lessened. The conceptual framework of the study was shown in Figure 2 below.

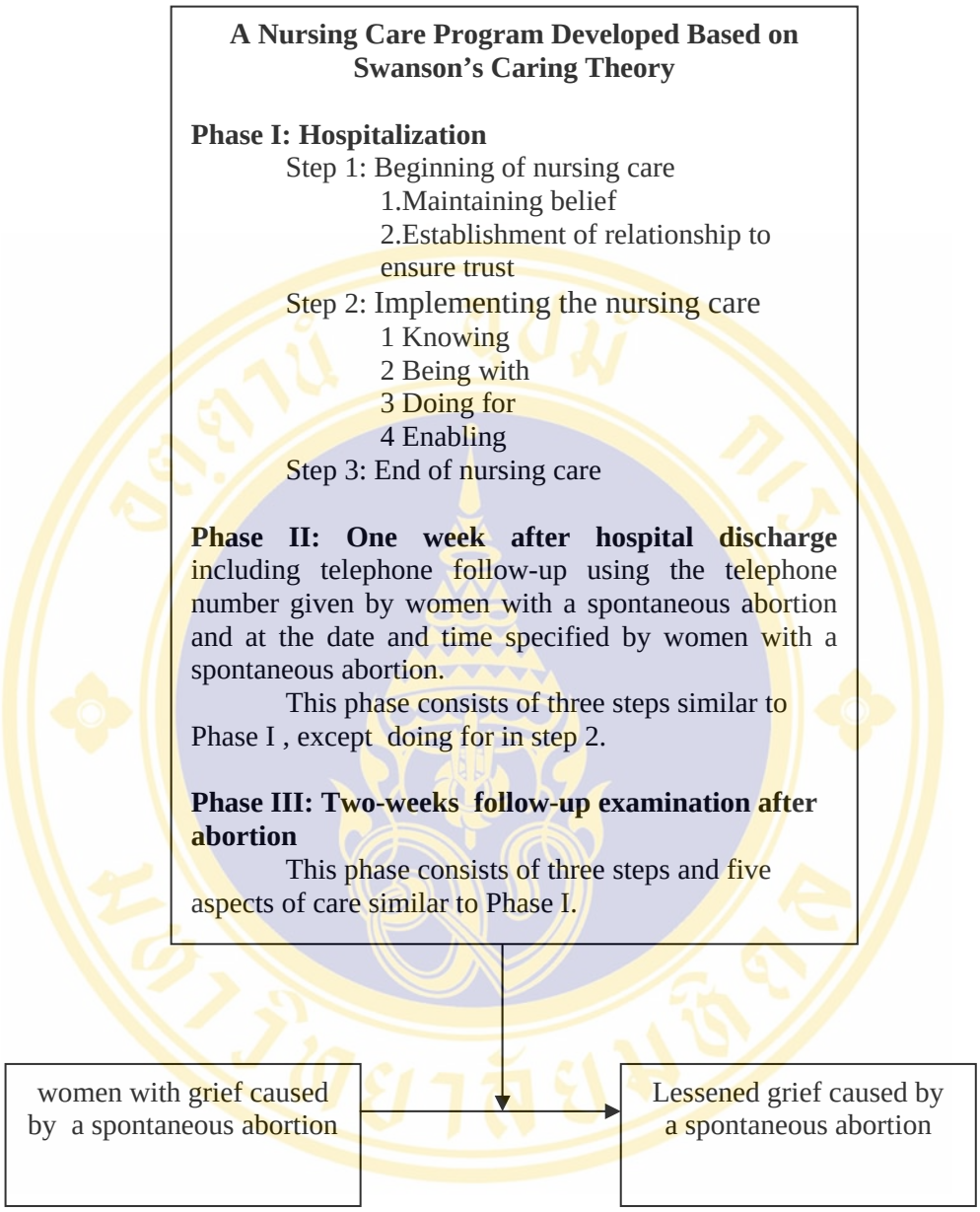

Figure 2: Conceptual Framework of the Study

Scope of the Study

The present study aimed at investigating the effects of a nursing care program developed based on Swanson's Caring Theory on the level of grief of pregnant women with spontaneous abortion. The subjects of the study were 60 pregnant women with spontaneous abortions who sought treatment at the 100th Years Somdech Phra Srinagarindra Ward 8/1 and 8/2, Siriraj Hospital, from January to July, 2008.

Definition of Terms

Grief referred to the behavioral reactions of pregnant women with spontaneous abortion which were expressed in their feelings, thoughts, physical symptoms, and behaviors. The feelings expressed by women with a spontaneous abortion included sadness, anger, guilt, self-accusation, loneliness, and longing for the lost fetus. The thinking expressions included obsessive thoughts about the lost fetus and confusion caused by disbelief in the spontaneous abortion. Physical symptoms included heartburn, choking feeling, shortness of breath, and muscle atrophy, and behavioral expressions included insomnia, loss of appetite, and social isolation. In the present study, grief of women with a spontaneous abortion was assessed using The Perinatal Grief Scale (PGS) developed by Toedter, Lasker, & Alhadef (1989) and adapted by Ngeicharoen (1998).

A nursing care program developed based on Swanson's Caring Theory referred to nursing care activities to respond to physical, psychological, emotional, social, and spiritual needs of women with spontaneous abortion. It was developed based on Swanson's Caring Theory which consisted of three nursing care phases as follows:

Phase 1: Hospitalization: Care was first provided to women with a spontaneous abortion when they participated in the study. , and it was continued on the following days until the women were discharged from the hospital. In cases they experienced complications and needed to be hospitalized for a long period of time, subsequent visits were made until they were finally discharged and returned home.

Phase II: One week after hospital discharge: The researcher conducted telephone follow-ups to pay women with a spontaneous abortion a visit using the

telephone number the women gave to the researcher. The calls were made on the date and time specified by the women.

Phase III: Two-weeks Follow-up Examination after abortion : Follow-up examinations were conducted two weeks after the spontaneous abortion occurred.

Each phase consisted of three-step nursing plans as follows:

Step 1: Beginning of nursing care consisting of the following:

1 Maintaining belief was the adjustment of the researcher's attitudes to develop confidence in the ability of women with a spontaneous abortion to undergo the grief process and to meaningfully face their future. This is considered an internal factor of the nurses who needed to have a positive attitude toward the patients before offering nursing care.

2 Establishment of relationship with women with a spontaneous abortion was conducted to ensure their trust in the researcher.

Step 2: Implementing the nursing care program to women with a spontaneous abortion according to the caring plan consisting of the following:

1 Knowing was conducted when the researcher attempted to understand the meaning of spontaneous abortion with the women with spontaneous abortion as the center.

2 Being with was a step in which the researcher offered emotional support to women with spontaneous abortion by offering to keep them company, asking questions to give them opportunity to release their feelings with no obstruction, and giving them the researcher's telephone number so that they could call the researcher anytime they had problems or needed advice.

3 Doing for was conducted when the research assisted women with spontaneous abortion in carrying out various activities in terms of happiness, comfort, safety, rest and relaxation, food intake, and cleanliness of the environment, as expected or as needed.

4 Enabling referred to assistance that offered to women with spontaneous abortion to help them regain their capability and functionality, recover from their condition, and perform appropriate self-care.

Step 3: End of nursing care involving summarizing daily nursing care given to women with a spontaneous abortion, the next appointment, or the termination of the nursing care.

Routine nursing care referred to nursing care practice which consisted of physical and psychological care given to women with a spontaneous abortion who were hospitalized at the 100th years Somdech Phra Srinagarindra Ward 8/1 and 8/2, Siriraj Hospital. In particular, nurses provided psychological care to comfort women with a spontaneous abortion based solely on their own experiences to help these women recover from their losses.

Expected Outcomes and Benefits

1. The findings of the present study could be used as a guideline in developing nursing care provided to women with spontaneous abortions.

2. The present study could also be utilized as a guideline for further research on nursing care to lessen grief in other groups of subjects.

CHAPTER II
LITERATURE REVIEW

The present study aimed at investigating the effects of a nursing care program developed based on Swanson's Caring Theory on grief of women with spontaneous abortions. In this chapter, related literature and research are reviewed in the following topics:

1. Spontaneous abortion
2. Grief of women with spontaneous abortion
3. A nursing care based on Swanson's Caring Theory
4. Effects of a nursing care based on Swanson's Caring Theory on grief

Spontaneous Abortion

Definition

Spontaneous abortion is defined as an unintended to end of pregnancy by any means before the fetus has grown enough to survive outside the uterus. In the United States, women with spontaneous abortion means an unintended to end of pregnancy before the gestational age of 20 weeks counted from the first day of the last menstruation or when the fetus weight less than 500 grams. In some European countries, as well as at Department of Obstetrics & Gynaecology, Faculty of Medicine Siriraj Hospital, abortion is an unintended termination of pregnancy when the infant weighs less than 1,000 grams or when the gestational age is less than 28 weeks (Chalermchockcharoenkit & Benjapibal, 2003). Spontaneous abortion refers to unintended to end of pregnancy of the pregnant women. It is considered a natural failure of pregnancy (Chalermchockcharoenkit & Benjapibal, 2003). It can be found in about 10 to 15% of all pregnancies (Kampitak, 1999). About 80% of abortion takes place within the first 12 weeks of pregnancy, and the most common cause of abortion is chromosomal abnormality. Other factors which can lead to abortion include

infections, chronic illnesses, hormonal abnormality, and malnutrition, among many others (Chalermchockcharoenkit & Benjapibal, 2003).

Type of abortion

1. Threatened abortion refers to the condition in which pregnant women experience vaginal bleeding during the initial period of pregnancy. The amount of bleeding may be small, but it may persist for days or weeks. Most of the pregnant women experience bleeding which is followed by an abdominal pain or a back pain. The treatment includes rest and pain medication. If the bleeding is excessive until it causes anemia or abnormality in blood coagulation , the doctor may have to terminate the pregnancy (Cunningham et al., 2001).

2. Inevitable abortion refers to the condition in which pregnant women experience vaginal bleeding together with leakage of amniotic fluid and pain in the lower abdomen. They also experience cervical dilation, which necessitates termination of pregnancy (Cunningham et al., 2001).

3. Incomplete abortion refers to the condition in which there is a discharge of tissues through the vagina, which is followed by vaginal bleeding. This can result in abnormal circulation as the remaining placenta in the vagina disrupts the contraction of the uterus, hence an immediate abortion is required (Cunningham et al., 2001).

4. Complete abortion refers to the condition in which the fetus, placenta, and membranes are discharged through the vagina. Pregnant women tend to suffer from severe abdominal pain and bleeding in the initial period, which subside after the discharge. An examination will reveal that the cervix is closed and the uterus is smaller than its usual size at that gestational age.

5. Missed abortion refers to the condition in which the fetus has been dead in the uterus for weeks without being discharged through the vagina. The pregnancy is initially normal, and after the death of the fetus there may or may not be any vaginal bleeding. The uterus will not become enlarged, or it may shrink. The weight will be slightly decreased. When the dead fetus remains in the uterus for a long time, it may cause abnormality in blood coagulation (Cunningham et al., 2001). In most cases, the dead fetus will eventually be discharged, but this may cause

psychological problems to the mothers, so induced abortion seems necessary (Chalermchockcharoenkit & Benjapibal, 2003).

6. Habitual abortion refers to the repeated occurrence of more than three spontaneous abortions in a row. Pregnant women who suffer from habitual abortion need to be examined to determine the exact cause of abortion—whether it results from the fetuses or the mother-so that appropriate treatment can be prescribed (Chalermchockcharoenkit & Benjapibal, 2003).

Causes of abortion

Causes of abortion may be related to the mother or the fetus as follows:

1. Maternal factors

1.1 Infection

1.2 Chronic diseases such as kidney disease, hypertension, etc.

1.3 Abnormality of the endocrine system such as diabetes mellitus

1.4 Malnutrition

1.5 Environment and substance abuse such as cigarettes, alcohol, coffee, and some types of medicines such as amphotericin, chemotherapy, oral contraceptive pills, radiation, and toxic environments including lead, formaldehyde, arsenic, benzene, and ethylene oxide, etc.

1.6 Abnormality of the immune system such as SLE

1.7 Too old sperm and egg before fertilization

1.8 Abdominal surgery

1.9 Severe accidents

1.10 Abnormality of the uterus such as a myoma uteri, uterine fascia, painless cervical dilation, etc.

2. Fetal factors

The fetal factors include abnormal growth of the fetus with abnormal numbers of chromosomes and abnormal chromosomes.

Effects of abortion

1. Physical effects

After abortion takes place, the body of the pregnant women will adjust itself to restore balance. The uterus will contract to close the ruptured blood vessels during abortion. This may result in slight vaginal pain and bleeding.

2. Psychological effects

When pregnant women suffer from abortion, they are likely to experience various psychological effects including the following (Athey & Spielvogel, 2000).

2.1 Anxiety : Pregnant women tend to put the blame on themselves for the loss and wonder what would have happened if they had been able to prevent abortion.

2.2 Grief : Grief is a normal reaction after a loss, which may be expressed in sadness, crying, and the need to talk to others about the loss and its meaning.

2.3 Depression : Depression may resemble grief as it is expressed through sadness, crying, loss of appetite, and insomnia, but depression also leads to sense of worthlessness and guilt. If depression is severe, women with spontaneous abortion may entertain a suicidal thought.

2.4 Trauma : Abortion is an unexpected event, so it leaves both physical and psychological wounds including nightmares, indifference, avoidance of thoughts or places that remind women with spontaneous abortion of memory about the lost fetus, sensitivity to stimulation, and excessive paranoia.

3. Effects on the family

When the loss from abortion takes place, the family of women with spontaneous abortion will also be affected including deteriorated relationships between husband and wife, accusation of the other spouse as the cause of abortion, fighting, and even separation. In terms of expression, the husband may express less grief or other feelings as they have to take care of both physical and psychological wellbeing of the wife, and possibly that of other family members such as the grandparents (Middleton & Quirk, 1990).

Based on the researcher's experience of providing care to women with spontaneous abortion, when the researcher asked these women about their feelings, most of them responded that they were sad and sorry and they wanted to talk to someone and learn about the cause of their abortion. They also cried as they missed the lost fetus. A study on grief and needs of care of women with spontaneous abortion conducted by Nguycharoen (1998) has revealed that women with spontaneous abortion had a rather high level of grief. Likewise, Tunlert (2001) found that women who lost their fetus had a rather high level of grief. A similar finding was also reported by Promanart (2004) that 5.3% of women with spontaneous abortion had a severe level of grief, while 37.9% had a moderate level of grief. For this reason, the researcher was interested in investigating the level of grief of women who experienced spontaneous abortion.

Grief of women with spontaneous abortion

The attachment between the pregnant women and their fetuses develops long before the fetuses were born. Thai society teaches women about the roles of wife and mother since they are young, and they develop attachment with the fetuses at the subconscious level by imagining of their wedding and pregnancy years before they actually take place. When they become pregnant, the attachment with the fetuses becomes stronger. Before they can detect the movement of the fetuses, pregnant women tend to think that the fetus is a part of them, but after they have felt the fetus moves, they tend to perceive the fetus as another individual. They begin to imagine about the fetus' face, appearance, and gender. They may even give it a nickname or plan for childcare. As a result, when pregnant women suffer from abortion, they will experience grief from loss of the child in their imagination (Kellner & Lake, 1993)

. **Definition of grief**

According to Gilbert and Harmon (1993), grief refers to human beings reaction to loss.

Todd and Baker (1998) define grief as individuals reaction to physical or psychological loss.

Watson (1985) defines grief as a natural reaction which takes place after a loss of something valuable, and it can even take place before the loss actually takes place, or anticipatory grief.

According to Chomsopha and Mongkol (1993), grief, mourning, or bereavement refers to a group of symptoms of sadness which result from a loss of a loved one.

Thus, it could be concluded that grief refers to individuals' reactions in response to their loss, which can be expressed in their feelings, thoughts, physical symptoms, and behaviors. The feelings expressed include sadness, anger, guilt, and self-accusation. They also feel lonely and miss their loss fetuses. As for cognitive expressions, these women with spontaneous abortions tend to be obsessed with the lost fetuses, and some are confused and in denial or disbelief that spontaneous abortion has already taken place. Moreover, they may have physical symptoms in response to grief caused by spontaneous abortions such as chest pain, choking feeling, shortness of breath, loss of muscle power, etc. Finally, their behavioral expressions include insomnia, loss of appetite, and social isolation. All of these may result from the death of a loved one, and it may take place before the loss actually occurs or anticipatory loss.

Phases of grief

Bowlby (1961 cited in Kellner & Lake, 1993) divides grief into four phases as follows:

1. Shock and disbelief: Individuals are in denial, which is mainly characterized by indifference, anxiety, and fear. The shock may last for a short period of time or weeks or even months.

2. Yearning, searching, and anxiety: Individuals feel that the world is empty and meaningless, and they keep thinking about the loved one they have lost. They also experience loneliness, insomnia, loss of energy, and anxiety, which are expressed through crying or anger. This phase may last months or years.

3. Disorganization, despair, and depression: Individuals are anxious, irritable, insomniac, and keep thinking about the memory of the loved one they lost.

4. Reorganization: Individuals reinvent their thinking process, pattern of thoughts, behaviors, and life goals. They are able to carry out daily living activities without feeling pressured. The grief begins to subside, and it is replaced with happy memories of the loved one they lost. The thought about the lost will be a normal thought.

Expression of grief

Ngamthipwattana (2000) divides expression of grief into four aspects as follows:

1. Feeling

The persons who experience a loss will express the following feelings:

Sadness: This is the most commonly found feeling. Individuals who suffer from a loss may cry or may not cry to express their sadness.

Anger: Anger is frequently found due to the feeling of inability to help the person they lost. Individuals may also feel angry toward the person they lost who left them alone in the world. Anger tends to lead to a lot of problems if it is left unattended to, and it may be expressed inappropriately such as self-accusation or putting a blame on the healthcare team.

Guilt: Guilt is also frequently found as individuals may feel that they did not pay enough attention to the health of the person they lost or they may have sent the person they lost to the hospital when it was already too late.

Anxiety: Anxiety may be normal anxiety, or it can be so severe that it becomes panic. Anxiety results from a concern about how individuals will continue living after losing the loved one. It is also possible that the death of a loved one makes individuals begin to think about their life and its uncertainty.

Loneliness: The feelings of fatigue, lifelessness, and helplessness can be found together with anxiety.

Missing: This is another common reaction after a loss. When this feeling subsides, it means that grief from a loss of a loved one has also ended.

Shock: This can take place as soon as individuals learn about the unexpected loss of a loved one.

Relief: This may result when individuals feel that the loved one has finally been freed from long years of suffering and pain caused by a sickness.

2. Thinking

The reactions in thinking and feeling tend to occur simultaneously. Frequently found reactions include disbelief that the loss has actually taken place, confusion, and obsession with the lost person. Individuals may feel that the spirit of the lost person is still around them, and they may suffer from hallucination which can be found during the first few weeks. If it does not persist, it is not considered a sign of a mental illness.

3. Physical symptoms

Frequently found physical symptoms are chest pain, choking feeling, being easily startled when hearing a noise, feeling that the environment or oneself has changed, shortness of breath, fatigue, loss of energy, and dry mouth and throat.

4. Behavioral symptoms

Individuals who suffer from a loss tend to undergo behavioral changes and changes in their daily living activities including insomnia, loss of appetite, and social isolation.

Task of mourning

Individuals who are able to overcome grief are those who are successful with the task of mourning. According to Worden (2002 cited in Wallerstredt, Lilley, & Baldwin, 2003), the task of mourning can be divided into four aspects:

1. Accept the reality of death: Women with spontaneous abortion still feel that that their baby is alive. Thus, caregivers need to help them accept the reality of loss by stimulating them to touch, hold, or look at the baby, name the dead baby, or organize the funeral for the baby.

2. Work through the pain of grief: Caregivers should support women with spontaneous abortion to have emotional expression and give them knowledge about the grieving process. Caregivers have to listen to them and correct their

misunderstanding, give information about the cause of death, and try to understand their beliefs.

3. Adjust to a new environment where the deceased in missing: Women with spontaneous abortion should receive support about their beliefs, but caregivers should give them information to change their feelings and beliefs and to enable them to accept that loss is part of life.

4. Emotionally relocate the deceased and move on with life: During this phase, women with spontaneous abortion still have memories about death, so caregivers should advise them to remember the deceased by writing a letter, writing poems, or making a donation, etc.

The duration of grief depends on different factors, and it is not possible to specify the time frame, but some researchers point out that the grieving period can last one to two years (Lindemann cited in Lucus & Pritchett, 1993).

Spontaneous abortion is an unintentional and unexpected event, and it brings profound pain to the mothers who have attachment to the fetus (Middleton & Quirk, 1990). Thus, the grieving process may not be as good as it should be, and this can put women with spontaneous abortion at risk of mental health problems including depression (Neugebauer et al., 1997). When women with spontaneous abortion are unable to adjust their mental condition to comply with the grieving process, they may have abnormal expression of grief.

Abnormal grief

Abnormal grief includes the following (Gilbert & Harmon, 1993):

1. Delayed and absent grief

1.1 Delayed grief

The delayed pain of grief slows down the grieving process, preventing it from beginning and ending. The reaction of delayed grief may result from mental mechanisms to overly avoid grief through denial and suppressed feelings. When this happens, individuals will not enter the grieving process, and when they are stimulated by a subsequent loss, they are likely to overreact.

1.2 Absent grief

Absent grief is similar to delayed grief, but there is no grief reaction and it takes longer.

2. Distorted grief

Distorted grief means excessive grief that is accompanied with other emotional problems including depression which prevent individuals from functioning. They may have panic which turns into paranoia, or they may become addicted to alcohol or other substances to heal their feelings.

3. Inhibited grief

Inhibited grief results from lack of acceptance of loss. Individuals tend to suppress their feelings, which are then expressed through physical symptoms or nagging, or changes in daily living behaviors including eating, sleeping, and doing activities.

Effects of grief on women with spontaneous abortion

The effects of grief on women with spontaneous abortion are as follows:

1. Effects on mental health

Studies have shown that women with spontaneous abortions are more likely to suffer from depression when compared to normal women (Neugebaure et al., 1997). Some experience intense guilt which leads to depression as they believe that they make their husband and family disappointed when they are unable to give birth to a healthy baby (Brier, 1999).

2. Effects on family relationship

Women with spontaneous abortion are more strongly attached to the fetus than the husband, and they are more likely to grieve more. This may be because society expects man to be stronger and not to show emotions. They may also be in different phases of grief, so the one who is grieving more intensely feel mad with the other who seems to grieve less. On the other hand, the one who grieves less undergoes the grieving process less than the other, hence confusion and lack of understanding of the other (Andosek, 1990).

3. Effects on the next pregnancy

Women with spontaneous abortion will have anxiety with the next pregnancy and try to avoid behaviors that may put them at risk of another abortion (Cote-Arsenault, 1998).

Even though grief after loss of a fetus can subside within one year without mental help or support, grief after the loss of a fetus can make mental health of the women worsened, especially during the first six months after the loss (Janseen, Cusinier, Hoogduin, & Graauw, 1996).

Factors affecting grief

The loss caused by spontaneous abortion causes a great deal of grief and pain to the women. In order to go through the grieving process, individuals need to depend on their ability and adjustment mechanisms. The factors affecting grief are as follows:

1. Age: Age is a factor that affects individuals' grief. Individuals of ages have different perceptions of and reactions to grief. Zeanah (1993) conducted a study and found that there was a relationship between the mothers' age and grief because younger mothers had fewer problem-solving mechanisms than older mothers. Furthermore, mothers who are younger are more likely to have more grief and physical and psychological symptoms than those who are older (Steen, 1998). However, Tunlert (2001) found that age is positively associated with grief.

2. Education: Education is a factor which enables individuals to develop their learning systematically and to have more opportunity to search for knowledge. However, study findings are contradictory as sometimes there is no relationship between education and grief of mothers (Neugebauer, 1997) or it is negatively related to grief (Jultanmas, 2002).

3. Gestational age: Peppers and Knapp (1990 cited in Toedter et al., 1988) conducted a study with mothers with spontaneous abortion, stillborn, and newborn mortality and found that these mothers had a similar level of grief. However, Toedter et al. (1988) found that there is a positive relationship between gestational age and severity of grief. Likewise, Jultanmas (2002) found that gestational age is positively related to severity of grief.

4. Previous experience with loss: Loss experience may have an influence on reactions to loss. If the previous loss was not taken care of or dealt with, it may make it more difficult for mothers to undergo the grieving process (Kennell et al., 1970). However, Tunlert (2001) found that experience with previous loss is not associated with reaction to loss of mothers who lost their fetus.

5. Need to have a baby: Graham et al. (1987) found that the need to have a baby is not related to grief. Similarly, Tunlert (2001) also discovered that the need for a baby is not associated with grief of mothers who lost their infants.

Assessment of grief from spontaneous abortion

When experiencing loss, individuals have to adjust themselves by going through the grieving process, during which grief can be assessed in different ways such as observation of expression of different feelings, physical expressions, thinking, behavioral expressions. Also, grief can be assessed through the grief assessment scale.

A structural development of an instrument to assess grief began in 1970 when Kennel, Styler, and Klaus developed The Perinatal Bereavement Scale which assessed six aspects of women who lost their fetus. After that, Toedter, Lasker, and Alhadeff (1988) constructed the Perinatal Grief Scale from a study of grief of women with abortion, stillborn, infant mortality within 27 days after birth, and myopic pregnancy, with the items developed based on The Expanded Texas Grief Inventory (Zisook, Devaul, & Click, 1982) and the Perinatal Grief Scale designed by Kennel, Styler, and Klaus (1989). This instrument was then revised, with the total number of items reduced to 33 items, and it has been widely used to assess grief of mothers who lost their fetus or infant.

In the present study, the Perinatal Grief Scale (PGS) developed by Toedter, Lasker, and Alhadeff (1989) and translated into the Thai language by Ngeoicharoen was used. In the Thai version, some of the original items were omitted, while additional items related to frequently found symptoms almost immediately after the abortion were added. Some of the original items were also revised to make them better suit the Thai cultural context. The total number of items in the PGS is 28.

Grief from loss of a fetus affects individuals' feelings, physical symptoms, ideas, and behaviors. Thus, nurses need to provide care that covers individuals' both

physical and psychological wellbeing so as to enable them to adjust themselves to the loss until they are able to accept the loss and undergo the grieving process while preventing abnormal grief.

Ways to help those with grief

There are a number of studies which propose ways to care for individuals who are suffering from grief caused by a loss in life.

First, Gilbert and Harmon (1993) apply the ten principles in offering consultancy to prevent abnormal grief. They are as follows: helping individuals to accept the reality of grief, giving meaning to normal behaviors, accepting differences in expression of grief, giving time to deal with grief, assessing mechanisms to prevent and solve problems, enabling individuals with grief to live without the deceased, offering emotional assistance, enabling individuals to express their feelings toward grief, providing continuous care, and monitoring for abnormal grief for medical referrals.

According to Kellner and Lake (1993), assistance needs to be provided to women with loss to enable them to carry out the grief work. They need to accept pain caused by death and free themselves from former attachment. They also need to adjust themselves to a new environment and create a new relationship with others. The individuals who play a role in offering care to these women are healthcare team members, family members, friends, and society who offer them emotional support.

Fulton and Metress (1995) point out that provision of assistance to those with grief can be done as follows:

1. Don’t rush someone through grief which may take weeks, months, or years
2. Don’t trivialize someone’s grief
3. Make your support available especially beyond the funeral period
4. Allow the deceased to be important during the grieving by supporting individuals to remember the deceased
5. Give permission to grieve and allowing grieving individuals to express their grief through talks
6. Help the bereaved deal with any guilt or anger
7. Realizing the importance of obsessive

8. Remember that grief is highly individual

9. Help the bereaved to get on with living, to form new relationships

Davis, Stewart, and Harmon (1988) assert that in order to help individuals with grief, emotional support needs to be given to let individuals with a loss realize that they have to accept the birth and death of the infant. They should also be enabled to search for feelings of loss and despair, and they should also learn about grief and easy options available to them.

Watson (1985) points out that nurses can play a major role in individuals' stressful periods in life such as when they encounter changes, conflicts, losses, etc. Nursing care is an art and science that enables nurses to respond to individuals' need for holistic nursing care.

A nursing care based on Swanson's Caring Theory

Swanson's Caring Theory has been developed from three qualitative research studies as follows:

1. A study of caring behaviors which could help women with spontaneous abortion. The study was conducted by means of an interview of 20 women with spontaneous abortions which led to five aspects of the caring process.

2. A study of behaviors of 19 caregivers in the neonatal intensive care unit consisting of one administrative nurse, one medical ethicist, one social worker, five mothers, two fathers, four physicians, and five practical nurses. The study was conducted by means of an observation and an interview, and the findings led to five aspects of the caring process.

3. A study of the relationship between nurses and eight teenage mothers with social risks in self-care and childcare which also led to five aspects of the caring process.

After that, the five aspects of the caring process were summarized into the middle-level of care, which can be explained as follows:

1. Maintaining belief : This is the basic thought of caregivers in confidence in the ability of the care recipients to undergo different events or changes and to cope with future events meaningfully. This is an internal factor in the nurses who need to have positive attitudes toward patients before offering nursing care.

2. Knowing : Caregivers are trying to understand the meaning of the events that have taken place with the care recipients. Caregivers need to avoid formulating hypotheses beforehand, hold the patients as the center of attention, avoid leading, and have understanding of individuality of the care recipients.

3. Being with : Caregivers make care recipients realize the emotional support provided to them by keeping them company and sharing both happiness and pain. Expressing and sharing feelings is the duty that needs to be fulfilled constantly, and it must not cause sufferings to the care recipients. Being with is more than merely understanding individuals' symptoms, but it includes appropriate expression of emotions toward individuals.

4. Doing for : Caregivers help individuals carry out activities that they are unable to do by themselves and ensuring comfort and responses to different needs fully making use of different skills.

5. Enabling : This means helping care recipients overcome the incident which results in changes and unfamiliarity. Caregivers are individuals who use knowledge and skills in helping others with an aim to increase the ability of the care recipients to take care of themselves and recover from the sickness. Enabling also refers to provision of information and explanation which makes care recipients understand problems and options for different situations.

Women with spontaneous abortion want caregivers to understand what loss means to them. Caregivers have to provide care according to their context of loss. Knowing means caregivers' intention to understand the meaning of abortion without prior meaning given to the situation by caregivers. Being with means caregivers truly understand the feelings and emotions of women with spontaneous abortion , but they do not have to feel as much as the women with spontaneous abortion do. Being with can be done with an intention to see women with spontaneous abortion overcome this experience and carry out various activities they used to be able to do by themselves, with both physical and mental strength. Women with spontaneous abortion or care recipients need to receive care from experts who are skillful and know how to appropriately enable care recipients to go through the grief process. They can assure women with spontaneous abortion that negative feelings or grief after abortion is considered a normal condition. In addition, the feelings of the husband need to be

taken care of as well. They need others to believe in their ability to overcome the loss successfully as well as their ability to become pregnant again and give birth.

It can be seen that Swanson's Caring Theory consists of physical, psychological, emotional, and social care. It promotes understanding of loss and grief, as well as supports expression of loss to overcome it. This begins with the establishment of relationship between caregivers and care recipients as well as the intention of caregivers to provide informed care to care recipients without using caregivers' ideas to judge the feedings of care recipients.

Effects of a nursing care based on Swanson's Caring Theory on Grief

Swanson's Caring Theory is a holistic care which emphasizes physical care of doing for and physiological care of knowing, which is an understanding of the meaning of loss of women with spontaneous abortion. Furthermore, being with is emotional support including both happiness and pain, while enabling is aimed at helping women with spontaneous abortion to overcome the grieving process by offering information, explanation, support, and advice to enable women with spontaneous abortion to release their feelings, which is similar to counseling which aims at expressing existing feelings or problems, allowing care recipients to make decision and solve problems by themselves with caregivers stimulate them to develop self-understanding and search for appropriate solutions. As for grieving women with spontaneous abortion , they should receive advice from nurses (Redman, 2003) because after experiencing grief caused by abortion, these women will have emotional pain and require assistance from experts to overcome the grief process (Herkes, 2002). Giving women with spontaneous abortion a chance to express their feelings can help reduce the impacts that may follow such as guilt or negative effects on marital relationship (Leppert & Pahlka, 1984) to improve mental health condition (Dowling, Hubert, White, & Hollins, 2006).

In Thailand, Pengkasukuntho (2004) investigated the effects of a supportive nursing care program with adjustment to grief in women with spontaneous abortion and found that nursing activities based on the nursing supportive program could reduce grief of women with spontaneous abortion before hospital discharge. This means that nursing activities carried out for women with spontaneous abortion can

reduce grief and other effects. Therefore, a theory of caring which involves physical, psychological, emotional, and social care should be studied to determine its effects on nursing care so as to ensure appropriate care for women with spontaneous abortion . The details of the nursing care program developed based on Swanson's theory of care are as follows:

The nursing care program based on Swanson's Caring Theory consisted of five domains of care with an emphasis on responses to individuals' physical, mental, emotional, social, and spiritual conditions. It also involved provision of information related to spontaneous abortion and self-care practice after spontaneous abortion. The researcher implemented the nursing care program with the women with spontaneous abortion in the experimental group in the following three phases:

Phase 1: During hospitalization: The researcher gave care to women with spontaneous abortion as soon as they participated in the study, after they were admitted into the 100th years Somdech Phra Srinagarindra Ward 8/1. The follow-up visit was conducted on the following day, and the care continued until these women were discharged from the hospital. If the women had complications or had to be hospitalized for a longer period of time, the researcher visited them and gave care to them until they were able to return home.

Phase 2: One week after hospital discharge: The researcher made telephone calls to the numbers given by the women with spontaneous abortion on the day and at the time that were previously agreed upon by the researcher and the women with spontaneous abortion.

Phase 3: Two-weeks follow-up examination: The researcher met the women with spontaneous abortion on the day they came to the hospital for follow-up examinations after spontaneous abortion.

The nursing care provided in each phase could be divided into three stages as follows:

Stage 1: Beginning the nursing care program as follows:

1 Maintaining belief: In this stage, the researcher adjusted her attitudes of the researcher to develop confidence that women with spontaneous abortion were able to undergo the process of grief and meaningfully face their future. This was

considered an internal factor of the nurses who needed to have positive attitudes toward the patients before nursing care could be offered to them.

2 Establishing relationships: The researcher established relationships with women with spontaneous abortion to ensure their trust in the researcher.

Stage 2: Implementing the nursing care program including the following:

1 Knowing: The researcher tried to understand the meaning of loss of the fetus due to spontaneous abortion with the women with spontaneous abortion as the center of nursing care. The researcher talked to the women and used questions to ask them about the meaning of their current loss. The researcher also used observation skills to observe the gestures and body language of spontaneous abortion during the talks in an attempt to better understand them.

2 Being with: The researcher provided emotional assistance to women with spontaneous abortion by offering to keep them company, using questions to make them freely release their feelings caused by loss of their fetuses, and giving them the researcher's telephone number that they could call anytime they had a problem or wanted advice.

3 Doing for: The researcher did various activities for women with spontaneous abortion, skillfully and to the best of the researcher's ability, regarding their comfort, safety, rest, food intake, and cleanliness of the environment, as expected and as needed by them.

4 Enabling: The researcher helped women with spontaneous abortion overcome the situation, ensured their rehabilitation, and enabled them to recover and regain their ability to appropriately take care of themselves, which could be divided into three aspects as follows:

4.1 The researcher supported and helped women with spontaneous abortion cope with their problems by asking them questions to stimulate them to accept their loss and understand the grieving process. The researcher assessed which stage of grief the women were in and provided the assistance according to their symptoms in each stage as follows:

The stage of shock and disbelief: The women were in denial. They were characterized by indifference, anxiety, fear, and disbelief in the loss that had already taken place.

Provision of nursing care: The researcher made sure that the women with spontaneous abortion had privacy and separated from mothers who had their infants with them to prevent further sadness and to give them opportunity to fully and freely express their feelings. The researcher listened to them attentively without arguing with them but without supporting or promoting their denial.

The stage of yearning, searching, and anxiety: The women with spontaneous abortion felt that the world was empty and meaningless. They were characterized by constant thought about the lost fetus. They also felt lonely and suffered from insomnia, loss of energy, and listlessness, which were expressed through their crying and anger.

Provision of nursing care: The researcher encouraged the women with spontaneous abortion to have behavioral expressions without obstructing them such as crying and being angry by accepting that these reactions reflected their loss. The researcher refrained from showing any negative reactions. Instead, the researcher listened to the women with spontaneous abortion quietly and later on explained that these behaviors were normal and commonly found expressions of grief.

The stage of disorganization, despair, and depression: The symptoms of women with spontaneous abortion become clearer. They were characterized by restlessness, irritability, insomnia, and obsessive thoughts and memories of the loss fetus.

Provision of nursing care: The researcher stimulated women with spontaneous abortion to talked about the situations or the symptoms they were experiencing. The researcher listened to them attentively and did not try to intervene or change the subject of the talk. Also, the researcher did not rush women with spontaneous abortion to undergo the grieving process while ensuring that they were able to freely express their feelings without having to keep anything to themselves.

The stage of reorganization: Women with spontaneous abortion were finally able to develop new thinking processes, thinking patterns, behaviors, and goals in life. They were able to carry out daily living activities without feeling pressured. Their grief began to subside and was replaced with beautiful memories about the deceased. Their thinking of the deceased was also normal.

Provision of nursing care: The researcher made sure that women with spontaneous abortion were able to cope with and overcome their grief and reassured them that they were able to get pregnant again.

4.2 Information support: The researcher gave knowledge to women with spontaneous abortion regarding the process of grief, spontaneous abortion, and other information required by them.

4.3 Promotion of family's participation in care: The researcher encouraged family members to take part in giving care to women with spontaneous abortion by giving them knowledge about the process of grief, spontaneous abortion, and provision of care to women with spontaneous abortion.

Stage 3: Terminating the nursing care program as follows:

The researcher summarized the nursing care activities provided to women with spontaneous abortion on each day, made an appointment for the next visit, or terminated the nursing care.

In conclusion, the nursing care program developed based on Swanson's Caring Theory enables women with a spontaneous abortion to receive truly holistic nursing care which makes them able to understand the cause of their spontaneous abortion and their grief toward their loss of the fetus, and helps them search for ways to adjust their psychological condition to return to normal condition. The nursing care program also helps them locate sources of social support within the family, which enables them to lessen different feelings caused by their loss such as unreasonable guilt or inferiority. In addition, the program reassures them that they are able to become pregnant again after they have adjusted their psychological condition. They have a chance to learn that they need to seek appropriate care from the healthcare team as soon as they learn about their pregnancy to ensure suitable self-care practices. As a result, it is believed that the nursing care program developed based on Swanson's theory of care can help women with spontaneous abortion reduce and eventually overcome the grief caused by their loss of the fetus.

CHAPTER III
METHODOLOGY

The present study was quasi-experimental research (Pretest- Posttest design with nonequivalent group) which aimed at investigating the effects of a nursing care program based on Swanson's Caring Theory on level of grief of women with spontaneous abortions.

Population and Sample

The population of the study consisted of women with spontaneous abortion who older than 18 years old, gestational age was no more than 20 weeks, had no previous history of illegal abortion, intended to pregnancy and were admitted for treatment at the 100th years Somdech Phra Srinagarindra Ward 8/1 and 8/2, Siriraj Hospital .

The study sample was recruited by means of purposive sampling with the following inclusion criteria:

1. They did not have a history of mental illness.
2. They were able to communicate and did not have visual impairment.
3. They were willing to participate in the study and able to come to the follow-up appointment on the second week after the abortion.
4. They could be reached by telephone.
5. Their level of grief was at a moderate level of higher (the mean grief scores $\geq$ 2.50 points).
6. They did not have any medical illnesses such as SLE, diabetes mellitus, HIV infection, hypertension, or heart disease.

Calculation of Sample Size

The sample size was calculated by means of power analysis proposed by Polit & Beck (2004):

$$\gamma = \frac{\mu_1 - \mu_2}{\sigma}$$

γ = Effect size

μ_1 = mean of the control group

μ_2 = mean of the experimental group

σ = standard deviation

In a study on the effects of a nursing promotion program on grief of women with spontaneous abortion conducted by Pengkasukantho (2002), the formula was calculated as follows:

μ_1 = 77.67

μ_2 = 64.80

σ = 16.01

Thus, $\gamma = \frac{77.67 - 64.80}{16.01}$

γ = .80

After that, the calculation outcome was used in the table with the following specified values:

The significance criterion (α) = .05

Power ($1-\beta$) = .80

Therefore, the sample size of the subjects in the present study was equal to 25. To prevent subject loss, 20% of the sample size was added, and the final sample size was 30.

After the sample was obtained, they were then divided into two groups—the experimental group and the control group.

The control group consisted of those who received only routine nursing care from the nurses.

The experimental group received the nursing care based on Swanson's Caring Theory coupled with routine nursing care from the nurses.

Assignment of Subjects into the Experimental and Control Groups

As the subjects of the study were women with spontaneous abortion who sought medical services at Siriraj Hospital, data collection and participation in the study were carried out with one group of subjects until the data were collected from the desired number of subjects before moving on to the other group of subjects. In this study, assignment of subjects into the control group and experimental group was done as follows:

The control group: The subjects in the control group were women with spontaneous abortion who sought treatment at Siriraj Hospital and met the inclusion criteria previously set. Data were first collected from all 30 the subjects in the control group before they were collected from the subjects in the experimental group. This was done to prevent contamination of the data resulting from differences in nursing care given to the subjects in the control group and those in the experimental group, and it did not have affect nursing care or research ethics.

The experimental group: The subjects in this group were those with spontaneous abortion who sought treatment at Siriraj Hospital and met the inclusion criteria previously set. After data collection was completely carried out with the control subjects, data were collected from the experimental subjects until data were collected from 30 of them. When pregnant women who met the inclusion criteria came to seek treatment at Siriraj Hospital, those with similar characteristics would be paired (in accordance with the order of the pregnancy) as specified in the general information record forms of women with spontaneous abortion which had previously been collected.

Termination of Participation

The participation of the subjects could be terminated if the assessment of their mental condition showed that they were having a mental health problem

(Poomsrisawad, 2000). This could be observed from their appearances, talking, levels of consciousness, emotions, as well as the assessment of their thinking, perception, intellectual ability, and decision-making and problem-solving skills through talks. If any sign of abnormality was detected, a consultation with a gynecologist would be sought to assess their depression and a referral would then be made to a psychiatrist. In the present study, there was no woman with spontaneous abortion who also had any form of mental disorder.

Research Setting

Data were collected from the infectious postpartum ward (the 100th years Somdech Phra Srinagarindra Ward 8/1) and the infectious delivery room (the 100 th years Somdech Phra Srinagarindra Ward 8/2), the Obstetric and Gynaecological nursing division of the Faculty of Medicine, Mahidol University, which generally offers medical treatment and care to pregnant women who had a contagious disease or an infection, those with spontaneous abortions, pregnant and postpartum women with mental symptoms, pregnant women with hyperemesis gravidarum, and pregnant and postpartum women with substance abuse.

At the infection delivery room (the 100th years Somdech Phra Srinagarindra Ward 8/2), the nursing care provided to the women with spontaneous abortion included physical care before the abortion, care during abortion, and care within the first two hours after spontaneous abortion. The psychological care provided to these women depended on the nurses' professional experiences with no basis on nursing skills or nursing care theory.

At the infection postpartum ward (the 100 th years Somdech Phra Srinagarindra Ward 8/1), the nursing care provided to the mothers was mainly physical care. The psychological care provided to these women depended on the nurses' professional experiences with no basis on nursing skills or nursing care theory. The dissemination of knowledge about self-care practice after spontaneous abortion was done through a manual on spontaneous abortion until the patients were discharged from the hospital.

Research Instruments

In this study, the research instruments were divided into two parts: the research instruments and the data collection instruments, which could be explained as follows:

1. Research instruments were developed by the researcher to be used with the women with spontaneous abortion in the experimental group including the following:

1.1 Nursing care program: The nursing care program was developed based on the Swanson's Caring Theory which consisted of five aspects of care with an emphasis on physical, psychological, emotional, social, and spiritual responses together with dissemination of information on spontaneous abortion and self-care practice after spontaneous abortion. The researcher carried out the nursing care plan with the experimental subjects who were women with spontaneous abortion in the following three phases:

Phase 1: During hospitalization: The care began with the women with spontaneous abortion first participated in the study on the day they were move to 100th years Somdech Phra Srinagarindra Ward 8/1 It also included follow-up visits on the following day and provision of care until the women were discharged from the hospital. In cases the women suffered from complications and had to stay at the hospital for several days, the researcher would repeatedly pay them a visit until they were discharged.

Phase 2: One week after hospital discharge: Telephone calls were made according to the number, day, and time the women with spontaneous abortion informed the researcher.

Phase 3: Two-weeks follow-up examinations: This was when the women came back to the hospital for a follow-up examination about two weeks after the abortion took place.

Each phase of the nursing care was divided into three steps which covered all five aspects of care based on the concept proposed by Swanson as follows:

Step 1: Prior to nursing care provision

1 Maintaining belief: The researcher adjusted her confidence in women with spontaneous abortion who were able to go through their grief and meaningfully able to face the future. This was an internal factor in nurses who needed to have a positive attitude toward the patients before offering nursing care.

2 Establishing relationships: The researcher created a relationship with women with spontaneous abortion to ensure trust in the researcher.

Step 2: Implementing the nursing care

1 Knowing: The researcher tried to understand the meaning of spontaneous abortion by having the women with the loss as the center of care. The researcher used words and questions regarding spontaneous abortion and its meaning and also employed observation skills to ensure more understanding.

2 Being with: The researcher provided emotional support to women who lost their baby by offering to keep them company and using questions to let women with spontaneous abortion to freely express their feelings. The researcher also gave the researcher's telephone number that they could call anytime they had a problem

3 Doing for: The researcher did various activities for women with spontaneous abortion in terms of comfort, safety, rest, nutrition, cleanliness of the environment, and expectations and needs, skillfully and with fullest potential.

4 Enabling: The researcher helped women with spontaneous abortion to recover from their condition and appropriately take care of themselves in three areas as follows:

4.1 Enabling women with spontaneous abortion to cope with problems: The researcher used questions to stimulate women with spontaneous abortion to accept their loss and understand the grieving process by assessing which phase of grief they were at and offering services according to those symptoms as follows:

4.1.1 Shock and disbelief **:** As for nursing care, the researcher arranged the environment to ensure privacy and separated the women with spontaneous abortion from other mothers to prevent more grief and to enable them to freely express their feelings without arguing with them but also without supporting or promoting their denial.

4.1.2 Yearning, searching, and anxiety **:** As for nursing care, the researcher enabled women with spontaneous abortion to express their behaviors without obstructing them. The researcher accepted that crying or anger was their reactions to their loss, and the researcher did not respond or react, but listened to

them calmly and explained that such behaviors were normal expressions of grief that could be found in others as well.

4.1.3 Disorganization, despair, and depression **:** As for nursing care, the researcher stimulated the women with spontaneous abortion to talk about the events and listened to them attentively without stopping them or persuading them to talk about other topics. The researcher did not try to push the women to undergo through their grieving process and assured them that they could express their feelings freely without having to keep them all to themselves.

4.1.4 Reorganization **:** As for nursing practice, the researcher assured women with spontaneous abortion that they were able to cope with and overcome their grief and that they were able to get pregnant again.

4.2 Giving informational support: The researcher disseminate knowledge about grieving process, spontaneous abortion, and other information needed by women with spontaneous abortion.

4.3 Promoting family participation: Family members were encouraged to take part in care of women with spontaneous abortion by giving them knowledge about the grieving process, spontaneous abortion, and care of women with spontaneous abortion

Step 3: Ending of the nursing care: The researcher summarized the nursing care giving to women with spontaneous abortion on each day, made an appointment for the next examination, or terminating the nursing care.

1.2 The teaching plan on spontaneous abortion and self-care practice for women with spontaneous abortion

The researcher developed the teaching plan with the contents consisting of the meaning of abortion, causes of abortion, types of abortion, treatment, self-care after abortion, duration of grief, expression of grief, and reduction of grief.

1.3 The teaching plan on spontaneous abortion and self-care practice for family members of women with spontaneous abortion

The researcher developed the teaching plan whose contents covered the following topics: the meaning of abortion, causes of abortion, types of abortion, treatment, care of women with spontaneous abortion, duration of grief, expression of grief, and care to reduce grief of women with spontaneous abortion.

1.4 A manual on care after spontaneous abortion and management of grief for women with spontaneous abortion

The researcher distributed the manual for women with spontaneous abortion to study at home. The contents of the manual involved the meaning of abortion, causes of abortion, types of abortion, treatment, self-care after abortion, duration of grief, expression of grief, and reduction of grief.

1.5 A manual for family members of women with spontaneous abortion

The researcher distributed the manual especially designed for family members of women with spontaneous abortion to study at home as a guideline in caring for women with spontaneous abortion. The contents of the manual involved the meaning of abortion, causes of abortion, types of abortion, treatment, care of women with spontaneous abortion, duration of grief, expression of grief, and care to reduce grief of women with spontaneous abortion.

Validation of the instruments

The nursing care plan developed based on Swanson's Caring Theory, the teaching plan on abortion and self-care practice after abortion for women with spontaneous abortion, the teaching plan on abortion and grief for family members of women with spontaneous abortion, the manual on self-care practice after abortion and coping with grief after for women with spontaneous abortion, and the manual for family members to support women with spontaneous abortion were examined by a panel of five experts to ensure content validity and language appropriateness as follows:

- One nursing instructor specializing in obstetric-gynecological nursing
- Two nursing instructors specializing in mental health and psychiatric nursing
- One psychiatrist
- One obstetrician

2. Data collection instruments

2.1 A demographic characteristics questionnaire was designed to elicit data regarding age, the order of pregnancy, educational background, religion,

marital status, occupation, income, residence, duration of marriage, acknowledgement of pregnancy before the abortion, consultancy with physicians on infertility, contraception, and gestational age when the abortion took place.

2.2 A perinatal grief scale was designed by Toedter, Lasker, and Alhadeff (1989) and translated into the Thai language by Ngeoicharoen (1998) before it was revised and improved based on experts's comments and suggestions. The scale consisted of 28 items with 25 negative items (items 1-25) and three positive items (items 26-28).

The items in the perinatal grief scale were arranged in a five-point Likert rating scale with the following choices of response:

Strongly disagree	meant	the item least reflected the feelings, ideas, or behaviors of women with spontaneous abortion or did not reflect the feelings, ideas, or behaviors of women with spontaneous abortion at all.
Disagree	meant	the item slightly reflected the feelings, ideas, or behaviors of women with spontaneous abortion.
Uncertain	meant	the item half reflected the feelings, ideas, or behaviors of women with spontaneous abortion.
Agree	meant	the item greatly reflected the feelings, ideas, or behaviors of women with spontaneous abortion.
Strongly agree	meant	the item mostly reflected the feelings, ideas, or behaviors of women with spontaneous abortion.

The scoring of the items was as follows:

For positive items,

Strongly disagree was equal to 5 points

Disagree	was equal to	4 points
Uncertain	was equal to	3 points
Agree	was equal to	2 points
Strongly agree	was equal to	1 point

For negative items,

Strongly disagree	was equal to	1 point
Disagree	was equal to	2 points
Uncertain	was equal to	3 points
Agree	was equal to	4 points
Strongly agree	was equal to	5 points

As regards interpretation of scoring, the mean scores ranged from one to five points, with higher mean scores reflecting higher levels of grief, and lower mean scores reflecting lower levels of grief as follows:

4.50 – 5.00 points	meant a high level of grief
3.50 – 4.49 points	meant a rather high level of grief
2.50 – 3.49 points	meant a moderate level of grief
1.50 – 2.49 points	meant a rather low level of grief
1.00 – 1.49 points	meant a low level of grief

Validation of the instrument

A perinatal grief scale translated into Thai by Ngeicharoen was validated by a panel of five experts as follows:

- Three nursing instructors in Obstetric and Gynecological Nursing Department
- One nursing instructor in Mental Health and Psychiatric Nursing Department
- One instructor from the department of Psychiatry, Faculty of Medicine, Siriraj Hospital

With regard to reliability, the scale was tried out with 20 women with spontaneous abortion who had similar characteristics to the women with spontaneous

abortion in the main study. Cronbach's Alpha Coefficient revealed that the reliability of the instrument was equal to 0.886.

Before a perinatal grief scale was used in the present study, it was reexamined by a panel of five experts to confirm its validity as follows:

- One nursing instructor in Obstetric and Gynecological Nursing Department
- Two nursing instructors specializing in Mental Health and Psychiatric Nursing Department
- One psychiatrist
- One obstetrician

After all five experts had examined the instrument, they all agreed that the instrument had content validity without and did not make any suggestion regarding revision or addition of the instrument.

After that, the scale was tried out with 20 women with spontaneous abortions who had similar characteristics to the women with spontaneous abortion in the main study. Cronbach's Alpha Coefficient revealed that the reliability of the instrument was equal to 0.80.

2.3 An Anecdotal Record

An anecdotal record was a form used to record the nursing care practices in each phase. It was developed by the researcher to record information regarding grief of women with spontaneous abortion so as to follow up on the grieving process and changes of each of the women with spontaneous abortion. An anecdotal record was used to record information including the time when psychological nursing care was first given after spontaneous abortion, meaning of loss of the fetus, feelings of women with spontaneous abortion toward each nursing care they received, behavioral expressions, duration of grief, family care, and nursing care offered at each phase. It was also used to record the conversations when women with spontaneous abortion made a telephone call to the researcher.

Validation of the instrument

The anecdotal record was examined by the following panel of experts to confirm the comprehensiveness of important issues and language appropriateness:

- One nursing instructor in Obstetric and Gynecological Nursing Department
- Two nursing instructors specializing in Mental Health and Psychiatric Nursing Department
- One psychiatrist
- One obstetrician

Data Collection

1. Preparation stage

As the nursing care plan developed based on Swanson's Caring Theory aimed at providing psychological care to women with spontaneous abortions to give them emotional support and to let them release their grief, the researcher was enrolled a 50-hour health counseling course and sought more experience in psychological care by attending a 52-hour workshop on group counseling and another 52-hour workshop on family counseling organized by the Mental Health Center 1, Ministry of Public Health, from September 6 to 10, 2004 and November 28 to December 2, 2004, respectively.

2. Operation stage

2.1 The researcher asked for approval from the Committee on Research Involving Human Subjects of Siriraj Hospital.

2.2 The research conducted data collection by submitting the letter from the Graduate School, Mahidol University to the Director of Siriraj Hospital through the Dean of the Faculty of Medicine, Siriraj Hospital, Mahidol University to ask for cooperation in data collection.

2.3 The researcher met with the head of obstetric-gynecological nursing, and the heads of the 100th years Somdech Phra Srinagarindra Ward 8/1 and 8/2, Siriraj Hospital to introduce herself and ask for cooperation in data collection. Data were first collected from 30 subjects in the control group before they were collected from the other 30 subjects in the experimental group. The steps involved in data collection were as follows:

Control group

1. Women with spontaneous abortion who met the inclusion criteria were selected from the document. The researcher introduced herself to the women with spontaneous abortion, explained the research objectives and human rights protection, and asked for their cooperation in data collection. If they agreed to participate in the study, the researcher asked them to sign the informed consent form. If they declined to take part in the study, the researcher thanked them and recruit next subjects.

2. After the subjects agreed to take part in the study, the researcher asked them to complete a demographic characteristics questionnaire and a perinatal grief scale without time constraints. The researcher waited nearby so that assistance could be provided in time if the subjects had questions or doubts. The researcher then collected the questionnaires back from the subjects and examined them to ensure completeness. If it was found that the data were incomplete, the researcher asked if the subjects were willing to give additional data. If they did, the researcher let them complete the questionnaires. However, if they did not want to give further information, the researcher thanked them for their time, but the data collected from them would be discarded. The researcher then recruited the next subjects.

3. While the subjects were recuperating and receiving routine nursing care from on-duty nurses, the researcher met them and asked them to meet on the day they came for the check-up two weeks later. Then, the subjects were asked to complete the perinatal grief scale before they were discharged from the hospital.

4. When the subjects returned to the hospital two weeks after spontaneous abortion, they were asked to complete a perinatal grief scale one more time. After that, the researcher terminated the data collection after allowing the subjects to ask questions and giving them a manual on self-care practice and grief after spontaneous abortion. The researcher also thanked them for their participation in the study.

Experimental group

1. Women with spontaneous abortion who met the inclusion criteria were selected from the document. The researcher introduced herself to the women

with spontaneous abortion, explained the research objectives and human rights protection, and asked for their cooperation in data collection. If they agreed to participate in the study, the researcher asked them to sign the informed consent form. If they declined to take part in the study, the researcher thanked them and recruit next subjects.

2. Phase I : While the subjects were recuperating at the 100th years Somdech Phra Srinagarindra Ward 8/1, the researcher provided nursing care program based on Swanson's Caring Theory to individual subjects who were fully conscious and did not suffer from any effects of the sedating medications or pain medications. The subjects also received routine nursing care from the ward.

Step 1: Prior to nursing care provision

1.Maintaining belief: The researcher adjusted her confidence in women with spontaneous abortion who were able to go through their grief and meaningfully able to face the future. This was an internal factor in nurses who needed to have a positive attitude toward the patients before offering nursing care.

2.Establishing relationships: The researcher created a relationship with women with spontaneous abortion to ensure trust in the researcher.

Step 2: Implementing the nursing care

1.Knowing: The researcher tried to understand the meaning of spontaneous abortion by having the women with the loss as the center of care. The researcher used words and questions regarding spontaneous abortion and its meaning and also employed observation skills to ensure more understanding.

2.Being with: The researcher provided emotional support to women who lost their baby by offering to keep them company and using questions to let women with spontaneous abortion to freely express their feelings.

3.Doing for: The researcher did various activities for women with spontaneous abortion in terms of comfort, safety, rest, nutrition, cleanliness of the environment, and expectations and needs, skillfully and with fullest potential.

4.Enabling: The researcher helped women with spontaneous abortion to recover from their condition and appropriately take care of themselves in three areas as follows:

4.1 Enabling women with spontaneous abortion to cope with problems: The researcher used questions to stimulate women with spontaneous abortion to accept their loss and understand the grieving process by assessing which phase of grief they were at and offering services according to those symptoms as described in research instrument .

4.2 Giving informational support: The researcher disseminate knowledge about grieving process, spontaneous abortion, and other information needed by women with spontaneous abortion.

4.3 Promoting family participation: Family members were encouraged to take part in care of women with spontaneous abortion by giving them knowledge about the grieving process, spontaneous abortion, and care of women with spontaneous abortion

Step 3: Ending of the nursing care: The researcher summarized the nursing care giving to women with spontaneous abortion on each day, made an appointment for the next examination, or terminating the nursing care.

The researcher met women with spontaneous abortion at least twice—once when they were first admitted into the ward after spontaneous abortion, and the other time was on the following day. The researcher visited women with spontaneous abortion on a daily basis until they were discharged from the hospital. Similar nursing care in the aforementioned three stages was provided to them during each visit. Women with spontaneous abortion were asked to fill out a perinatal grief scale before they returned home

3. Phase II : A telephone call was made to each of them after they had returned home for one week.

Step 1: Prior to nursing care provision

1.1 Maintaining belief: The researcher adjusted her confidence in women with spontaneous abortion who were able to go through their grief and meaningfully able to face the future. This was an internal factor in nurses

who needed to have a positive attitude toward the patients before offering nursing care.

1.2 Establishing relationships: The researcher created a relationship with women with spontaneous abortion to ensure trust in the researcher.

Step 2: Implementing the nursing care program

2.1 Knowing: The researcher reviewed the meaning of spontaneous abortion as discussed with the women with spontaneous abortion in Phase I

2.2 Being with: The researcher made a telephone call to women with spontaneous abortion to offer them emotional support by offering to keep them company and allowing them opportunity to freely release their feelings caused by loss of their fetuses without obstructing them in any way.

2.3 Enabling: The researcher helped women with spontaneous abortion to recover from their condition and appropriately take care of themselves in two areas as follows:

2.3.1 Enabling women with spontaneous abortion to cope with problems: The researcher used questions to stimulate women with spontaneous abortion to accept their loss and understand the grieving process by assessing which phase of grief they were at and offering services according to those symptoms as described in research instrument .

2.3.2 Giving informational support: The researcher disseminate knowledge about grieving process, spontaneous abortion, and other information needed by women with spontaneous abortion.

Step 3: Ending of the nursing care: The researcher summarized the nursing care giving to women with spontaneous abortion on each day, made an appointment for the next examination, or terminating the nursing care.

4.Phsae III : The nursing care program was implemented again when the women with spontaneous abortion returned to the hospital to the 100th years Somdech Phra Srinagarindra Ward 8/2 for follow-up examinations two weeks after spontaneous abortion. The nursing care program developed based on Swanson's caring Theory was provided to women with spontaneous abortion on an individual basis, together with routine nursing care from the hospital.

Step 1: Prior to nursing care provision

1.Maintaining belief: The researcher adjusted her confidence in women with spontaneous abortion who were able to go through their grief and meaningfully able to face the future. This was an internal factor in nurses who needed to have a positive attitude toward the patients before offering nursing care.

2.Establishing relationships: The researcher created a relationship with women with spontaneous abortion to ensure trust in the researcher.

Step 2: Implementing the nursing care program

1.Knowing: The researcher reviewed the meaning of spontaneous abortion as discussed with the women with spontaneous abortion in Phases 1 and 2. The researcher also observed the gestures and body language of women with spontaneous abortion to ensure true understanding of them.

2.Being with: The researcher provided emotional support to women who lost their baby by offering to keep them company and using questions to let women with spontaneous abortion to freely express their feelings.

3.Doing for: The researcher helped prepared women with spontaneous abortion for a follow-up examination by assisting them when they had to change into a wrap-around sarong before a pelvic examination, making sure they urinated before receiving the examination, putting them in the lithotomy position, giving them knowledge about pain relief by teaching them how to inhale and exhale deeply and slowly until the examination was completed.

4.Enabling: The researcher helped women with spontaneous abortion to recover from their condition and appropriately take care of themselves in two areas as follows:

4.1 Enabling women with spontaneous abortion to cope with problems: The researcher used questions to stimulate women with spontaneous abortion to accept their loss and understand the grieving process by assessing which phase of grief they were at and offering services according to those symptoms as described in research instrument .

4.2 Giving informational support: The researcher disseminate knowledge about grieving process, spontaneous abortion, and other information needed by women with spontaneous abortion.

Step 3: Ending of the nursing care: The researcher summarized the nursing care activities provided to women with spontaneous abortion and terminated the nursing care program. The researcher gave them opportunity to ask questions to clarify their doubts and offered explanation to make them understand and accept the termination of the nursing care program in phase 3

After that, women with spontaneous abortion in the experimental group were asked to respond to a perinatal grief scale one more time. More opportunity to ask further questions was given to them, and the researcher thanked them for their participation and cooperation in the study.

Each application of the nursing care plan based on Swanson's theory of care lasted approximately 15 to 60 minutes.

The researcher collected data from 30 subjects in the control group before moving on to those in the experimental group until data were collected from 60 women with spontaneous abortion. The scoring criteria were then applied, and the data collected were analyzed using various statistical analyses.

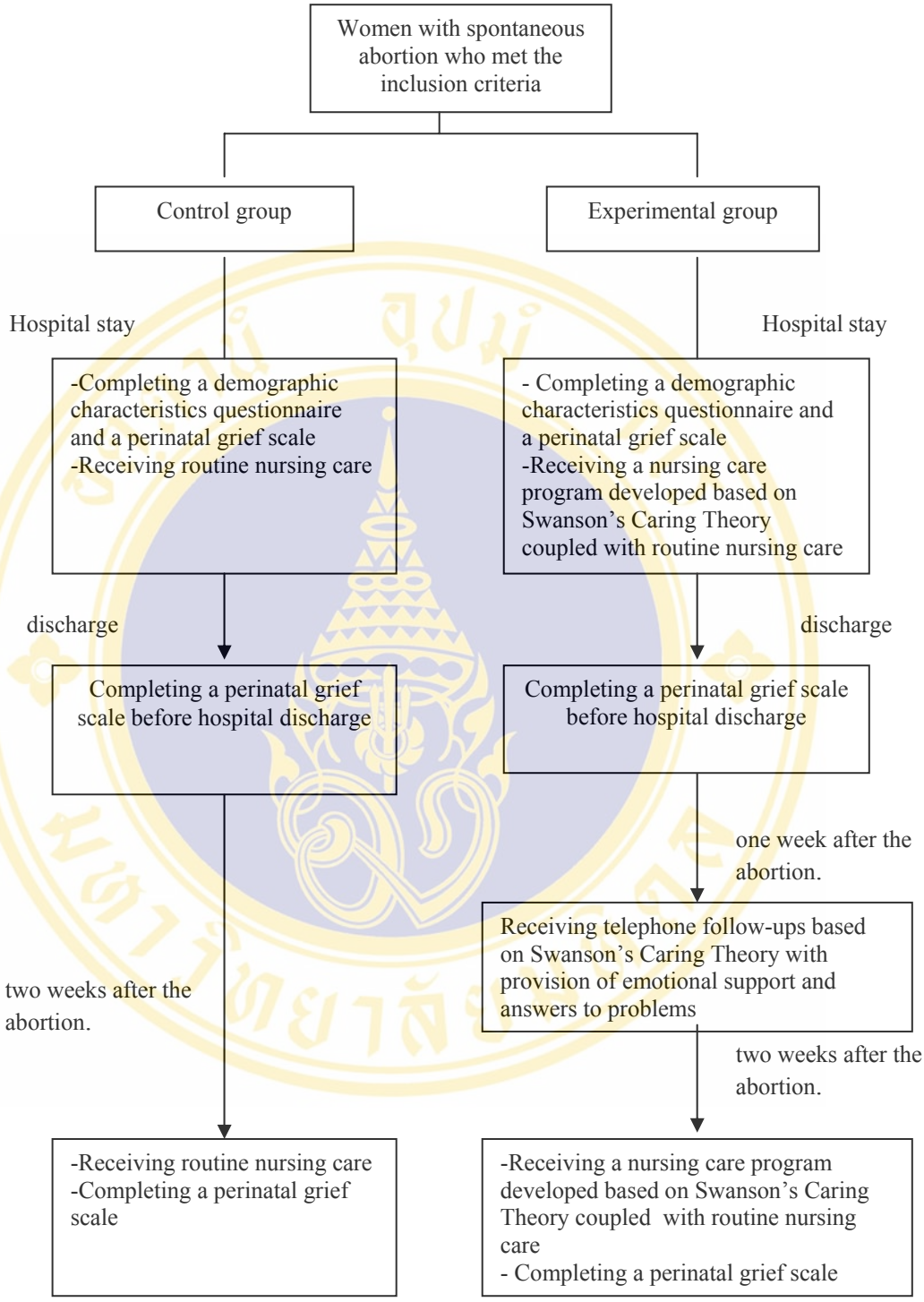

Figure 3: Steps involved in the research

Protection of The Rights of Human Subjects

The researcher protected the rights of the study subjects by asking for approval Research Involving Human Subjects from the Siriraj Ethics Committee, Faculty of Medicine, Siriraj Hospital, Mahidol University. The researcher approached the would-be subjects, introduced herself, and explained the research objectives and data collection procedures to them. The researcher gave them the opportunity to ask questions before they decided to participate in the study or refused to do so. After they agreed to participate in the study, they were assured that the data collected from them would be kept strictly confidential and would be reported only as group data. The subjects were asked to sign the informed consent form and completed the questionnaires by themselves. The researcher was very careful when asking them questions and avoided leading them in decision making. Finally, the researcher reassured the subjects that they were able to withdraw from the study at any time if they wished, and their decision would not affect the treatment and care they would receive from the hospital in any way.

Data Analysis

Data collected from the subjects were analyzed using the SPSS computer program as follows:

1. Demographic characteristics of the subjects were analyzed using frequency and percentage.

2. Mean and standard deviation were employed to analyze age, the order of pregnancy, gestational age, family income, and duration of marriage. Chi-square was then used to determine the differences in these aspects between the subjects in the control group and the experimental group.

3. Chi-square was utilized to determine the differences in educational background, religion, marital status, occupation, residence, acknowledgement of pregnancy before the abortion, consultation regarding infertility, and contraception between the subjects in the control group and the experimental group.

4. Mean and standard deviation of grief scores before and after the study of the subjects in the control group and the experimental group were analyzed. The

differences between the subjects in the control group and the experimental group were determined using the independent t-test, and the differences within the subjects in the control group and the experimental group were determined using Repeated- measures ANOVA.

5. The significance level was set at .05.

CHAPTER IV
RESULTS

The present study was quasi-experimental research (Pretest- Posttest design with nonequivalent group) which aimed at investigating the effects of a nursing care program developed based on Swanson's Caring Theory on the level of grief of women with spontaneous abortion. The subjects of the study were spontaneous abortion who sought medical treatment at Siriraj Hospital from January to July 2008. There were 60 subjects, 30 of whom were assigned into the experimental group, and another 30 subjects into the control group. The experimental subjects received the nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care, whereas the control subjects received only routine nursing care from the hospital. The findings of the study are presented in the following order:

Part I: Comparison of demographic characteristics and obstetric characteristics of the experimental group and the control group

Part II:: Comparison of mean scores of grief of the experimental group and the control group before and after participating in the study

Part I: Personal data of the subjects

1.1 Demographic characteristics of the subjects

The mean age of women with spontaneous abortion in the experimental group was 27.80 years (SD = 7.40, Min – Max = 18-42), while that of women with spontaneous abortion in the control group was 28 years (SD = 6.91, Min – Max = 18-41). As for educational background, the subjects in the experimental group could be divided into three levels-junior high school, senior high school and vocational education, accounting for 23.3% in each group. On the other hand, the largest group of the subjects in the control group, or 30%, had vocational education. 73.3% of the experimental subjects and 80% of the control subjects lived in Bangkok or its vicinity. the largest group was wage earners, making up 46.7% of the experimental group and 36.7% of the control group. In terms of family income, the subjects in both groups had a rather similar amount of income, with the mean of 18,967 and SD of 8,122 in the experimental group and the mean of 20,000 and SD of 9,392 in the control group. All of the subjects in the experimental group and the control group were married, almost all of the subjects in both groups were Buddhists, accounting for 96.7% and 93.3% of the experimental group and the control group .

Chi-square test revealed that the differences in age, educational background, residence, occupation, family income, marital status and religion of the experimental subjects and the control subjects were not statistically significant, as depicted in Table 1 below.

Table 1: Comparison of demographic characteristics of women with spontaneous abortion in the experimental group and the control group using chi-square

Demographic characteristics	Experimental group (n=30)		Control group (n=30)		χ^2	P-value
	Number	Percent	Number	Percent		
Age (years)					1.763	.414 ns
< 20	5	16.7	2	6.7		
20-34	18	60.0	22	73.3		
≥35	7	23.3	6	20.0		
	Min = 18 Max = 42 Mean = 27.97 SD = 7.40		Min = 18 Max = 41 Mean = 28.00 SD = 6.91			
Educational level					1.828	.767 ns
Primary School	4	13.3	5	16.7		
Junior High School	7	23.3	5	16.7		
Senior High School	7	23.3	5	16.7		
Vocational	7	23.3	9	30.0		
Undergraduate	5	16.7	6	20.0		
Residence					.373	.542 ns
Bangkok and vicinity	22	73.3	24	80.0		
Other provinces	8	26.7	6	20.0		
Occupation					2.623	.758 ns
Government officials or public enterprise employees	2	6.7	2	6.7		
Government permanent or temporary employees	1	3.3	0	0		
Traders	7	23.3	10	33.3		
Wage earners	14	46.7	11	36.7		
Agriculturists	2	6.7	1	3.3		
Housewives	4	13.3	6	20.0		

Table 1: Comparison of demographic characteristics of women with spontaneous abortion in the experimental group and the control group using chi-square (Continued)

Demographic characteristics	Experimental group (n=30)		Control group (n=30)		χ^2	P-value
	Number	Percent	Number	Percent		
Family income (baht/month)					4.542	.064 ns
< 5,000	0	0.0	1	3.3		
5,001 – 10,000	7	23.3	3	10.0		
10,001 – 15,000	6	20.0	7	23.3		
15,001 – 20,000	7	23.4	11	36.7		
20,001 – 25,000	4	13.3	3	10.0		
> 25,000	6	20.0	5	16.7		
	Min = 8,000		Min = 3,000			
	Max = 40,000		Max = 50,000			
	Mean = 18,967		Mean = 20,000			
	SD = 8,122		SD = 9,392			
Marital status						
Married	30	100.0	30	100.0		
Religion						1.000 ns
Buddhism	29	96.7	28	93.3		
Christianity	1	3.3	2	6.7		

ns p >.05

1.2 Obstetric characteristics

More than half of the experimental subjects, or 56.7%, had been multigravidarum , whereas the control subjects had been primigravidarum equal with multigravidarum, 50% equal. About two-thirds of the subjects in both groups had been married for less than five years, accounting for 63.3% and 66.7% of the experimental and control subjects, respectively. Almost all of them, 93.3% of the experimental subjects and 86.7% of the control subjects, knew that they were pregnant. In addition, all of the experimental subjects and almost all of the control subjects, or 96.7%, had never consulted their physician about infertility. Moreover, none of the subjects in both groups had used any means of contraception. Finally, 63.3% of the experimental subjects and 66.7% of the control subjects were diagnosed with incomplete abortion, and most of them had spontaneous abortion before their gestational age reached 12 weeks, making up 73.3% and 80% of the experimental and control subjects, respectively.

Chi-square test showed that the differences in order of pregnancy, duration of marriage, acknowledgement of pregnancy, consultation regarding infertility, contraception, medical diagnosis and gestational age of the experimental subjects and the control subjects were not statistically significant, as shown in Table 2 below.

Table 2: Comparison of obstetric characteristics of women with spontaneous abortion in the experimental group and the control group using Chi-square

Obstetric characteristics	Experimental group (n=30)		Control group (n=30)		χ^2	P-value
	Number	Percent	Number	Percent		
Order of pregnancy					.268	.605 ns
Primigravidarum	13	43.3	15	50.0		
Multigravidarum	17	56.7	15	50.0		
Duration of marriage (years)					.226	.893 ns
< 5	19	63.3	20	66.7		
5-10	8	26.7	8	26.7		
> 10	3	10.0	2	6.7		
	Min =1 Max =15 Mean = 4.43 SD = 3.471		Min = 1 Max = 15 Mea n= 4.40 SD = 3.838			
Acknowledgement of pregnancy						.671 ns
Known	28	93.3	26	86.7		
Unknown	2	6.7	4	13.3		
Consultation regarding infertility						1.000 ns
Yes	0	0.0	1	3.3		
No	30	100.0	29	96.7		
Contraception						
No	30	100.0	30	10.0		

ns p >.05

Table 3: Comparison of obstetric characteristics of women with spontaneous abortion in the experimental group and the control group using Chi-square (Continued)

Obstetric characteristics	Experimental group (n=30)		Control group (n=30)		χ^2	P-value
	Number	Percent	Number	Percent		
Medical diagnosis					1.026	.096 ns
Blighted ovum	3	10.0	3	10.0		
Complete abortion	1	3.3	1	3.3		
Death fetus in utero	6	20.0	6	20.0		
Incomplete abortion	19	63.3	20	66.7		
Missed abortion	1	3.3	0	0.0		
Gestational age					.373	.542 ns
≤ 12 weeks	22	73.3	24	80.0		
> 12 – 20 weeks	8	26.7	6	20.0		
	Min = 7 Max = 18 Mean = 10.70 SD = 2.867		Min = 5 Max = 16 Mean = 10.07 SD = 2.912			

ns p >.05

Part II: Comparison of grief scores of the experimental group and the control group before and after receiving the nursing care program developed based on Swanson's Caring Theory

Hypothesis 1: The mean scores of grief of women with spontaneous abortions who received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of the women who received only routine nursing care after the experiment.

Before implementing a nursing care program developed based on Swanson's Caring Theory, the levels of grief of women with spontaneous abortion in the experimental group and the control group were rather similar ($\overline{X}$ = 3.56 and SD = .29 in the former and $\overline{X}$ = 3.52 and SD = .19 in the latter). Independent t-test indicated that there was no statistically significant difference (t = -.676, p > .05).

Before hospital discharge, the mean score of grief of women with spontaneous abortion in the experimental group who received the nursing care program developed based on Swanson's Caring Theory ($\overline{X}$ = 2.75 and SD = .25) was lower than that of the control group who received only routine nursing care ($\overline{X}$ = 3.36 and SD = .24) with statistically significant difference (t = 9.581, p < .001).

At two-weeks follow-up examinations, the mean score of grief of women with spontaneous abortion in the experimental group who received the nursing care program developed based on Swanson's Caring Theory ($\overline{X}$ = 2.06 and SD = .31) was lower than that of the control group who received only routine nursing care ($\overline{X}$ = 2.63 and SD = .21) with statistically significant difference (t = 8.423, p < .001), as illustrated in Table 3.

Table 3 : Comparison of mean scores of grief of women with spontaneous abortion in the experimental group who received the nursing care program coupled with routine nursing care and the control group who received only routine nursing care before receiving the nursing care program developed based on Swanson's Caring Theory, before discharge, and at two-weeks follow-up examination

time	Experimental group (n = 30)				Control group (n = 30)				t	P-value
	Min - Max	Mean	SD	Grief level	Min - Max	Mean	SD	Grief level		
Before receiving the program	2.86-4.11	3.56	.29	rather high	3.18-3.93	3.52	.19	rather high	-.676	.502 ns
Before discharge	2.25-3.64	2.75	.25	Moder-ate	2.54-3.86	3.36	.24	Moder-ate	9.581	.000 ***
At two-weeks follow-up	1.86-3.11	2.06	.31	rather low	2.29-3.32	2.63	.21	Moder-ate	8.423	.000 ***

ns p >.05, ***p < .001

When classifying the levels of grief at each assessment time point, it was found that before receiving a nursing care program, more than half of the subjects in the experimental group and control group had mean scores of grief at a rather high level, accounting for 60% and 56.7%, respectively.

Before hospital discharge, most of the experimental and control subjects had mean scores of grief at a moderate level, making up 96.7% and 80%, respectively.

At the two-weeks follow-up examination, all of the women with spontaneous abortion in the experimental group, or 100%, had a rather low level of grief. On the

other hand, most of the women with spontaneous abortion in the control group, or 83.3%, still had a moderate level of grief, as depicted in Table 4 below.

Table 4 : Number and percentage of levels of grief of the experimental group and the control group at each time point

time	Experimental group (n = 30)			Control group (n = 30)		
	Grief level	**Number**	**Percent**	**Grief level**	**Number**	**Percent**
Before receiving the program	high	0	0.0	high	0	0.0
	rather high	18	60.0	rather high	17	56.7
	moderate	12	40.0	moderate	13	43.3
	low	0	0.0	low	0	0.0
	rather low	0	0.0	rather low	0	0.0
Before discharge	high	0	0.0	high	0	0.0
	rather high	0	0.0	rather high	6	20.0
	moderate	29	96.7	moderate	24	80.0
	low	1	3.3	low	0	0.0
	rather low	0	0.0	rather low	0	0.0
At two-weeks follow-up	high	0	0.0	high	0	0.0
	rather high	0	0.0	rather high	0	0.0
	moderate	0	0.0	moderate	25	83.3
	low	30	100.0	low	5	16.7
	rather low	0	0.0	rather low	0	0.0

Comparison of mean scores of grief of women with spontaneous abortion in the experimental group and the control group at three time points

When comparing the mean scores of grief of women with spontaneous abortion in the experimental group and the control group at three time points-before implementing a nursing care program, before hospital discharge, and at two-weeks follow-up examinations using Repeated-Measures ANOVA, it was found that the mean scores of grief of the subjects in both groups were statistically significantly different ($F_{1,58}$ = 61.16; p = .000). Such finding confirmed the result of the Independent t-test which tested the differences between the two groups of subjects at three time points as shown in Table 4 above that the mean scores of grief of women with spontaneous abortion in the experimental group were lower than those of the control group before implementing a nursing care program, before hospital discharge, and at two-weeks follow-up examinations with statistical significance ($F_{2,58}$ = 517.88; p = .000) and that the interaction between groups and the measurement times had a statistically significant effect on the level of grief of women with spontaneous abortion ($F_{2,58}$ = 47.48; p = .000), as illustrated in Table 5.

Table 5: Comparison of mean scores of grief of women with spontaneous abortion in the experimental group and the control group using Repeated – Measures ANOVA

Source of variance	df	SS	MS	F	P - value
Between subject					
Group	1	6.409	6.409	61.16	.000 ***
Error1	58	6.078	.105		
Within subject					
Time	2	43.455	43.455	517.88	.000***
Group*Time	2	3.984	3.984	47.48	.000***
Error 2	116	4.867	.084		

*** p < .001

As the findings showed that the levels of grief of women with spontaneous abortion measured at three time points of before receiving a nursing care program developed based on Swanson's Caring Theory, before hospital discharge, and at two-week follow-up were statistically significantly different, multiple comparisons between the experimental group and the control group were made. It was found that at all time points measured in this study, the levels of grief of women with spontaneous abortion in the experimental group and the control group were statistically significantly different, as illustrated in Table 6 below.

Table 6: Multiple comparisons of mean scores of grief of women with spontaneous abortion in the experimental group and the control group at each time point using Bonferroni correction

group	Compare time		Mean difference of grief score (before-after)	SD	P-value
	before	after			
Experimental	Time 1	Time 2	.81	1.039	.000***
group	Time 1	Time 3	1.5	2.045	.000***
	Time 2	Time 3	.69	1.325	.000***
Control	Time 1	Time 2	.16	.993	.000***
group	Time 1	Time 3	.89	1.315	.000***
	Time 2	Time 3	.73	1.851	.000***

*** $p < .001$

Remarks : Time 1 : referred to the assessment conducted before implementing a nursing care program.

Time 2 : referred to the assessment conducted before hospital discharge.

Time 3 : referred to the assessment conducted at the two-weeks follow- up examination.

The findings supported Hypothesis 1; that is, the mean score of grief of women with spontaneous abortion after receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of the women with spontaneous abortion who received only the routine nursing care.

Hypothesis 2: The mean scores of grief of women with spontaneous abortions obtained after receiving the nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that obtained before receiving the nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care.

When considering the mean scores of grief of women with spontaneous abortion in the experimental group before and after receiving a nursing care program developed based on Swanson's Caring Theory and the mean scores of grief of women with spontaneous abortion in the control group before and after receiving routine nursing care from the hospital illustrated in Table 3 above, when comparing the mean scores within the experimental group and the control group at three time points—before receiving a nursing care program developed based on Swanson's Caring Theory, before hospital discharge, and at two-weeks follow-up examinations using Repeated-Measures ANOVA, it was discovered that the mean scores within the experimental group were statistically significantly different ($F_{2,58} = 379.108$; $p = .000$). Likewise, the mean scores within the control group were statistically significantly different ($F_{2,58} = 172.517$; $p = .000$), as illustrated in Table 7 below.

Table 7 : Comparison of mean scores of grief of women with spontaneous abortion in the experimental group and the control group before and after receiving the nursing care using Repeated –Measures ANOVA

Source of variance	df	SS	MS	F	P-value
Experimental group					
Time	2	33.925	33.925	379.108	.000***
Error	58	2.595	.089		
Control group					
Time	2	13.513	13.513	172.517	.000***
Error	58	2.272	.078		

*** $p < .001$

According to Table 7, Multiple Comparisons of mean scores of grief at each time point of the women with spontaneous abortion in the experimental group and the control group indicated that the mean score of the experimental subjects at two-weeks follow-up examinations was lower than those obtained before receiving the nursing care program and before hospital discharge. Likewise, the mean score of the control subjects at two-weeks follow-up examinations was lower than those obtained before receiving routine nursing care and before hospital discharge as well.

The findings, therefore, supported Hypothesis 2 that the mean score of grief of women with spontaneous abortion after receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care reduced and became lower than that obtained before receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care.

CHAPTER V
DISCUSSION

The present study aimed at investigating the effects of a nursing care program developed based on Swanson's Caring Theory on grief of women with spontaneous abortion. The subjects of the study consisted of 60 women with spontaneous abortions who sought medical treatment at Siriraj Hospital. Of these, 30 were assigned into the experimental group, and the other 30 were assigned into the control group. The former received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care, while the latter received only routine nursing care from the hospital. In this chapter, the findings of the present study are discussed.

The subjects in both groups were in their adulthood, with the mean age of 27.97 years and 28 years in the experimental group and the control group, respectively. At this age, individuals are more likely to solve problems effectively than those who are teenagers (Zeanah, 1993). In addition, it was found that educational background was associated with the level of grief. In this study, the experimental subjects could be divided into three groups according to their educational background - junior high school, senior high school and vocational educate, whereas most of the subjects in the control group had vocational education. In general, educational background is a factor that enables individual to develop their systematic thinking and learning. However, this finding was inconsistent with the finding of Tunlert (2002) that education was not related to grief. One plausible explanation is that when women have to change their role to that of a mother, which is a new role, they develop attachment and bonding to their baby and learn to adjust themselves. When they face such a loss, they are in an imbalanced situation, which results in different feelings in women with spontaneous abortion. Furthermore, all subjects in both experimental group and control group were married, and their husband helped take care of them, hence an important source of social support that enabled them to face their loss

(Kennell et al., 1970). Besides, their gestational age was mostly less than 12 weeks, when there was no movement of the fetus, hence a lack of attachment and bonding to the fetus (Klaus & Kennell, 1992). The findings of the present study can be explained in accordance with research hypotheses as follows:

Hypothesis 1: The mean scores of grief of women with spontaneous abortions who received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of the women who received only routine nursing care after the experiment.

The study findings revealed that the mean scores of grief of women who received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of the women who received only routine nursing care with statistical significance both before hospital discharge and at the two-week follow-up ($p < .001$, as shown in Tables 3 and 5). Before hospital discharge, it was found that 96.7% of the subjects in the experimental group had a moderate level of grief, while 3.3% had a rather low level of grief. On the other hand, 20% of the subjects in the control group had a high level of grief, whereas 80% of them had a moderate level of grief. In addition, at the two-weeks follow-up examination, it was found that all of the subjects in the experimental group, or 100%, had a rather low level of grief. In contrast, 83.3% of the subjects in the control group had a moderate level of grief, whereas 16.7% of them had a rather low level of grief. This could be explained that when women with spontaneous abortion received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care, they had a chance to develop relationships with the nurse, understand their grief, have the nurses who kept them company, receive physical care, and receive needed information, all of which could help these women with spontaneous abortion reduce their grief than those who received only routine nursing care. Therefore, Hypothesis 1 was accepted.

Before hospital discharge, the subjects in the experimental group received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care on an individual basis. Grief is a perception and feeling of

individuals, and it is a psychological loss which cannot be directly assessed by others. Thus, grieving women need care to make them calm down and return to their normal state of mind by getting over their grief. Individual care enables caregivers to understand the true feelings of the women caused by grief, especially individual feelings, and to appropriately provide care to deal with such feelings. In general, nursing care is divided into three phases-during hospitalization, at one week after hospital discharge through telephone calls, and at a two-week check-up after spontaneous abortion. A nursing care program developed based on Swanson's Caring Theory is composed of three steps: initial step, nursing care step, and final step. The effects of a nursing care program developed based on Swanson's Caring Theory can be explained below.

At the beginning of the study, the researcher adjusted the subjects' attitudes to ensure "**maintaining belief**" to make all women with spontaneous abortions realize that they were able to go through the grieving process and face their future with meaning, including becoming pregnant again. This was seen as an internal factor of nurses who needed to have a positive attitude toward patients before providing care and assistance. In this study, when the researcher was establishing relationships with women with spontaneous abortion, the researcher began by introducing herself and talked to these women in a friendly manner, expressing a wish to help take care of them through soft and delicate manners and words to make the women develop their familiarity and eventually their trust in the researcher. Also, when the women with spontaneous abortion felt that the researcher sincerely wanted to help them, they would then be more open to the researcher and willing to share their feelings caused by their loss. The next step was "**knowing**" which was when the researcher tried to understand the meaning of spontaneous abortion with the women with spontaneous abortion as the center of care. The researcher talked to the women and asked questions about spontaneous abortion and its meaning. Women with spontaneous abortion defined the abortion as the loss of what they had been waiting for, the loss of their hope and intention, the loss of their husband's and family's hope, a great loss in life, the death of someone they had not yet seen, a loss of a loved one, and a separation, and there were some women who stated that spontaneous abortion was similar to intentional abortion. Moreover, the researcher observed these women's manners

during the conversations to try to understand their true feelings and needs, which could be used as a basis for provision of care that best suited each woman's feelings. According to Swanson (1986), care which is based on understanding, good intention to help, and compassion can also reflect the true needs of each of the women with spontaneous abortion. The next aspect of care in this study was "**being with**" which was carried out when the researcher gave emotional support to women with spontaneous abortion by offering to keep them company, using questions to make them understand their current emotions and feelings, helping them understand the situation, and enabling them to express their feelings caused by abortion, all of which could be done freely with full support from the researcher. Swanson (1986) points out that "being with" enables caregivers to understand the feelings of each of the women with spontaneous abortion. In other words, with "being with" even though the researcher was not the one who experienced losses, the researcher was still able to understand these women and be by their side. Also, the researcher's comfort and encouragement also enabled these women to search for the meaning of life again. During this stage, when women with spontaneous abortion were hospitalized, they found themselves in an unfamiliar environment among unfamiliar faces, so they may feel lonely and need someone to be with them for spiritual support. When the researcher kept them company, even though it was not all the times, the time women with spontaneous abortion spent with the researcher was still precious for them as the researcher offered to be with them, was sincere, and was willing to develop a relationship with them. The researcher's expressions and behaviors including verbal messages, manners, and touches enabled these women to fully express their emotions and feelings. Most of them cried or had teary eyes when they were sharing their feelings with the researcher. According to the researcher's conversations with women with spontaneous abortion, it was found that different women had different types of grief. Some felt guilty, while others still felt confused. Some women began to be able to accept it and let go. Examples of the feelings and thoughts expressed by these women are as follows:

"I am so sad. I had never thought this could happen to me. I intended to have this baby and planned to have sterilization after this. Why did this never happen to me

before this? What had I done wrong with this pregnancy? I had never thought I would have to face this myself. I want my husband to be near me, to comfort me."

"I felt lost. I still don't want to believe that my fetus will not be born. I don't know what I had done wrong to have the spontaneous abortion. I dreamed about my baby the other day. I assumed that she would come to live with me, never thinking that she came to say good-bye. Or didn't she make enough merits, so she didn't get to be born?"

"At first, I was shocked. I didn't think this was true. I was so sad. I never thought my baby would not be with me for only a short period like this. This may have been the Karma that we did in the past, so the baby had our sins and couldn't be born. I am sorry I disappointed my family. I don't want anybody to know that I had a spontaneous abortion."

"I was so sad and shocked. I didn't want to believe it. I blamed myself for not taking enough care of myself, so I had the spontaneous abortion. I don't want to go back and meet people. I want to be alone."

"I was shocked and unhappy. I didn't want to believe it. I took a very good care of myself, so how could this happen? Or had I done any wrong so I was punished by God so that I would be sorry. If I had taken a better care of myself, this wouldn't have happened."

"I am so sorry. I had a very high expectation. It was so unexpected. I still don't want to believe that I had a spontaneous abortion. I still feel as if the baby was still in my womb, still moving."

"I am sad and shocked. I didn't know that bleeding could cause spontaneous abortion because I had never seen anybody with this before. I didn't know why I had it. I never knew spontaneous abortion could make me this sad."

"My family had a very high expectation, and I never thought my baby would die in my womb like this. I had never prepared for it, so I felt so lonely in my heart. I want to lie down and close my eyes for a long, long time. I never want to hear a baby cry. Why did this have to happen to my family?"

"I am sad, disappointed, and want to cry loudly. I want to go home to my parents."

"I didn't prepare for this. All of a sudden I had bleeding. I was shocked and in disbelief. When the doctor performed uterine curettage, it was like my uterus was pulled out of me. I didn't want my baby to leave. I want the baby back."

Some women with spontaneous abortion who began to accept the situation and let go shared their feelings as follows:

"I am sorry. I think my baby didn't want to live with me. This is a natural thing because I already have two children before this."

"At first I was sad that my fetus didn't get to be born. Now I have begun to accept it that it is a natural thing that can happen to anyone. I cried before I came to the hospital, but now I feel better. My husband said it was okay because we have two children at home already. Life has to go on."

"I am sad and shocked, but I accepted it since I learned the U/S result."

"I don't think much because I had had a spontaneous abortion before, but after that I could have a successful pregnancy. I don't think much, but I am a bit sad."

And some patients asked questions to clarify the doubts that had been in their mind, such as one who asked, "*Was it because I had a sexual intercourse with my husband, so I had spontaneous abortion?"*

According to the responses indicated in the perinatal grief scale, it was found that one of the items that had a lower mean score was item 1, stating "I am shocked when I found out that I had a spontaneous abortion." The mean scores of the experimental subjects reduced from a high level (4.70) before implementation of a nursing care program and a high level (4.63) before hospital discharge to a rather high level (4.20) at the two-weeks follow-up examination. However, the mean scores of the control subjects remained unchanged at a rather high level (4.47, 4.47, and 4.23, respectively). Another item was item 2, stating "I feel very sad that I have lost my fetus in this pregnancy." The mean scores of the experimental subjects reduced from a high level (4.63) before implementation of a nursing care program and a high level (4.57) before hospital discharge to a rather high level (4.10) at the two-weeks follow-up examination. However, the mean scores of the control subjects remained unchanged at a rather high level (4.43, 4.43, and 4.20, respectively), as illustrated in

the Appendix. It is worth noting that even though the subjects indicated that they still had a rather high level of grief at the two-weeks follow-up examination, with the mean scores of 4.10 and 4.20 in the experimental group and the control group, respectively, and the subjects were afraid that they may experience spontaneous abortion again in the next pregnancy, a nursing care program provided to them helped reduce their feelings in other aspects, hence a decrease in the overall grief scores. For example, a nursing care program made women with spontaneous abortion understand their true feelings and accept the truth that spontaneous abortion had taken place and they had experienced a great loss, as can be seen in item 3, stating "I am confused whether the abortion has actually occurred to me or I am just dreaming." whose mean scores reduced from a rather high level to a moderate level to a rather low level, respectively. Thus, it can be concluded that a nursing care program enables women with spontaneous abortion to accept the truth of their loss and prevents their abnormal grief (Gilbert & Harmon, 1993). Furthermore, having the husbands participated in care could reduce the fear that their husbands would not understand them among the subjects, as evidenced by the mean scores of item 20, stating "I am worried that this abortion will make my husband and me do not understand each other." with the mean scores reducing from a moderate level (2.97) to a rather low level (2.20) and a low level (1.47), respectively. Moreover, promoting the opportunity to express their feelings, understand themselves, and have appropriate perceived self-efficacy for the next pregnancy made the experimental subjects lessened the subjects' feelings of worthlessness, as evidenced by the mean scores of item 22, stating "Spontaneous abortion made I am less valuable than other mothers." with the mean scores reducing from a rather high level (3.36) to a rather low level (2.10), and a low level (1.33), respectively. Finally, the mean scores for item 28, stating "I think I still have the opportunity to conceive again." reduced from a moderate level (2.87) to a rather low level both before hospital discharge and at two-weeks follow-up examinations (2.23 and 1.83, respectively), hence an indication that the experimental subjects were confident that they could be pregnant again after this.

Having a chance to relieve feelings and accept the loss that has happened can prevent abnormal grief (Gilbert & Harmon, 1993), and it also enables individuals to pass through the grieving process and finally accept the pain caused by their loss

(Kellner & Lake, 1993). In this study, the researcher gave women with spontaneous abortion the opportunity to express their feelings freely, without rushing them, and also offered to help them continuously. The researcher also provided assistance to some women who suffered from the guilt that they were the cause of spontaneous abortion and blamed themselves for the loss by giving them knowledge about the causes of spontaneous abortion so that they had better understanding and better able to deal with their guilt. The responses of the experimental subjects in a perinatal grief scale showed that their sinful feelings when thinking about the abortion reduced from a rather high level (4.13) to a moderate level (2.63) and a rather low level (2.00), respectively. This was in congruence with the principle proposed by Fulton & Metress (1995) that individuals suffering a loss should be assisted to release their guilt.

Giving the researcher's cell phone number to women with spontaneous abortion so that they could call when they needed help or wanted to share their feelings also made these women feel that there was someone who understood them and was ready to listen to them. There was one woman who called the researcher and asked whether her vaginal bleeding was abnormal. This meant that the woman trusted that the researcher was able to help her with her problems. A nurse as a company while the patients are facing a loss can reduce suffering or grief more than half. Likewise, Flores and Standish (1982) investigated grief of mothers who lost their fetus and found that a psychological support program or consultancy provided within the first 24 hours after a loss could decrease the duration of guilt. Moreover, Brown (1992) reported that mothers who lost their fetus and received support and consultation were able to undergo the grieving process more effectively than those who did not receive support or consultation. Research has pointed out that a team should be established to offer care and assistance to mothers who lose their fetus and their family. In this study, when the women with spontaneous abortion had a chance to express their feelings with the researcher constantly by their side, the "enabling" process was conducted to help women with spontaneous abortion go through the loss, rehabilitate their ability, enhance their recovery, and help them develop their self-care appropriately, beginning with helping them undergo the first task of grieving, which was accepting the truth of the loss. This was done by using questions to stimulate them to accept the loss. Initially, all women with spontaneous abortion acknowledged

that they had lost the fetus, but some felt as if the fetus was still in their womb. Some even said that they could still feel the fetus moving. When the researcher used questions to make them think of the situations in the delivery room and reflect their thoughts, they began to accept that they had actually lost their baby. For example, when one woman said that, *"I still feel that the baby was in my womb, still close to me,"* the researcher asked her to talk about the situation before the abortion took place, during the spontaneous abortion, and during the uterine curettage. This made them realize that uterine curettage meant the pregnancy was terminated and there was no longer a fetus in their womb. When they were able to accept the truth, their words would be changed to something like, *"The baby is no longer in my womb. It is now in heaven."* Or, when women with spontaneous abortion blamed themselves for the loss, saying the following sentiments, *"If I had taken a better care of myself, the spontaneous abortion may not have happened."* or *"I wish I could turn back time so that I could take a better care of myself."* the researcher would allow them to express their thoughts freely and accepted their resulting emotions without any objections. After the women had calmed down, the researcher would comfort them and asked for the causes of the guilt and the blame they had for themselves. The researcher would also explain to them that guilt could occur in the time of loss and give them knowledge about different causes of spontaneous abortion. Dissemination of knowledge would be done with the husbands as well to prevent them from putting the blame on their wife or themselves. In some cases, the women with spontaneous abortion felt lonely and expressed their desire to have their husband by their side, saying *"I want my husband to be near me, to comfort me."* When the researcher realized this, knowledge about the grieving process and care would be given to the husbands who were encouraged to take care of the women's psychological well-being. After dissemination of knowledge, some women said that they hugged their husbands and both of them cried. Their husbands also tried to comfort them or take them to the temple to make merits, and they felt better after that. Some women with spontaneous abortion also expressed their concern with the husbands' feelings, stating, *"I don't know what my husband is like now. I want [the nurse] to help and talk to him."* Then the researcher would talk to the husband to give them moral support and knowledge about spontaneous abortion. Some women with spontaneous abortion later told the researcher that their husband

followed the researcher's advice and the instruction in the manual, which made them feel that their husband understood them more.

In terms of information support, the researcher provided knowledge on the grieving process, spontaneous abortion, and other information needed by each of the women. The researcher also encouraged the family to take part in the care provided to women with spontaneous abortion by giving knowledge about the grieving process, spontaneous abortion, and care of women with spontaneous abortion to other family members. Furthermore, a talk to these women's husbands revealed that they experienced grief just like their wives. Similarly, Sukarawan (2005) showed that the husbands whose wives lost the fetus had a moderate level of grief. When the researcher talked to the husbands, they had a chance to learn that their wives needed moral support, encouragement, and comfort from them. The researcher also gave them knowledge about the causes of spontaneous abortion and taught them how to take care of their wives after they had returned home. Some of the husbands stated that if they had received such advice earlier, they would not have been so confused and would have been better able to comfort their wives. In addition to the husbands, the researcher gave knowledge to one mother of women with spontaneous abortion. Her daughter later informed the researcher that her mother comforted her as told to do so by the researcher. In the second phase, the researcher conducted a telephone follow-up with women with spontaneous abortion. Most of them indicated that their husbands took care of their physical and mental well-being well. They talked about the loss, cried together, went to make merits together, and did not blame each other for the loss. Some women with spontaneous abortion said that their mother-in-law took a very good care of them after reading the manual the researcher gave their husband. Swanson (1986) found that women with spontaneous abortion needed caregivers to support them to express their grief and go through the grieving process. Besides, they needed comfort that the resulting grief was a normal occurrence of those who had lost something as well, and their husband's needs should be satisfied.

During the time when women with spontaneous abortion were still unable to take care of themselves, due to injection of painkillers or administration of sleeping pills, the researcher performed the "**doing for**" step to help them carry out various activities. In terms of physical comfort, women with spontaneous abortion laid down

on the hospital bed with a bell they could ring if they needed help or when they wanted the researcher to accompany them to the bathroom. They had a bowel movement on the bed, and the cleanliness of their environment was well taken care of. Their safety was also taken into account as the rails on both sides of the hospital bed were raised. In short, the researcher provided care skillfully and to the best of her ability to meet the needs and expectations of women with spontaneous abortion. Ngeoychareon (1998) found that women with spontaneous abortion had a high level of the need for physical comfort and safety. In particular, they needed nurses to protect them from harms that may result from the spontaneous abortion, and they needed painkillers. Likewise, Swanson (1986) conducted a study and reported that women with spontaneous abortion needed assistance from nurses who were highly experienced, careful, and skillful so as to make them feel confident in care and safe.

After the end of each nursing care or at the termination of the research, the researcher summarized the care given to women with spontaneous abortion and gave them opportunity to ask questions to clarify their doubts. The researcher also showed her determination and commitment to help these women with spontaneous abortion overcome their grief by not rushing them to share their feelings and showing the researcher's readiness to listen to women with spontaneous abortion when they were ready. Such effort helped the women with spontaneous abortion develop trust in the researcher and confidence to share their feelings in the following meetings.

As for the subjects in the control group, they received routine nursing care from the hospital. That is, they received knowledge about spontaneous abortion on an individual basis or in a group of one to three members, depending on the number of patients with spontaneous abortion who were hospitalized at that time. There was no psychological care or dissemination of knowledge to the husband or relatives of women with spontaneous abortion, thus the mean scores of grief of women with spontaneous abortion who received a nursing care program developed based on Swanson's Caring Theory was lower than that of women with spontaneous abortion who received only routine nursing care from the hospital.

According to a nursing care offered to women with spontaneous abortion before hospital discharge, when assessing their level of grief, it was found that the level of grief of the experimental subjects was much lower that that of the control

subjects since before they returned to their home, as depicted in Table 4. When comparing the levels of grief in these two groups of subjects, it was discovered that the levels of grief of the experimental subjects reduced from rather high and moderate levels before implementation of a nursing care program to moderate and rather low levels before hospital discharge, accounting for 96.7% and 3.3%, respectively. On the other hand, the control subjects still had rather high and moderate levels of grief before hospital discharge, which did not reduce from the levels of grief they had before the implementation of the nursing program, at 20% and 80%, respectively. Thus, it could be concluded that a nursing care program based on Swanson's Caring Theory could be used to reduce the levels of grief of women with spontaneous abortion even before they were discharged from the hospital.

In the second phase, at one week after hospital discharge, the researcher made a telephone call to follow up on the women with spontaneous abortion. It was found that most of them received care from their husbands, children, or family members. For instance, they comforted them, took them to the temple to offer food to monks, took them out to dinner, cooked for them, or did the household chores for them, which were specified in the manual given by the researcher. There was one husband who prohibited everyone from mentioning the abortion. The researcher also got a chance to talk to this husband on how to care for grieving women. He told the researcher that he then better understood his wife, tried to comfort her, and would not stop her from talking about the abortion. After that, when the researcher met the wife when she came to the follow-up examination at the hospital, she stated that she was then able to discuss the abortion with her husband because he had learned from the researcher that having a chance to express feelings and having someone who was willing to listen helped the woman recover. This is also one of the reasons why the mean score of grief of the experimental group was lower than that of the control group.

In the third phase, when the women with spontaneous abortion came to the hospital for two weeks follow-up examinations after the abortion, the researcher followed the nursing care plan by keeping them company when they were examined by the doctor. Some women with spontaneous abortion said that they were afraid of the vaginal examination and wanted the researcher to be by her side. The researcher responded to their needs by keeping them company during the examination and when

they were having the results told to them. The researcher also offered them opportunity to discuss the loss, the care given to them by their family members, or their problems. Some women with spontaneous abortion stated that they felt better and could let go, while others said that they were still sad deep down in the their mind but they missed their baby less often. Another sign that they became better was that some women were able to openly discuss their loss with their neighbor. Also, everyone agreed that receiving care and support from their husbands and family made them feel that there was someone who understood them.

Due to a nursing care program which was divided into three phases-during hospitalization, during a telephone visit, and at the two-weeks follow-up examination, the mean grief score of all (100%) women with spontaneous abortion in the experimental group was at a rather low level (2.06) as shown in Tables 4 and 5. On the other hand, the mean score of most of the women with spontaneous abortion in the control group, or 80%, was at a moderate level (2.63). This could be explained that the women with spontaneous abortion in both groups received care from their family members after they had returned home. However, for those in the experimental group, their husbands received advice and a manual on how to perform physical and psychological care for women with spontaneous abortion. In other words, the women with spontaneous abortion in the experimental group received guided support from their family members, whereas those in the control group received only unguided support from their family members. For this reason, the level of grief of women with spontaneous abortion reduced only slightly to a moderate level.

Based on the above reasons, the mean score of grief of women with spontaneous abortion in the experimental group who received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of the women with spontaneous abortion who received only routine nursing care with statistical significance ($p < .001$).

Hypothesis 2: The mean scores of grief of women with spontaneous abortions obtained after receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that obtained before receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care.

The present study showed that the mean score of grief of women with spontaneous abortion obtained after receiving a nursing care program developed based on Swanson's Caring Theory was lower than that obtained before receiving a nursing care program developed based on Swanson's Caring Theory with statistical significance ($p < .001$, as shown in Tables 3, 6, and 7). The mean score of grief before receiving a nursing care program developed based on Swanson's Caring Theory differed from that obtained at the follow-up examination after two weeks with statistical significance, which can be explained below.

When women with spontaneous abortion experienced the loss, they would develop grief, which was a natural reaction. Thus, the level of grief was at a high level. After that, these women in the experimental group received a nursing care program developed based on Swanson's Caring Theory which emphasized individual care and holistic care offered through various nursing activities including physical care and psychological care. Physical care was offered when nurses made sure that the women had comfort, safety, appropriate food consumption, and rest, while psychological care was offered when the researcher offered to keep them company, listened to their feelings, tried to understand the meaning of loss of each woman, gave nursing care with sincerity and friendliness, provided verbal knowledge and a manual on self-care after spontaneous abortion and management of grief, and encouraged the husbands and family members to take care of the women. Thus, these women were able to accept their loss and express their feelings to relieve their grief. After the hospital discharge, the women returned home and found that their husbands tried to take care of them, and the researcher also called them to ask how they were doing and gave them further advice or gave their husbands more knowledge if they still did not fully understand the women. When the women came back to the hospital for follow-up examinations, the researcher kept them company in the examination room and gave

them more chance to express their feelings. Thus, their level of grief was reduced and became lower than the level of grief they had when they first had the spontaneous abortion and before receiving a nursing care program from the researcher.

The grief process is a dynamic and reversible process that constantly changes (Cowles & Rodgers, 1991). Generally grief can disappear within four to six weeks, and it lasts no more than two years (Lindemann, cited in Lucus & Pritchett, 1993). Thus, the women with spontaneous abortion in this study had a high level of grief at the beginning of the study, equal to 3.56 and 3.52 in the experimental group and the control group, respectively. After time passes, grief will gradually subside. Therefore, in this study, the grief level of the control subjects was lower even though they did not receive a nursing care program developed based on Swanson's Caring Theory. It can be seen that the level of grief of the women with spontaneous abortion in the experimental group who received a nursing care program developed based on Swanson's Caring Theory reduced more than that of the women with spontaneous abortion in the control group who received only routine nursing care from the hospital both before hospital discharge and at the two-weeks follow-up examination. Furthermore, the differences in the levels of grief of women with spontaneous abortion in the experimental group who received a nursing care program developed based on Swanson's Caring Theory and of the women with spontaneous abortion in the control group who received only routine nursing care from the hospital were statistically significantly different both before hospital discharge and at the two-week follow-up examination. Therefore, it can be concluded that a nursing care program developed based on Swanson's Caring Theory is appropriate in providing nursing care to enable women with spontaneous abortion to appropriately cope with grief and undergo the grieving process faster than those who do not receive a nursing care program developed based on Swanson's Caring Theory.

To conclude, the level of grief of the women with spontaneous abortion who received a nursing care program developed based on Swanson's Caring Theory was lower than that of the women with spontaneous abortion who received only routine nursing care with statistical significance ($p < .001$).

CHAPTER VI
CONCLUSION

The present study was quasi-experimental research (Pretest- Posttest design with nonequivalent group) which aimed at investigating the effects of a nursing care program developed based on Swanson's Caring Theory on grief of women with spontaneous abortion. The subjects of the study consisted of 60 women with spontaneous abortions who sought medical treatment at Siriraj Hospital from January to July 2008. There were 30 subjects in the experimental group, and another 30 subjects in the control group. The experimental subjects received a nursing care program developed based on Swanson's Caring Theory, whereas the control subjects received only routine nursing care. The research proposal was approved by Siriraj Ethic Committee on Research Involving Human Subjects of the Faculty of Medicine, Siriraj Hospital, Mahidol University. The data collection instruments consisted of a demographic characteristics questionnaire and a perinatal grief questionnaire of women with spontaneous abortion. Demographic data were analyzed using frequency, percentage, and Chi-square. Also, independent t-test was used to compare the mean scores of grief of the experimental subjects and the control subjects, and Repeated-Measures ANOVA was used to compare the mean scores of grief of the subjects in both groups at three points in time-before the experiment started, before hospital discharge, and at two-weeks follow-up examinations. The research findings can be summarized as follows:

1. As regards demographic characteristics, it was found that the women with spontaneous abortion in the experimental group were between 18 and 24 years, with the mean age of 27.97 years, while the control subjects ranged in age from 18 to 41 years, with the mean age of 28 years. In terms of education, the experimental subjects could be almost equally divided into three groups- junior high school, senior high school and vocational education. On the other hand, most of the subjects in the control group had vocational education. Moreover, most of the subjects were

Buddhists, and all of them were married. In addition, most of the subjects were employees, and the subjects in the experimental group had a monthly income ranging from 8,000 to 40,000 baht, with the mean income of 18,976 baht, whereas the control subjects earned between 3,000 and 50,000 baht, with the mean income of 20,000 baht. Finally, most of the subjects in both groups lived in Bangkok or its vicinity.

2. As for obstetrics data of women with spontaneous abortion, most of the women in experimental group were multigravidarum, in control group equal in primigravidarum and multigravidarum. The duration of marriage of the experimental subjects ranged from 1 to 15 years, with the mean of 4.43 years, and that of the control group also ranged from 1 to 15 years, with the mean of 4.40 years. Most of them knew that they were pregnant, and all of the women in the experimental group had never consulted a physician about infertility, while there was only one subject in the control group who had consulted a doctor about infertility. In addition, all of the women with spontaneous abortion did not use any contraception before becoming pregnant, and most of them were diagnosed with incomplete abortion. Finally, the gestational age of the experimental group ranged from 7 to 18 weeks, with the mean of 10.70 weeks, whereas that of the control group was between 5 and 16 weeks, with the mean of 10.07 weeks.

3. The findings related to grief were as follows:

3.1 Before provision of a nursing care program, the levels of grief of both the experimental subjects and the control subjects were at a rather high level ($\overline{X}$ = 3.56, SD = .29 and $\overline{X}$ = 3.52, SD = .19, respectively). As for the experimental subjects, 60% had a rather high level of grief, while 40% had a moderate level of grief. Likewise, 56.7% of the control subjects had a rather high level of grief, whereas 43.3% had a moderate level of grief.

3.2 Before hospital discharge, both the experimental subjects and the control subjects had a moderate level of grief ($\overline{X}$ = 2.75, SD = .25 and $\overline{X}$ = 3.36, SD = .24, respectively). Almost all of the subjects in the experimental group, or 96.7%, had a moderate level of grief, while 3.3% had a rather low level of grief. On the other hand, about 20% of the subjects in the control group had a rather high level of grief, whereas 80% of them had a moderate level of grief.

3.3 At the two-weeks follow-up examination, it was found that the experimental subjects had a rather low level of grief ($\overline{X}$ = 2.06, SD = .31), while the control subjects had a moderate level of grief ($\overline{X}$ = 2.63, SD = .21). All of the subjects in the experimental group, or 100%, had a rather low level of grief. In contrast, most of the subjects in the control group, or 83.3%, had a moderate level of grief, and only 16.7% had a rather low level of grief.

4. The mean scores of grief of the women with spontaneous abortion who received a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that of the women with spontaneous abortion who received only routine nursing care with statistical significance ($p < .001$).

5. The mean scores of grief of the women with spontaneous abortion after receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care was lower than that obtained before receiving a nursing care program developed based on Swanson's Caring Theory coupled with routine nursing care with statistical significance. ($p < .001$).

Recommendations

The findings of this study have suggested that a nursing care program developed based on Swanson's Caring Theory can greatly reduce the grief of women with spontaneous abortion. For this reason, nurses should implement this nursing care program to provide care to women with spontaneous abortion as well as women who have lost their fetus due to other reasons. Based on the findings of the study, the following recommendations can be made:

For nursing practice

1. The researcher found that women with spontaneous abortion have a rather high level of grief, and they need to be hospitalized in an unfamiliar environment. Thus, nurses and other healthcare team members should pay attention to both physical and mental well-being of these women by using a nursing care program developed based on Swanson's Caring Theory as a guideline in reducing their grief since their hospital admission until hospital discharge and when they come back to the hospital for follow-up examinations.

2. The grief of women with spontaneous abortion questionnaire should be used to assess the grief level of all women with spontaneous abortion to enable nurses to provide nursing care that better suits their level of grief.

3. The findings of the study indicated that after the completion of a nursing care program the overall mean scores of grief of the subjects in both groups were lower that those obtained before program implementation. However, when considering each item of grief, it was found that the subjects in the experimental and control groups continued to have a rather high level of grief. Therefore, care should be continuously provided to them until the assessment has shown that their grief has already reduced such as for a period of six months after spontaneous abortion took place.

For nursing administration

As nurses who can implement a nursing care program developed based on Swanson's Caring Theory need to possess some basic skills in consultancy, the following recommendations are made:

1. Training should be organized to equip nurses with the skills necessary in providing consultancy to effectively carry out a nursing care program developed based on Swanson's Caring Theory to reduce grief of women with spontaneous abortion.

2. A team of nurses should be appointed to be directly responsible for implementing a nursing care program developed based on Swanson's Caring Theory to reduce grief of all women with spontaneous abortion.

3. A nursing care program should further be developed into the clinical nursing practice guideline to be used as a standard nursing care practice for women with spontaneous abortion.

For nursing research

1. A nursing care program developed based on Swanson's Caring Theory should be used to reduce grief of other groups of women with different types of abortion.

2. A nursing care program developed based on Swanson's Caring Theory should also be implemented to reduce grief of the husband of women with spontaneous abortion.

3. In this study, husbands and family members of women with spontaneous abortion were encouraged to participate in provision of care to the women, but the effectiveness of their participation was not determined. As a result, further research should be conducted to shed light on the effectiveness of husbands' and family members' participation in care of women with spontaneous abortion.

4. Research should also be carried out to investigate long-term grief of women with spontaneous abortion such as six months after the abortion took place.

Limitations

The researcher was unable to control the environment in 100th years Somdech Phra Srinagarindra Ward 8/1 and 8/2, Siriraj Hospital, such as treatment from physicians, counseling or emotional support from physicians, nurses or relatives , advice knowledge from physicians or staff nurses , all of that might have affected on grief of women with spontaneous abortion.

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APPENDIX

APPENDIX A
LIST OF RXPERTS

The data collecting instruments comprising a nursing care program was developed based on Swanson's Caring Theory, The teaching plan on spontaneous abortion and self-care practice for women with miscarriage , The teaching plan on spontaneous abortion and self-care practice for family members of women with miscarriage, A manual on care after spontaneous abortion and management of grief for women with miscarriage, A manual for family members of women with miscarriage, A demographic characteristics questionnaire , A perinatal grief scale and Anecdotal Record were submitted to a panel of experts for examination of content validity. The panel was composed of following five experts :

1. Associate Prof. Dr.Kitirat Techatraisak
   Department of Obstetrics & Gynaecology
   Faculty of Medicine, Siriraj Hospital
   Mahidol University
2. Asisstant Prof.Dr.Atirat Wattanapailin
   Department of Mental Health & psychiatric Nursing
   Faculty of Nursing, Mahidol University
3. Asisstant Prof.Acharaporn Seeherunwong
   Department of Mental Health & Psychiatric Nursing
   Faculty of Nursing, Mahidol University
4. Lect. Kanyarak Ngeoicharoen
   Department of Obstetric and Gynaecological Nursing
   Faculty of Nursing, Mahidol University
5. Prayuk Serisathien,MD.
   Mental Health Center 1, Department of Mental Health,
   Ministry of Public Health

APPENDIX B

แบบยินยอมเข้าร่วมการศึกษา

เอกสารชี้แจงผู้เข้าร่วมการวิจัย
(Participant Information Sheet)

สำหรับกลุ่มควบคุม

ในเอกสารนี้อาจมีข้อความที่ท่านอ่านแล้วยังไม่เข้าใจ โปรดสอบถามหัวหน้าโครงการวิจัย หรือผู้แทนให้ช่วยอธิบายจนกว่าจะเข้าใจดี ท่านอาจจะขอเอกสารนี้กลับไปอ่านที่บ้านเพื่อปรึกษาหารือกับญาติพี่น้อง เพื่อนสนิท แพทย์ประจำตัวของท่านหรือแพทย์ท่านอื่น เพื่อช่วยในการตัดสินใจเข้าร่วมการวิจัย

ชื่อโครงการ ผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง

ชื่อผู้วิจัย นางสาวสุภาพันธ์ เหมือนวัดไทร
นักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต
สาขาการพยาบาลมารดา-ทารกแรกเกิดและสุขภาพสตรี
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

สถานที่วิจัย หอผู้ป่วย100ปีสมเด็จพระศรีนครินทร์ ชั้น 8/1 และ
หอผู้ป่วย100ปีสมเด็จพระศรีนครินทร์ ชั้น 8/2 โรงพยาบาลศิริราช

หมายเลขโทรศัพท์ที่ติดต่อได้ทั้งในและนอกเวลาราชการ 081-1702887

ผู้ให้ทุน ไม่มี

โครงการวิจัยนี้จัดทำขึ้นเพื่อศึกษาแนวทางการให้การพยาบาลเพื่อลดความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเองโดยใช้แนวทางการพยาบาลตามกรอบทฤษฎีการดูแล(Thoery

of caring) ของแสวนสัน ซึ่งเป็นแนวคิดที่เป็นการดูแลแบบองค์รวมเน้นการการมีปฏิสัมพันธ์กับผู้ป่วย มีการระบายความรู้สึกหรือมีการแสดงออกต่อความเศร้าโศกอย่างเหมาะสม รู้จักตนเอง เข้าใจสิ่งที่เกิดขึ้นในชีวิต เข้าใจกระบวนการเศร้าโศก สามารถแสดงความเศร้าโศกและผ่านกระบวนการเศร้าโศกไปได้ด้วยดี เพื่อเป็นประโยชน์ในการวางแผนการพยาบาลแก่หญิงที่สูญเสียบุตรจากการแท้งเองต่อไป

ท่านได้รับเชิญให้เข้าร่วมโครงการนี้เพราะท่านเป็นผู้หนึ่งที่มีคุณสมบัติเหมาะสมตามเกณฑ์การคัดเลือกที่ผู้วิจัยจะทำการศึกษาในครั้งนี้ คือเป็นหญิงที่สูญเสียบุตรจากการแท้งเองที่มีอายุ 18 ปีขึ้นไป อายุครรภ์ไม่เกิน 20 สัปดาห์ที่มารับการรักษาที่โรงพยาบาลศิริราช จะมีผู้เข้าร่วมการวิจัยครั้งนี้ 30 คน รวมระยะเวลาที่ทำการวิจัยทั้งสิ้นประมาณ 2 สัปดาห์

หากท่านตัดสินใจเข้าร่วมการวิจัยแล้วท่านจะได้รับการพยาบาลตามปกติจากพยาบาลประจำการ ในส่วนของการวิจัยผู้วิจัยใคร่ขอความร่วมมือจากท่านในการตอบแบบสอบถามข้อมูลส่วนบุคคลของหญิงที่สูญเสียบุตรจากการแท้งเองจำนวน 13 ข้อ เมื่อยินดีเข้าร่วมการวิจัยในวันแรก และ แบบสอบถามความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง จำนวน 28 ข้อเป็นจำนวน 3 ครั้งโดยเป็นแบบสอบถามชุดเดิมทั้ง 3 ครั้ง ใช้เวลาครั้งละประมาณ 5-10 นาที คือ

ครั้งที่1 เมื่อยินดีเข้าร่วมการวิจัยในวันแรก

ครั้งที่ 2 ก่อนจำหน่ายกลับบ้าน

ครั้งที่3 เมื่อมารับการตรวจตามนัดหลังแท้งบุตร 2 สัปดาห์

ผู้เข้าร่วมการวิจัยสามารถที่จะไม่ตอบข้อใดก็ได้หรือหยุดตอบแบบสอบถามเมื่อใดก็ได้ตามความสมัครใจ

การเก็บข้อมูลจากท่านในครั้งนี้เป็นการใช้แบบสอบถาม อาจมีความเสี่ยงหรือผลข้างเคียงที่อาจจะเกิดขึ้นจากการวิจัยกับท่าน เช่น เสียเวลาในการตอบแบบสอบถามประมาณ 10-15 นาที อาจมีคำถามบางข้อที่ทำให้ท่านรู้สึกไม่สบายใจ เศร้าโศกคิดถึงบุตรที่สูญเสียไป ท่านสามารถที่จะไม่ตอบข้อใดก็ได้หรืออาจหยุดตอบแบบสอบถามก็ได้ตามความสมัครใจ โดยผู้วิจัยจะพูดคุยปลอบโยน อยู่เป็นเพื่อนท่านเพื่อให้ท่านระบายความรู้สึกจากการสูญเสียบุตรของท่านจนกว่าจะสบายใจและคลายความเศร้าโศกลง

หากท่านไม่เข้าร่วมการวิจัยครั้งนี้ท่านก็จะได้รับการรักษาพยาบาลตามวิธีการที่เป็นมาตรฐานของโรงพยาบาล

หากท่านมีข้อสงสัยหรือข้อข้องใจที่จะสอบถามเกี่ยวกับการวิจัย ท่านสามารถติดต่อผู้วิจัยได้โดยตรงที่ นางสาวสุภาพันธ์ เหมือนวัดไทร เบอร์โทรศัพท์ 081-1702887

การเข้าร่วมการวิจัยในครั้งนี้ไม่มีค่าตอบแทนใดๆที่ท่านจะได้รับหรือค่าใช้จ่ายที่ท่านต้องรับผิดชอบเอง

หากมีข้อมูลเพิ่มเติมทั้งประโยชน์และโทษที่เกี่ยวข้องกับการวิจัยนี้ผู้วิจัยจะแจ้งให้ท่านทราบโดยเร็วและไม่ปิดบัง

ข้อมูลส่วนตัวของผู้เข้าร่วมการวิจัยจะถูกเก็บรักษาไว้เป็นความลับ ไม่เปิดเผยต่อสาธารณะเป็นรายบุคคล แต่จะรายงานผลการวิจัยเป็นข้อมูลส่วนรวม ข้อมูลของผู้ร่วมการวิจัยเป็นรายบุคคลอาจมีบุคคลบางกลุ่มเข้ามาตรวจสอบได้เช่น ผู้ให้ทุนการวิจัย สถาบันหรือองค์กรของรัฐที่มีหน้าที่ตรวจสอบการวิจัย คณะกรรมการสิทธิมนุษยชนเกี่ยวกับการวิจัยในคนคณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล เป็นต้น

ผู้เข้าร่วมการวิจัยมีสิทธิ์ถอนตัวออกจากการวิจัยเมื่อใดก็ได้ โดยไม่ต้องแจ้งให้ทราบล่วงหน้า และการไม่เข้าร่วมการวิจัยหรือถอนตัวออกจากการวิจัยนี้จะไม่มีผลกระทบต่อการบริการและการรักษาพยาบาลที่สมควรจะได้รับแต่ประการใด

หากท่านได้รับการปฏิบัติที่ไม่ตรงตามที่ระบุไว้ในเอกสารการชี้แจงนี้ ท่านสามารถแจ้งให้ประธานคระกรรมการจริยธรรมการวิจัยในคนทราบได้ที่ สำนักงานคณะกรรมการจริยธรรมการวิจัยในคน ตึกอดุลยเดชวิกรม ชั้น 6 โรงพยาบาลศิริราช เบอร์โทรศัพท์ 02-4196405-6 fax 02-4196405

ข้าพเจ้าได้อ่านรายละเอียดในเอกสารนี้ครบถ้วนแล้ว

ลงชื่อ..... วันที่.....

(.....)

เอกสารชี้แจงผู้เข้าร่วมการวิจัย
(Participant Information Sheet)

สำหรับกลุ่มทดลอง

ในเอกสารนี้อาจมีข้อความที่ท่านอ่านแล้วยังไม่เข้าใจ โปรดสอบถามหัวหน้าโครงการวิจัย หรือผู้แทนให้ช่วยอธิบายจนกว่าจะเข้าใจดี ท่านอาจจะขอเอกสารนี้กลับไปอ่านที่บ้านเพื่อปรึกษาหารือกับญาติพี่น้อง เพื่อนสนิท แพทย์ประจำตัวของท่านหรือแพทย์ท่านอื่น เพื่อช่วยในการตัดสินใจเข้าร่วมการวิจัย

ชื่อโครงการ ผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง

ชื่อผู้วิจัย นางสาวสุภาพันธ์ เหมือนวัดไทร
นักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต
สาขาการพยาบาลมารดา-ทารกแรกเกิดและสุขภาพสตรี
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

สถานที่วิจัย หอผู้ป่วย100ปีสมเด็จพระศรีนครินทร์ ชั้น 8/1 และ
หอผู้ป่วย100ปีสมเด็จพระศรีนครินทร์ ชั้น 8/2 โรงพยาบาลศิริราช

หมายเลขโทรศัพท์ที่ติดต่อได้ทั้งในและนอกเวลาราชการ 081-1702887

ผู้ให้ทุน ไม่มี

โครงการวิจัยนี้จัดทำขึ้นเพื่อศึกษาแนวทางการให้การพยาบาลเพื่อลดความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเองโดยใช้แนวทางการพยาบาลตามกรอบทฤษฎีการดูแล(Thoery of caring) ของแสวนสัน ซึ่งเป็นแนวคิดที่เป็นการดูแลแบบองค์รวมเน้นการการมีปฏิสัมพันธ์กับผู้ป่วย มีการระบายความรู้สึกหรือมีการแสดงออกต่อความเศร้าโศกอย่างเหมาะสม รู้จักตนเอง เข้าใจสิ่งที่เกิดขึ้นในชีวิต เข้าใจกระบวนการเศร้าโศก สามารถแสดงความเศร้าโศกและผ่านกระบวนการเศร้าโศกไปได้ด้วยดี เพื่อเป็นประโยชน์ในการวางแผนการพยาบาลแก่หญิงที่สูญเสียบุตรจากการแท้งเองต่อไป

ท่านได้รับเชิญให้เข้าร่วมโครงการนี้เพราะท่านเป็นผู้หนึ่งที่มีคุณสมบัติเหมาะสมตามเกณฑ์การคัดเลือกที่ผู้วิจัยจะทำการศึกษาในครั้งนี้ คือเป็นหญิงที่สูญเสียบุตรจากการแท้งเองที่มีอายุ 18 ปีขึ้นไป อายุครรภ์ไม่เกิน 20 สัปดาห์ที่มารับการรักษาที่โรงพยาบาลศิริราช จะมีผู้เข้าร่วมการวิจัยครั้งนี้ 30 คน รวมระยะเวลาที่ทำการวิจัยทั้งสิ้นประมาณ 2 สัปดาห์

หากท่านตัดสินใจเข้าร่วมการวิจัยแล้วจะมีขั้นตอนการวิจัยดังต่อไปนี้คือ

1. ตอบแบบสอบถามข้อมูลส่วนบุคคลของหญิงที่สูญเสียบุตรจากการแท้งเองจำนวน 13 ข้อ เมื่อยินดีเข้าร่วมการวิจัยในวันแรก และแบบสอบถามความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง จำนวน 28 ข้อเป็นจำนวน 3 ครั้ง โดยเป็นแบบสอบถามชุดเดิมทั้ง 3 ครั้ง ใช้เวลาครั้งละประมาณ 5-10 นาที คือ

ครั้งที่1 เมื่อยินดีเข้าร่วมการวิจัยในวันแรก

ครั้งที่2 ก่อนจำหน่ายกลับบ้าน

ครั้งที่3 เมื่อมารับการตรวจตามนัดหลังแท้งบุตร 2 สัปดาห์

2.ผู้วิจัยจะนัดพบท่านเพื่อเข้าร่วมโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสัน จำนวนอย่างน้อย 4 ครั้ง ใช้เวลาครั้งละประมาณ 15-60 นาที คือ

ครั้งที่1 เมื่อยินดีเข้าร่วมการวิจัยในวันแรก

ครั้งที่2 วันรุ่งขึ้นหลังแท้งจนจำหน่ายกลับบ้าน

ครั้งที่3 การโทรศัพท์ติดตามเยี่ยมที่บ้านจากผู้วิจัยเมื่อกลับบ้านได้ 1 สัปดาห์

ครั้งที่4 เมื่อมารับการตรวจตามนัดหลังแท้งบุตร 2 สัปดาห์

3. ท่านจะได้รับ “คู่มือการปฏิบัติตัวหลังแท้งบุตรและการจัดการกับความเศร้าโศกสำหรับหญิงที่สูญเสียบุตรจากการแท้งเอง”

4.สมาชิกในครอบครัวของท่านจะได้รับ “คู่มือการช่วยเหลือสนับสนุนหญิงหลังแท้งบุตรสำหรับสมาชิกในครอบครัวของหญิงที่สูญเสียบุตรจากการแท้งเอง “

5. ท่านจะได้รับการพยาบาลตามปกติจากพยาบาลประจำการร่วมด้วย

การเก็บข้อมูลจากท่านในครั้งนี้ อาจมีความเสี่ยงหรือผลข้างเคียงที่อาจจะเกิดขึ้นจากการวิจัยกับท่าน เช่น เสียเวลาในการตอบแบบสอบถามประมาณ 10-15 นาที อาจมีคำถามบางข้อที่ทำให้ท่านรู้สึกไม่สบายใจ เศร้าโศกคิดถึงบุตรที่สูญเสียไป ท่านสามารถที่จะไม่ตอบข้อใดก็ได้ หรืออาจหยุดตอบแบบสอบถามก็ได้ตามความสมัครใจ และในระหว่างร่วมโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันอาจมีคำถามที่ทำให้ท่านรู้สึกไม่สบายใจ ท่านสามารถที่จะไม่

ตอบก็ได้หรืออาจหยุดเข้าร่วมโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันก็ได้ตามความสมัครใจ โดยผู้วิจัยจะพูดคุย ปลอบโยน อยู่เป็นเพื่อนท่านเพื่อให้ท่านระบายความรู้สึกจากการสูญเสียบุตรของท่านจนกว่าจะสบายใจและคลายความเศร้าโศกลง

หากท่านไม่เข้าร่วมการวิจัยครั้งนี้ท่านก็จะได้รับการรักษาพยาบาลตามวิธีการที่เป็นมาตรฐานของโรงพยาบาล

หากท่านมีข้อสงสัยหรือข้อข้องใจที่จะสอบถามเกี่ยวกับการวิจัย ท่านสามารถติดต่อผู้วิจัยได้โดยตรงที่ นางสาวสุภาพันธ์ เหมือนวัดไทร เบอร์โทรศัพท์ 081-1702887

การเข้าร่วมการวิจัยในครั้งนี้ไม่มีค่าตอบแทนใดๆที่ท่านจะได้รับหรือค่าใช้จ่ายที่ท่านต้องรับผิดชอบเอง

หากมีข้อมูลเพิ่มเติมทั้งประโยชน์และโทษที่เกี่ยวข้องกับการวิจัยนี้ผู้วิจัยจะแจ้งให้ท่านทราบโดยเร็วและไม่ปิดบัง

ข้อมูลส่วนตัวของผู้เข้าร่วมการวิจัยจะถูกเก็บรักษาไว้เป็นความลับ ไม่เปิดเผยต่อสาธารณะเป็นรายบุคคล แต่จะรายงานผลการวิจัยเป็นข้อมูลส่วนรวม ข้อมูลของผู้ร่วมการวิจัยเป็นรายบุคคลอาจมีบุคคลบางกลุ่มเข้ามาตรวจสอบได้เช่น ผู้ให้ทุนการวิจัย สถาบันหรือองค์กรของรัฐที่มีหน้าที่ตรวจสอบการวิจัย คณะกรรมการสิทธิมนุษยชนเกี่ยวกับการวิจัยในคนคณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล เป็นต้น

ผู้เข้าร่วมการวิจัยมีสิทธิ์ถอนตัวออกจากการวิจัยเมื่อใดก็ได้ โดยไม่ต้องแจ้งให้ทราบล่วงหน้า และการไม่เข้าร่วมการวิจัยหรือถอนตัวออกจากการวิจัยนี้จะไม่มีผลกระทบต่อการบริการและการรักษาพยาบาลที่สมควรจะได้รับแต่ประการใด

หากท่านได้รับการปฏิบัติที่ไม่ตรงตามที่ระบุไว้ในเอกสารการชี้แจงนี้ ท่านสามารถแจ้งให้ประธานคระกรรมการจริยธรรมการวิจัยในคนทราบได้ที่ สำนักงานคณะกรรมการจริยธรรมการวิจัยในคน ตึกอดุลยเดชวิกรม ชั้น 6 โรงพยาบาลศิริราช เบอร์โทรศัพท์ 02-4196405-6 fax 02-4196405

ข้าพเจ้าได้อ่านรายละเอียดในเอกสารนี้ครบถ้วนแล้ว

ลงชื่อ...../วันที่.....

(.....)

หนังสือแสดงเจตนายินยอมเข้าร่วมการวิจัย

วันที่.....เดือน.....พ.ศ. .....

ข้าพเจ้า.....อายุ.....ปี อาศัยอยู่บ้านเลขที่.....ถนน.....ตำบล.....**....** อำเภอ.....จังหวัด.....รหัสไปรษณีย์..... เบอร์โทรศัพท์.....

ขอแสดงเจตนายินยอมเข้าร่วมโครงการวิจัย **เรื่องผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตรจากการแท้งเอง**

โดยข้าพเจ้าได้รับทราบรายละเอียดเกี่ยวกับที่มาและจุดมุ่งหมายในการทำวิจัย รายละเอียดขั้นตอนต่างๆที่จะต้องปฏิบัติหรือได้รับการปฏิบัติ ประโยชน์ที่คาดว่าจะได้รับของการวิจัยและความเสี่ยงที่อาจจะเกิดขึ้นจากการเข้าร่วมวิจัย รวมทั้งแนวทางป้องกันและแก้ไขหากเกิดอันตรายขึ้น โดยได้อ่านข้อความที่มีรายละเอียดอยู่ในเอกสารชี้แจงผู้เข้าร่วมการวิจัยโดยตลอด อีกทั้งยังได้รับคำอธิบายและตอบข้อสงสัยจากหัวหน้าโครงการวิจัยเป็นที่เรียบร้อยแล้ว

ข้าพเจ้าจึงสมัครใจเข้าร่วมโครงการวิจัยนี้

หากข้าพเจ้ามีข้อข้องใจเกี่ยวกับขั้นตอนของการวิจัย หรือหากเกิดผลข้างเคียงที่ไม่พึงประสงค์จากการวิจัยขึ้นกับข้าพเจ้า ข้าพเจ้าจะสามารถติดต่อกับนางสาวสุภาพันธ์ เหมือนวัดไทร นักศึกษาหลักสูตรพยาบาลศาสตรมหาบัณฑิต สาขาการพยาบาลมารดา-ทารกแรกเกิดและสุขภาพสตรี คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล ที่เบอร์โทรศัพท์ 081-1702887 ได้ตลอด 24 ชม.

หากข้าพเจ้าได้รับการปฏิบัติไม่ตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าจะสามารถติดต่อกับประธานคณะกรรมการจริยธรรมการวิจัยในคนหรือผู้แทนได้ที่สำนักงานคณะกรรมการจริยธรรมการวิจัยในคน ตึกอดุลยเดชวิกรม ชั้น 6 ร.พ.ศิริราช โทร (02)419-6405-6

ข้าพเจ้าได้ทราบถึงสิทธิ์ที่ข้าพเจ้าจะได้รับข้อมูลเพิ่มเติมทั้งทางด้านประโยชน์และโทษจากการเข้าร่วมการวิจัย และสามารถถอนตัวหรืองดเข้าร่วมการวิจัยได้ทุกเมื่อ โดยจะไม่มีผลกระทบต่อการบริการและการรักษาพยาบาลที่ข้าพเจ้าจะได้รับต่อไปในอนาคตและยินยอมให้ผู้วิจัยใช้ข้อมูลส่วนตัวของข้าพเจ้าที่ได้รับจากการวิจัย แต่จะไม่เผยแพร่ต่อสาธารณะเป็นรายบุคคล โดยจะนำเสนอเป็นข้อมูลโดยรวมจากการวิจัยเท่านั้น

ข้าพเจ้าได้เข้าใจข้อความในเอกสารชี้แจงผู้เข้าร่วมการวิจัย และหนังสือแสดงเจตนายินยอมนี้โดยตลอดแล้ว จึงลงลายมือชื่อไว้

ลงชื่อ.....ผู้เข้าร่วมการวิจัย/ผู้แทนโดยชอบธรรม/วันที่.....

(.....)

ลงชื่อ.....ผู้ให้ข้อมูลและขอความยินยอม/หัวหน้าโครงการวิจัย/

วันที่.....

(.....)

ในกรณีผู้เข้าร่วมการวิจัยอ่านหนังสือไม่ออก ผู้ที่อ่านข้อความทั้งหมดแทนผู้เข้าร่วมการวิจัย

คือ.....จึงลงลายมือชื่อไว้เป็นพยาน

ลงชื่อ.....พยาน/วันที่.....

(.....)

APPENDIX C

NURSING CARE PROGRAM BASED ON SWANSON'S CARING THEORY

โปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของแสวนสัน

ผู้ให้การพยาบาล นางสาวสุภาพันธ์ เหมือนวัดไทร
นักศึกษาปริญญาโท สาขาการพยาบาลมารดา-ทารกแรกเกิดและสุขภาพ
สตรี คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

ผู้ที่ได้รับการพยาบาล หญิงที่สูญเสียบุตรจากการแท้งเอง

สถานที่ หอผู้ป่วยหลังคลอดติดเชื้อ (หอผู้ป่วย 100 ปีสมเด็จพระศรีนครินทร์ชั้น 8/1) และห้องคลอดติดเชื้อ (หอผู้ป่วย 100ปีสมเด็จพระศรีนครินทร์ชั้น 8/2) งานการพยาบาลสูติศาสตร์-นรีเวชวิทยา คณะแพทยศาสตร์ศิริราชพยาบาล มหาวิทยาลัยมหิดล

วัตถุประสงค์ เมื่อสิ้นสุดการปฏิบัติตามโปรแกรมการพยาบาลตามทฤษฎีการดูแลของแสวนสันแล้วหญิงที่สูญเสียบุตรจากการแท้งเอง
1. มีความรู้ ความเข้าใจ ความเศร้าโศกที่เกิดจากการสูญเสียบุตร
2. ยอมรับการสูญเสียจากการสูญเสียบุตรและคลายความเศร้าโศกลง

ระยะที่ 1 ขณะอยู่โรงพยาบาลที่หอผู้ป่วย100 ปี สมเด็จพระศรีนครินทร์ชั้น 8/1

ให้การดูแลดังเช่นหญิงที่คลอดบุตรจากการแท้งทั่วไป ยกเว้นการวิจัยในวันแรก วันรุ่งขึ้นติดตามเยี่ยมและให้การดูแลจนจำหน่าย

กลับบ้าน ในกรณีที่มีภาวะแทรกซ้อนหรือต้องอยู่โรงพยาบาลนานกว่าวันจะตามเยี่ยมจนกว่าจะจำหน่าย

APPENDIX D

การประเมินระยะของความเศร้าโศกและการพยาบาล

ระยะของความเศร้าโศก	พฤติกรรมการแสดงออก	คำพูด
ระยะช็อคและไม่เชื่อ (Shock and disbelief)	- อาการเฉยชา …….	“ไม่จริง” …….
ระยะคร่ำครวญโหยหาผู้ที่ตาย (Yearning , searching and anxiety)	…….	…….
ระยะสับสน หมดหวังและซึมเศร้า (Disorganization ,despair and depression)	…….	…….
ระยะตั้งหลักได้ใหม่ (Reorganization)	……. - พูดคุยเกี่ยวกับการแท้งบุตรและความสูญเสียที่เกิดขึ้นอย่างปกติ และวางแผนการดำเนินชีวิตในอนาคตได้	……. “ควรปฏิบัติตัวอย่างไร”

APPENDIX E

การพยาบาลตามระยะของกระบวนการเศร้าโศก

ระยะของความเศร้าโศก	การพยาบาล
ระยะช็อคและไม่เชื่อ (Shock and disbelief)	1.จัดสิ่งแวดล้อมให้มีความเป็นส่วนตัว เพื่อให้สามารถแสดงความรู้สึกได้อย่างอิสระ ……
ระยะคร่ำครวญโหยหาผู้ที่ตาย (Yearning , searching and anxiety)	……
ระยะสับสน หมดหวังและซึมเศร้า (Disorganization ,despair and depression)	……
ระยะตั้งหลักได้ใหม่ (Reorganization)	…… 2.แนะนำให้คิดในทางบวกเพื่อเป็นการเสริมสร้างจิตใจให้เข้มแข็ง

APPENDIX F

THE TEACHING PLAN ON SPONTANEOUS ABORTION AND SELF-CARE PRACTICE FOR WOMEN WITH SPONTANEOUS ABORTION

แผนการสอนเรื่องการแท้งบุตรและการปฏิบัติตนหลังแท้งบุตร

ผู้สอน นางสาวสุภาพันธ์ เหมือนวัฒไทร

นักศึกษาปริญญาโทสาขาการพยาบาลมารดา- ทารกแรกเกิดและสุขภาพสตรี

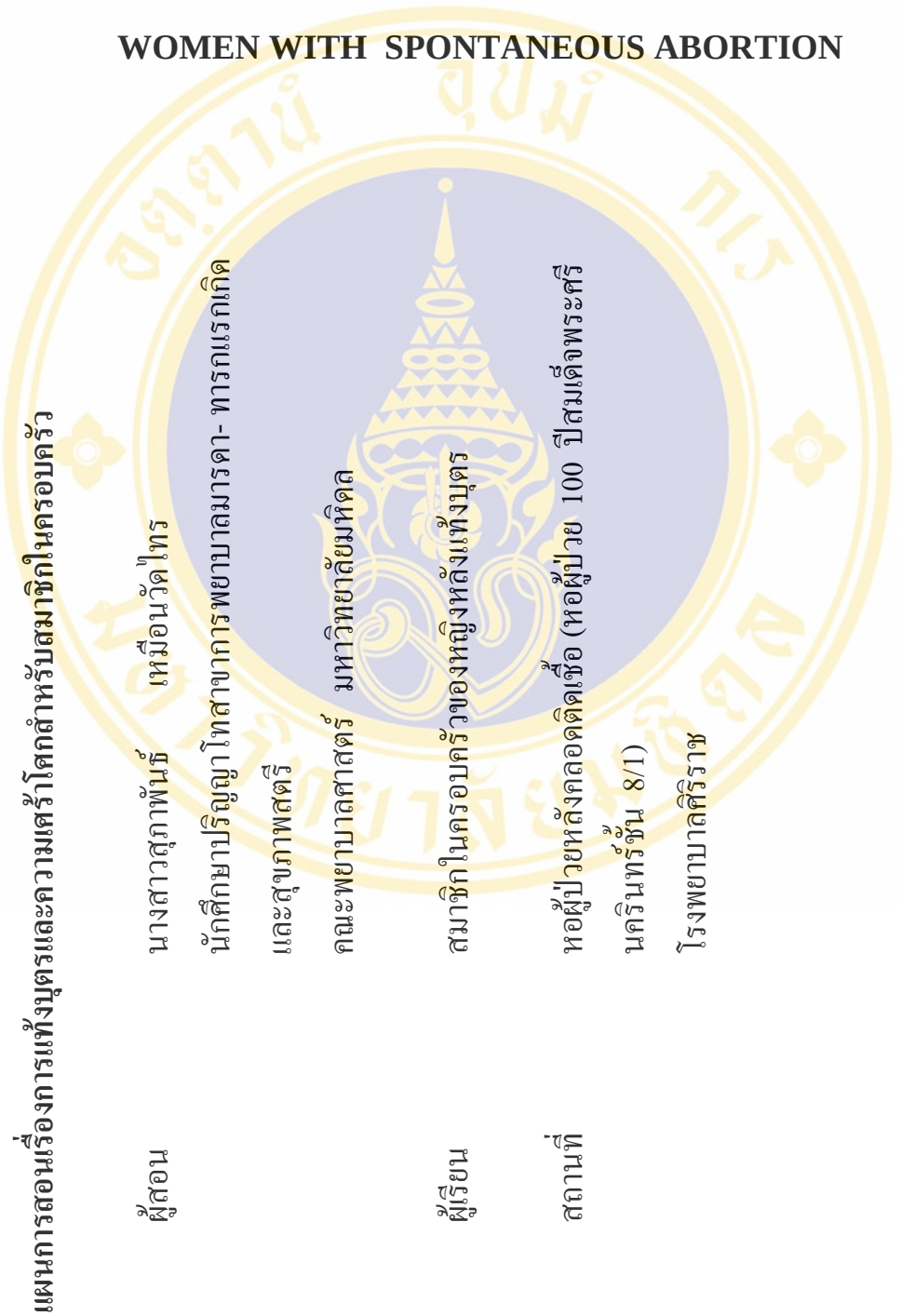
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

ผู้เรียน หญิงหลังแท้งบุตร จำนวน 1 คน

สถานที่ หอผู้ป่วยหลังคลอดศัลยศัลย์ (หอผู้ป่วย 100 ปีสมเด็จพระศรี นครินทร์ชั้น 8/1) โรงพยาบาลศิริราช

APPENDIX G

THE TEACHING PLAN ON SPONTANEOUS ABORTION AND SELF-CARE PRACTICE FOR FAMILY MEMBERS OF WOMEN WITH SPONTANEOUS ABORTION



APPENDIX H

A MANUAL ON CARE AFTER SPONTANEOUS ABORTION AND MANAGEMENT OF GRIEF FOR WOMEN WITH SPONTANEOUS ABORTION

คู่มือการปฏิบัติตัวหลังแท้งบุตร และการจัดการกับความเศร้าโศก

คู่มือเล่มนี้เป็นส่วนหนึ่งของวิทยานิพนธ์เรื่อง
ผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของ
แสวนสันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตร จากการแท้งเอง
จัดทำโดย นางสาวสุภาพันธ์ เหมือนวัดไทร
นักศึกษาพยาบาลศาสตรมหาบัณฑิต
สาขาการพยาบาลมารดา- ทารกแรกเกิดและสุขภาพสตรี
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

APPENDIX I

A MANUAL FOR FAMILY MEMBERS OF WOMEN WITH SPONTANEOUS ABORTION

คู่มือการช่วยเหลือสนับสนุนหญิงหลังแท้งบุตร สำหรับสมาชิกในครอบครัว

คู่มือเล่มนี้เป็นส่วนหนึ่งของวิทยานิพนธ์เรื่อง
ผลของโปรแกรมการพยาบาลโดยใช้ทฤษฎีการดูแลของ แสวน
สันต่อระดับความเศร้าโศกของหญิงที่สูญเสียบุตร จากการแท้งเอง
จัดทำโดย นางสาวสุภาพันธ์ เหมือนวัดไทร
นักศึกษาพยาบาลศาสตรมหาบัณฑิต
สาขาการพยาบาลมารดา- ทารกแรกเกิดและสุขภาพสตรี
คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล

APPENDIX J

A DEMOGRAPHIC CHARACTERISTICS QUESTIONNAIRE

คำชี้แจง : โปรดเติมข้อความลงในช่องว่างหรือใส่เครื่องหมาย ✓ ลงใน ☐ หน้าข้อความที่ตรงกับตัวท่าน

1.อายุ.....ปี

2.ตั้งครรภ์ครั้งที่ .....

3.ระดับการศึกษา

- □ ประถมศึกษา
- □ มัธยมศึกษาตอนต้น
- □ มัธยมศึกษาตอนปลาย
- □ อาชีวศึกษา
- □ อุดมศึกษา
- □ ไม่ได้รับการศึกษา

4.ศาสนา

- □ พุทธ
- □ อิสลาม
- □ คริสต์
- □ อื่นๆ ระบุ.....

5.สถานภาพสมรส

- □ คู่
- □ หย่าหรือแยกกันอยู่
- □ หม้าย (สามีถึงแก่กรรม)
- □ อื่นๆ ระบุ.....

6.อาชีพ

- □ รับราชการหรือรัฐวิสาหกิจ
- □ ลูกจ้างชั่วคราวหรือลูกจ้างประจำทางราชการ
- □ ค้าขาย
- □ รับจ้าง
- □ ทำไร่ ทำนา ทำสวน
- □ แม่บ้าน
- □ อื่นๆ ระบุ.....

7.รายได้เฉลี่ยของครอบครัวต่อเดือน .....บาท

8.ภูมิลำเนา .....

9.ระยะเวลาการสมรส.....ปี

10.ท่านทราบว่าตนเองตั้งครรภ์ก่อนการแท้ง

- □ ใช่
- □ ไม่ใช่

12.ท่านเคยปรึกษาแพทย์เรื่องการมีบุตรยาก

- □ เคย
- □ ไม่เคย

สำหรับผู้วิจัย

1. การวินิจฉัยของแพทย์.....

2.อายุครรภ์ขณะแท้งประมาณ.....สัปดาห์

APPENDIX K
A PERINATAL GRIEF SCALE

คำชี้แจง : ข้อความข้างล่างต่อไปนี้เป็นข้อความที่บรรยายถึงความรู้สึก ความคิด และพฤติกรรมของท่านในระยะหลังการแท้งเอง ข้อความเหล่านี้ไม่มีคำตอบใดที่ถูกหรือผิด โปรดอ่านข้อความในแต่ละข้อและทำเครื่องหมาย √ ไว้ในช่องที่อยู่ด้านขวาของข้อความซึ่งท่านได้พิจารณาแล้วว่าตรงกับความเป็นจริงของท่านมากที่สุดในขณะนี้เพียงคำตอบเดียว และกรุณาตอบให้ครบทุกข้อ แต่ละข้อมีคำตอบให้เลือก 5 ระดับ มีความหมายดังนี้

เห็นด้วยอย่างยิ่ง	หมายถึง	ข้อความนั้นตรงกับความรู้สึก ความคิด หรือพฤติกรรมของท่านมากที่สุด
เห็นด้วย	หมายถึง	ข้อความนั้นตรงกับความรู้สึก ความคิด หรือพฤติกรรมของท่านมาก
ไม่แน่ใจ	หมายถึง	ข้อความนั้นตรงกับความรู้สึก ความคิด หรือพฤติกรรมของท่านเพียงครึ่งหนึ่ง
ไม่เห็นด้วย	หมายถึง	ข้อความนั้นตรงกับความรู้สึก ความคิด หรือพฤติกรรมของท่านน้อย
ไม่เห็นด้วยอย่างยิ่ง	หมายถึง	ข้อความนั้นตรงกับความรู้สึก ความคิด หรือพฤติกรรมของท่านน้อยที่สุดหรือไม่ตรงกับความรู้สึก ความคิด หรือพฤติกรรมของท่านเลย

ข้อความ	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง
1.ฉันรู้สึกตกใจมาก.....					
2.ฉันรู้สึกเศร้าเสียใจ.....					
3. ฉันสับสนว่าการแท้ง...					
4. ฉันยังคิดถึงลูก.....					
.....					
.....					
.....					
.....					
27. ฉันสามารถเล่าถึงการแท้งลูก.....					
28. ฉันคิดว่าฉันยังมีโอกาส.....					

APPENDIX L

An Anecdotal Record

ระยะเวลาหลังแท้งที่เริ่มให้การพยาบาลด้านจิตใจ .....นาที

หัวข้อ	ระยะที่....
ความหมายของ.....	
ความรู้สึกของ.....	
พฤติกรรม.....	
ระยะของ.....	
การดูแลของ.....	
อื่นๆระบุ	

APPENDIX M

คะแนนเฉลี่ยแต่ละข้อคำถามของแต่ละช่วงเวลาที่วัดของกลุ่มทดลองและกลุ่มควบคุม

ข้อความ	กลุ่มทดลอง			กลุ่มควบคุม		
	ก่อนได้รับการพยาบาล	ก่อนกลับบ้าน	เมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์	ก่อนได้รับการพยาบาล	ก่อนกลับบ้าน	เมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์
1.ฉันรู้สึกตกใจมาก.....	4.70	4.63	4.20	4.47	4.47	4.23
2.ฉันรู้สึกเศร้าเสียใจ.....	4.63	4.57	4.10	4.43	4.43	4.20
3. ฉันสับสนว่าการแท้ง...	4.23	2.60	1.57	4.03	3.80	2.27
4. ฉันยังคิดถึงลูก.....	4.60	4.13	3.23	4.30	4.30	2.83
5.ฉันร้องไห้ทุกครั้ง.....	4.43	3.70	2.23	4.20	3.90	2.43
6. ฉันรู้สึกผิดบาป.....	4.13	2.63	2.00	4.10	3.93	2.70
7.ฉันรู้สึกโดดเดี่ยว.....	3.80	2.63	1.77	3.87	3.77	2.70
8. ฉันแน่นหน้าอก.....	2.77	2.00	1.37	2.87	2.73	2.07
9. ฉันรู้สึกหายใจไม่อิ่ม...	3.30	2.13	1.43	2.97	2.77	2.07
10. ฉันรู้สึกกล้ามเนื้ออ่อนแรง.....	3.47	2.57	1.43	3.27	3.07	2.07
11. ตั้งแต่ฉันแท้งลูกฉันไม่มีจิตใจ.....	3.73	2.83	1.77	3.83	3.77	2.90
12. ฉันรู้สึกโกรธ.....	1.73	1.73	1.33	1.83	1.90	1.90
13. ฉันรู้สึกว่า.....	3.77	3.03	2.33	4.00	4.00	3.77

ข้อความ	กลุ่มทดลอง			กลุ่มควบคุม		
	ก่อนได้รับการพยาบาล	ก่อนกลับบ้าน	เมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์	ก่อนได้รับการพยาบาล	ก่อนกลับบ้าน	เมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์
14. ฉันนอนไม่หลับ	4.07	3.93	2.23	4.13	3.93	2.67
15.ฉันเบื่ออาหาร	2.97	2.33	2.00	2.93	2.30	2.00
16. ฉันรู้สึกเหมือนลูก...	3.47	2.17	1.43	3.13	2.23	2.00
17.ฉันไม่ต้องการพักในตึกหลังคลอด.....	2.63	2.47	2.10	2.83	2.77	2.57
18.ฉันกลัวว่าการแท้ง.....	4.57	4.07	3.27	4.47	4.43	4.30
19. ฉันคิดว่าถ้าฉันได้รับการดูแล.....	3.87	3.57	2.73	3.80	3.80	3.47
20.ฉันวิตกกังวล.....	2.97	2.20	1.47	3.07	2.90	2.07
21.ฉันรู้สึกว่าเรื่องตลกขบขัน.....	3.73	2.43	2.00	3.63	3.57	2.43
22.การแท้งลูกทำให้ฉันมีคุณค่า.....	3.63	2.10	1.33	3.60	3.57	2.20
23.ตั้งแต่ฉันแท้งลูกฉันรู้สึกว่า.....	2.10	1.83	1.07	2.03	2.00	1.77
24. ตั้งแต่แท้งลูกฉันไม่สนใจ.....	3.40	2.57	1.80	3.43	3.30	2.33
25. ฉันไม่สามารถปฏิบัติกิจวัตร.....	2.60	1.93	1.37	2.47	2.10	1.97
26.ฉันรู้สึกว่าฉัน.....	3.83	3.10	2.13	4.07	3.83	2.57
27. ฉันสามารถเล่าถึงการแท้งลูก.....	3.83	3.20	2.27	3.93	3.80	3.03

ข้อความ	กลุ่มทดลอง			กลุ่มควบคุม		
	ก่อนได้รับการพยาบาล	ก่อนกลับบ้าน	เมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์	ก่อนได้รับการพยาบาล	ก่อนกลับบ้าน	เมื่อมารับการตรวจหลังแท้ง 2 สัปดาห์
28. ฉันคิดว่าฉันยังมีโอกาส.....	2.87	2.23	1.83	2.87	2.70	2.20

APPENDIX N

2 ถนนพรานนก 2 PRANNOK Rd.
บางกอกน้อย BANGKOKNOI
กรุงเทพฯ 10700 BANGKOK 10700

Tel. (662) 4197000 ต่อ 6405-6
FAX (662) 4197000 ต่อ 6405

Siriraj Ethics Committee

Certificate of Approval COA no.Si 007/2008

Protocol Title : THE EFFECT OF NURSING CARE PROGRAM BASED ON SWANSON CARING THEORY ON GRIEF OF WOMEN WITHMISCARRIAGE.

SiEC number : 469/2550(EC1)

Principal Investigator/Affiliation : Miss Supapun Muenwatzai
Faculty of Nursing , Mahidol University

Research site : Faculty of Medicine Siriraj Hospital

Approval includes :

1. EC Submission form dated December 21, 2007
2. Proposal
3. Participant information sheet dated December 21, 2007
4. Informed consent form dated December 21, 2007
5. Questionnaire dated December 21, 2007
6. Principal Investigator's Curriculum vitae

Approval date : January 3, 2008

Expired date : January 2, 2009

This is to certify that Siriraj Ethics Committee is in full Compliance with International Guidelines For Human Research Protection such as Declaration of Helsinki, The Belmont Report, CIOMS Guidelines and the International Conference on Harmonization in Good Clinical Practice (ICH-GCP)

Prof. Jariya Lertakyamanee, M.D.
Chairperson

January 21, 2008
date

(Clin. Prof. Teerawat Kulthanan, M.D.)
Dean of Faculty of Medicine Siriraj Hospital

January 24, 2008
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BIOGRAPHY

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