Thai Abused Women Living in a Shelter: The Process of Becoming a Mother

A DISSERTATION

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By

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Thai Abused Women Living in a Shelter: The Process of Becoming a Mother

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Becoming a mother (BAM) is a period that is challenging for women. Unfortunately, violence directed toward the mother and infant may serve as a barrier to attainment of the maternal role.

The purpose of this study was to describe the process of BAM as reported by Thai abused mothers who are living in shelters by using grounded theory methodology. A purposive sampling procedure was employed to recruit Thai abused mothers who lived in four non-profit, charitable shelters in Thailand.

A total of 21 participants, who were Thai and between 18 to 33 years of age, had resided in a shelter for two to ten months were interviewed. Four phases were reported: “Preparing to Be a Mother” described the process of BAM, noting that it began outside the shelter during pregnancy. Participant’s babies were a main factor that empowered them to get away from their abusive relationship, seek assistance, and prepare for their maternal role. “Struggling to Be a Good Mother”, the second theme of the process, reflected personal, environmental, and financial problems experienced and the strategies they used to better cope with their situation. The third theme, “Making Progress”, referred to behaviors that promoted a positive maternal role and mother-baby interaction. The final theme, “Being a Good Mother on their Own terms”, reflected how they achieved the role of being a good mother. They described that they needed to stand on
their own feet, go back into the world, and provide a better life to their baby by placing the baby up for adoption.

Results indicated that Thai mothers who lived in shelters were faced with high levels of tension and lived with limited resources. Despite these challenges, they still defined themselves as successful mothers, even if, this definition of being a good mother was different from the idealized mother. Thai policy makers and health care providers should incorporate the findings of this study into social policy and healthcare services for this vulnerable group. Such measures may include: (1) enacting laws which hold fathers at least partially responsible for child support; (2) encouraging services that minimize the stigma such women report; (3) offering more flexibility in terms of when women must participate in shelter activities; (4) ensuring adequate educational or job training programs for women who experience DV; and (5) establishing systems where mothers who place their child up for adoption or foster care are able to maintain a relationship with their infant.
This dissertation by Natthapat Buaboon fulfills the dissertation requirement for the doctoral degree in Nursing approved by Patricia McMullen Ph.D., JD, CNS, CRNP, Ordinary Professor and Dean, as Director, and by Barbara Moran, Ph.D, CNM, and Janice B. Griffin Agazio, Ph.D, CRNP, RN as readers.

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Dedication

To my family: Wilas; Nupian; Dussadee Buaboon; and Jiranat Rajchaleewong who always give me unconditional love.

To my professor: Patricia McMullen, Barbara Moran, and Janice B. Griffin Agazio who provided their enthusiastic support and devoted their times for my study.

To my friends and my colleagues at School of nursing, Thammasat University, Thailand, who help me pursue my dream, support me, so I could complete this project.

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To all participants who shared their tough experiences with me, without them I could not finish my research.
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Chapter 1

Introduction

Background of the Study

Domestic violence against women is a serious human rights issue and remains a significant health care issue in all parts of the world. Various terms are used to describe domestic violence including intimate partner violence, spousal abuse, domestic violence, courtship violence, battering, marital rape, date rape, and dating violence. The United Nations defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (World Health Organization, 2012).” Consequently, domestic violence can consist of physical abuse, sexual abuse, emotional abuse, economic abuse, or psychological abuse that has an influence on women or family members.

Violence against women and domestic violence are mostly committed by men and occurs regardless of race, age, socioeconomic status, religious or cultural background, or mental or physical ability (WHO, 2012). Currently, domestic violence has been reported in newspapers, on television, and by researchers: however, these reports may underestimate actual levels of domestic violence (Friends of Women, 2007). Statistics on domestic violence vary, but recent estimates have indicated that 22 million U.S. women have been assaulted in their lifetime. 63.84% of these women were abused by a current or former intimate partner (National Intimate Partner and Sexual Violence Survey, 2011). About one out of every four women will face
domestic abuse in her lifetime and 1.3 million women are sufferers of domestic violence each year (U.S. Conference of Mayors, 2008).

Violence can increase in frequency and intensity during pregnancy and child bearing (Chatchawanwit, 2008). In Thailand, all types of violence against women have increased (The government public relation department, 2008). The majority of cases of violence against women are committed by partners. From 2003 to 2006, the incidence of intimate partner violence (IPV) reported in five major Thai newspapers were 184, 386, 603, and 561 respectively (Friends of Women, 2007). It has been hypothesized that reasons for the increase in violence against Thai women is attributable to such factors as poverty and alcohol consumption (Aekplakorn and Kongsakon, 2007; Thai Government Public Relations Department, 2008). From the findings of Aekplakorn and Kongsakon (2007), they conducted a cross-sectional survey in 580 married women from seven slum communities in Bangkok. The result found that 27.2% were abused by their intimate partner abuse. The variables associated with partner violence conflicts included financial problems (OR 1.97, 95 percent CI 1.20-3.22) and regular alcohol consumptions (OR 3.72, 95 percent CI 2.02-6.89).

Moreover, the Thai government has launched the national campaign to stop violence against women and to draw the society’s attention of domestic abuse. In the past, Most Thai people perceived that domestic violence was family problems. It should be hidden only in their families and abused women were embarrassed to speak up for their rights. Throughout this campaign, many public and private organizations have arranged activities to societal awareness of the problem of violence against women. This campaign also helps to encourage women to speak out about this problem and promote Thai people to change their attitudes (Thai
Government Public Relations Department, 2008). Domestic violence is not a family problem. All Thais must aware this problem and help to stop any kind of abuse.

Despite this program has launched, the prevalence of IPV in Thailand still rises every day. Many evidences proved that violence can increase during pregnancy and child bearing. However, only few studies have been conducted among pregnant women and women during child bearing. Buaboon (2001) assessed the prevalence rate of abuse during pregnancy in 230 adolescent mothers that were admitted to postpartum wards in Queen Sawangwattana Memorial Hospital, Thailand, a facility created by the Thai Red Cross Society. Domestic violence status was evaluated using questions adapted from the Abuse Assessment Screen of McFarlane, Parker, and Soeken, which focused on experiences of psychosocial, physical, or sexual abuse by family members. The reliability of this questionnaire was 97.5% using a test-retest method. The prevalence rate of abuse during pregnancy in these adolescents was 16.8%. The rates of physical abuse, emotional abuse, and both types of abuse were 1.7%, 7.4%, and 21.7%, respectively.

In a study conducted by Ma-a-lee, Tongkumchum, Choonpradub, and Kuning (2007), 611 pregnant women visiting antenatal care clinics in Pattani Hospital, Thailand were surveyed. It was found that the majority of the pregnant women (54.8%) faced some form of abuse, with 5.2% experiencing sexual abuse only, 20.0% experiencing sexual and emotional abuse, and 29.6% suffering physical abuse. The study of Thananowan (2008) used a descriptive cross-sectional survey to survey IPV among 475 pregnant Thai women during antenatal care visits at five hospitals in the Bangkok area. Ten percent of women accounted they had been battered prior to pregnancy, 4.8% were abused during pregnancy, and 10.7%, 4.8%, and 4.8% reported they had ever experienced physical, sexual, or mental abuse, respectively. Most of the violence,
or 95.7% of the incidents, were caused by their husbands or partner. Another study conducted by Chatchawanit (2008), studied the prevalence and characteristics of violence against women among 300 pregnant women who were visiting an antenatal care at Maharat hospital. The study indicated that 34% of these women encountered abuse during pregnancy. The majority had been emotionally abused (28%), 12% had been sexually abused, and 8.7% reported they had been physically abused. The rates reported in these studies are similar to rates reported from other countries such as The United States, Karachi, and Uganda (Buaboon, 2001; Ma-a-lee, and et al., 2007; Thananowan, 2008, Chatchawanit, 2008).

In Belgium, Jeanjot, Barlow, & Rozenberg, (2008) studied 200 postpartum women receiving care in the CHU Saint-Pierre Maternity Department. The prevalence of physical or sexual abuse of these women during their recent pregnancy was estimated at 11%. These abused women had less social support, and had bad relationship with their partners and families.

In the United States, the study of McFarlane and et al. (2005) described the frequency and consequences of sexual assault. One hundred forty-eight African-American, Hispanic, and white women participated in this study. The instrument used in this study was the Severity of Violence Against Women Scales (SAVAWS). The reliability in this study was 0.92. The main finding was that 68% of the physically abused women reported sexual assault and 20% of the women experienced a rape-related pregnancy. Lutgendorf et al. (2009) conducted a prospective observational study to explore the prevalence of domestic violence. The sample consisted of 1,162 pregnant women visiting a naval hospital for prenatal care from January 2007 to March 2008. The findings indicated that 14.5% monitored positive for abuse (either current or past), and 1.5% of respondents reported recent pregnancy abuse.
Fikree and Bhatt (1999) assessed the prevalence rate of domestic violence and health status among women in Karachi: 15% reported having been physically abused while pregnant. This finding is consistent with research by Kaye, Mirembe, Bantebya, Johansson, and Ekstrom (2006), who studied 612 pregnant women in Mulago Hospital, Kampala, Uganda, from May 2004 through July 2005. Their research showed that 169 women (27.7%) had experienced violence that was sexual (2.7%), physical (27.8%) and psychological (24.8%).

Even though many people have attempted to prevent domestic violence, this problem continues to increase and has serious effects. McFarlane, Campbell, Sharps, and Watson (2002) found that 22.7% of abused American women were killed by their partners. Five percent of the femicide victims were killed while pregnant. Moreover, abuse during pregnancy has been associated with adverse maternal and fetal health outcomes (Tiwari, et al., 2008: McKie, 2003). For example, Tiwari, et al. (2008) surveyed 3,245 pregnant women in seven public hospitals in Hong Kong. They found that abused women, especially those who had experienced psychological abuse, had a higher risk of postnatal depression compared with non-abused women. These women were also at a higher risk of hurting themselves and had significantly poorer mental health-related quality of life. Another of Janssen et al. (2003), they studied 4750 pregnant women who gave birth between January 1999 and December 2000. A multivariate analysis was used to study the links with second- or third-trimester hemorrhage, intrauterine growth restriction, and perinatal death. The result reported that physical abuse was related to an increased risk of antepartum hemorrhage (adjusted odds ratio [OR]: 3.79, 95% CI 1.38-10.40), intrauterine growth restriction (OR: 3.06, 95% CI 1.02-9.14), and perinatal death (OR: 8.06, 95% CI 1.42-45.63). Research on the issue of domestic violence has been conducted in a number of countries, particularly in the United States. There is confirmation that domestic abuse is more
common during pregnancy and has a large number of adverse health implications for mothers and their babies (McKie, 2003). One main negative outcome of domestic violence is poor attachment. Attachment between mother and child has been described in several studies. Attachment has been used to refer to specific types of behaviors between the infant and caregiver (Bowlby, 1969). According to John Bowlby and Mary Ainsworth the human infant is different from some baby animal. It is born with an instinctive set of behaviors that need care from adult and are meant to keep adults close by, to protect the infant from risks or hazards, and to allow for living in the safe environment (Bowlby, 1969). The mother is also developing her own relationship to the infant, and so it is just as significant to address maternal attachment issues among abused women living in a shelter affects, since poor attachment has been associated to several adverse outcomes for mothers and infants. These infants increase the risk of maladaptive outcomes, including recurrence of dysfunctional parenting patterns (Karen, 1998). Furthermore, some evidence supports the hypothesis that intimate partner abuse has harmful effects on parenting abilities in abused women (Levendosky & Graham-bermann, 2000). Abused women may be not capable to provide appropriate infant care or develop a sense of her maternal role. Maternal role is a crucial developmental life event to transition into motherhood. Being a mother involves role reassignment, a modification in status positions, and value reorientation. Being a mother or maternal role is identified as the social practices of nurturing and caring for their children (Jirapet, 2001).

In the situation of abuse, women that are victims of abuse may seek assistance, including counseling, legal help, and temporary accommodations or shelters. According to the National Coalition for the Homeless (NCH) Conference of Mayors 2005 survey of cities with populations exceeding 30,000, determined that families with children reported for 33% of the total homeless
population (NCH fact sheet#12, 2006). Another survey of The U.S. Department of Housing and Urban Development (2009) has estimated that the number of homeless on a single night in January 2008 was 664,000 people. Regarding 1.6 million people resided in emergency shelters or transitional housing program during the year between October 1, 2007 and September 30, 2008. Approximately 68% of those homeless were individuals and about 32% were parents with their children.

Furthermore, the National Law Center on Homelessness and Poverty (2005) studied the annual number of homeless in the United States. The results indicated that 50% of homeless identified domestic violence as a primary cause of homelessness. This study also reported that between 2.3 and 3.5 million people experience homelessness. Some 56 percent of them were living in shelters and transitional housing and 44 percent were residing on the street. The result of this study is related to the report of U.S. Conference of Mayors (2008) that twenty eight percent of families chose to be homeless because of domestic violence.

In Thailand, epidemiological research from the Office of Women’s Affairs and Family Development indicates the rate of violence against women who requested assistance at the Ministry of Social Development and Human Security shelters increased from 15,750 in 2004 to 20,572 in 2005, and the number of women seeking assistance from non-governmental organizations (NGOs) rose from 2,172 in 2004 to 2,637 in 2005 (Office of Women’s Affairs and Family Development, 2009).

The significance of the increasing numbers of women living in shelters reflects the lack of current community-based resources to support such women. Living in a shelter negatively affects the overall health of the individual, especially in the case of abused pregnant women. The
state of living in a shelter is a complicated case of disconnection from support systems (Cone, 2006).

**Becoming a Mother**

Becoming a mother has variously also been referred to maternal role attainment or maternal-infant attainment. It is a period that is complex and challenging for women. This period was considered as a joyful time of being the parents of the infant and the immediate family. On the other hand, this time is full of uncertainty and often stressful (Mercer, 1995). In order to achieve a new maternal role, mothers use many strategies, including mothering skills, sensitivity, empathic responses, and nurturing behavior to promote the infant’s health and reflect their maternal role attainment (Mercer, 1995). Moreover, mothers need confidence in caring for their infants, relating to their intimate partners as a co-parent, and defining family responsibilities (Mercer, 2006).

Unfortunately, violence directed toward the mother and the infant may serve as barriers to attainment of the maternal role, and particularly among abused mothers residing in a shelter. They have to deal with a number of stressors, such as difficulties caring for their infants, lack of family supports, lack of positive role models for the development of positive maternal roles, and financial problems (Barnett et al., 2005). Under these conditions maternal and child attachment is frequently characterized by negative emotions, disturbed bonding, or lack of affection (Barnett et al., 2005). As a result of previous studies on domestic abuse, it can be suggested that these women will often experience delays in assuring the responsibilities of becoming a mother by failing to achieve competence in their roles. However, no studies were found concerning becoming a mother among Abused Thai women living in a shelter. Viewing the process of
becoming a mother in the context of living in a shelter will present a clearer picture of this phenomenon, provide a basic background for future studies, and improve nursing practice to assist Abused Thai women in adapting to maternal roles.

**Statement of purpose**

The purpose of this study is to describe the process of becoming a mother reported by Thai abused mothers who are living in shelters.

**Statement of research question**

The overarching research question is: What is the process of becoming a mother among Abused Thai women living in shelters? Depending on the women’s responses to the core question, the following or similar questions may be asked:

1. How would you describe your level of satisfaction in terms of becoming a mother while you are living in a shelter?
2. What made you feel like a successful or unsuccessful mother?
3. What do you do when you take care of your baby?
4. What experiences either helped or hindered how you viewed yourself as a mother?

**Definition of Terms**

The proposed study is guided by the following definition of terms:
Becoming a mother

Theoretical definition

Becoming a mother is the process that a mother learns in interaction with her child. These interactions include nurturing, caring, teaching, guiding, protecting, and loving, which enhance the infant’s physical, emotional, social, and cognitive development (Mercer, 1995). Becoming a mother is the process whereby a woman develops certain behaviors, emotions, and cognitive changes in order to view herself as a mother. Attributes of the successfully becoming a mother include caring, protecting, and loving.

Operational definition

Becoming a mother will be operationalized in terms of participant’s statements concerning interactions with her infant that enhance the infant’s physical, emotional, social, and cognitive development. This study will be study becoming a mother until first year of birth.

Abused Women

Theoretical definition

Abused women are theoretically defined as women that have experienced physical violence, sexual violence, and/or emotional violence by an intimate partner, a family member, or a dating acquaintance. Participants in this study will meet the criteria established by the Centers for Disease Control and Prevention (2003). There are three main types of violence (Saltzman et al., 2002):

- Physical violence is the intentional use of physical force with the potential for causing injury or death. These behaviors include pushing, shoving, throwing, grabbing, biting, choking or use of a weapon against another person.
- Sexual violence is the use of physical force, weapon, or power to compel a person to engage in a sexual act against his or her will, whether or not the act is completed.

- Emotional violence is the use of acts, threats of acts, or coercive tactics that can cause by trauma to the victim. This violence includes humiliating the victim, controlling the victim, withholding information from the victim, isolating the victim from friends and family, and denying the victim access to money or other basic resources.

**Operational definition**

Thai postpartum women that are 18 years old of age or older and that have had a healthy first born full-term birth (gestational age of at least 37 weeks, and infant weight of 2,500 grams or more at birth) and that have experienced violence (as theoretically defined above) during their current pregnancy.

**Women living in a shelter**

**Theoretical definition**

Women living in a shelter are theoretically defined by the criteria established by the McKinney Homeless Assistance Act of 1987 (Aday, 2001). Based upon these guidelines, women living in a shelter will include the following:

a) Lacking a fixed, regular, and adequate nighttime residence:

b) Having a primary nighttime residence in a publicly or privately operated shelter:

c) Living in temporary accommodations such as a congregate shelter, welfare hotels, or transitional housing for the mentally ill:

d) Living in a public or private place that is intended to be a temporary residence for people ordinarily institutionalized:

e) Living in a public or private place not designed for living.
Operational definition

The participants in the study may be residents of the four shelters in Thailand. These shelters are non-profit, charitable organization, designed for unemployed abused pregnant women or mothers with young children.

Philosophical perspective

The aim of this study is to explore the process of becoming a mother among Abused Thai women using a grounded theory perspective. Grounded theory is a specific methodology used to develop a theory from methodical data generation and exploration of social processes that indicate human interactions in natural settings (Corbin and Strauss, 2008; Speziale and Carpenter, 2007). The basic assumption of the grounded theory approach is that the methodology describes theoretical constructs by using common perceptions from particular social groups (McCann & Clark, 2003).

According to Strauss and Corbin (1990), grounded theory involves “systematic techniques and procedures of analysis that enable the researcher to develop a substantive theory that meets the criteria for doing good science: significance, theory, observation compatibility, generalizability, reproducibility, precision, rigor, and verification” (p.31). The process of grounded theory research is comprised of five steps, which are:

(1) The collection of empirical data. The researcher may collect data from interviews, observation, reports or publications, or a combination of all these sources. Data collection continues until each category is saturated and no new themes are found (Glaser & Strauss, 1967). Researchers generally tape record interviews and transcribe them verbatim to discover a core variable. “The researcher undertakes the quest for this essential element of the theory, which
illuminates the main theme of the actors in the setting, and explicates what is going on in the data” (Glaser, 1978, p.94).

(2) Concept formation. The nature of data analysis in grounded theory consists of three levels of coding: Level 1 coding. This level requires that the researcher apply a system of open coding, examine data line by line, and identify processes in the data. Level 2 coding. At this level, the researcher codes the data, compares each data set, and assigns the data to clusters according to obvious fit. Level 3 coding. This mandates that the researchers consider the central themes by asking the following questions: What is the spotlight of this study? What is going on in the data? What is the connection of the data to the study? What is the problem that the participants want to share with the researcher? What techniques or strategies are helping the participants to cope with the problem? (Speziale and Carpenter, 2007)

(3) Concept development. During data analysis, the researcher needs to compare categories to see how they connect and fit with each other. Many grounded theorists suggest that reviewing the literature before the study begins is unnecessary. Such theorists fear that a comprehensive literature review may lead to prejudgments and affect the themes and processes that are identified (Speziale and Carpenter, 2007, Stern, 1980, Glaser, 1978). As theory begins to develop, the researcher starts to learn what has been available about the emerging concept.

(4) Concept modification and integration. This process is completed as the researcher continues to analyze data that are related to the emerging theory.

(5) Production of the research report. The researchers’ report for a grounded theory study should provide ideas for readers. These ideas include the sources of data and how the concepts were integrated.
Theoretical Perspective

The theoretical framework for this study will be Mercer’s “becoming a mother” theory. Ramona T. Mercer first described a theoretical framework for the maternal role in the late 1960s. Mercer’s inspiration came from her professor, Reva Rubin. Rubin (1977), who is well known for describing maternal role attainment as a process “in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set so that she is comfortable with her identity as a mother” (p. 37). Rubin focused on maternal role attainment during pregnancy and the first month after birth (Mercer, 1985). Using Rubin’s definition of the maternal role, Mercer developed a theory on becoming a mother based on Rubin’s work, transition theory, the role theories of Thorton and Nardi, knowledge of the infant’s traits, and variables that control the maternal role in the first postpartum year (Mercer, 1985). She revised the stages of maternal identity acquisition based on qualitative data. These stages include: (1) obligation, attachment, and preparation for pregnancy: (2) acquaintance, learning, and physical restoration during the first two to six weeks following birth: (3) moving toward a new normal during the first two weeks to four months following childbirth: and (4) accomplishment of maternal identity.

Mercer (1979) contended that “[T]he maternal role may be considered… attained when the mother feels internal harmony with the role and its expectations. Her behavioral responses to the role’s expectations are reflexive and are seen in her concern for and competency in caring for her infant, in her love and affection for and pleasure in her infant, and (in) her acceptance of the responsibilities posed by the role” (Mercer, 1979a, p. 374).

Mercer also explained that the mothering role adopted from Thorton and Nardi (1975) is acquired through four developmental stages.
The developmental stage is the anticipatory stage. This stage represents the period before pregnancy marked by a time of psychological preparation for the mothering role. This stage focuses on the development of the female identity. Female identity refers role behaviors that women learn in order to relate with their infant. In order to achieve this stage, women need the basic determinants of female competency such as ego strength, self-confidence, and nurturing qualities. Typically, a woman’s sense of mothering is mimicked from her mother and is an indelible part of her identity. When there are crisis situations in a woman’s life, such as infertility, abuse, a baby that is born with a birth defect, premature labor, or miscarriage, these experiences affect maternal behavior and competence.

Mercer’s second stage is the formal/role-taking stage. This stage starts when the baby was born. After childbirth period, the new mother begins her mothering role by identifying her infant’s uniqueness and begins care-taking tasks by seeking help from experts and following their advice. This time is a reality shock if the anticipatory work and expectations of pregnancy are different from what the woman believed they would be. Many variables may affect the mother’s sense of competence, including pain during childbirth, fatigue, unexpected complications, and the loss of body functions or changes in body image. Moreover, the attachment process deepens and becomes clearer in this stage.

In the third stage maternal attachment and maternal-infant bonding start with the commencement of pregnancy, but following birth both the mother and infant get to know each other through visual contact, touching, and holding. Through this attachment, a mother learns to identify with her infant’s characteristics in order to gain competence in the mothering role. Mercer’s informal/role-making stage typically occurs during the first two months following birth and is a period of adaptation. A mother learns how to coordinate her mothering activities in
concert with the individual differences of her infant. After she gets to know her child, she becomes more comfortable with her identity as a mother. The woman organizes the maternal role to fit herself based on her past experiences and her future aims. During this period, a mother uses her judgment about how to best care for her infant.

The fourth of Mercer’s stages is that of maternal identity (Mercer, 1979). Maternal identity is differentiated by the mother’s confidence, the mother’s sense of harmony, satisfaction in the maternal role, and positive relationship between mother and child. Several factors impact maternal role attainment, including maternal age, the labor pain and birth experience, early maternal-infant participation, mother’s self confidence on childbearing, flexibility, role strain, the mother and child’s health status, the mother-father relationship, infant temperament, attitudes towards children, family functioning, social supports, and culture.

**Assumptions of this study**

Throughout the study, the following assumptions will be made:

(1) Participants will be able to describe, identify, and remember their experiences of becoming a mother.

(2) Participant women will have similar service regardless of the shelter in which they reside.

(3) Participants will respond truthfully to the researcher’s questions.

(4) All behavior has meaning and can be understand.
Limitations of this study

The study is influenced by the following constraints:

1. This study uses a purposive sample of participants who meet the study criteria.
2. The findings are only applicable to the study participants and cannot be generalized to the entire population of abused women.
3. There may be other variables that have an impact on becoming a mother that have not been examined or controlled in this study.

Significance of the study

Little is known about becoming a mother in those women that are abused and reside in a shelter. This is particularly true with respect to such women that are in Thailand. By recognizing the factors that impact on becoming a mother, nurses working in women’s shelters and in the community will be better able to craft evidence-based nursing interventions. Moreover, the findings of this research will improve nursing practice to assist Abused Thai women in adapting to the maternal role with more empathy and effectiveness. Further, this research will provide a clearer picture of this phenomenon and will serve as a springboard for future studies that focus on becoming a mother in those situations where a woman has been the victim of abuse.
Chapter 2

Review of the literature

Currently, there is a gap in the literature regarding domestic violence and its effects on becoming a mother. Domestic violence is a pervasive problem in our society and its full magnitude is truly unknown. This gap is largely influenced by variations in how research literature attempts to identify, define, and understand the problem (National Resource Center on Domestic Violence, 2002). Domestic violence is an issue that has lacked public attention, and controversy continues regarding both the definition and causes of such violence. Domestic violence during a pregnancy is widespread and raises numerous questions regarding how the occurrence of domestic violence during this vulnerable time for women impacts becoming a mother (Levendosky & Graham-Bermann, 2000). The understanding of becoming a mother and the influence of domestic violence, especially in women living in a shelter, is essential not only for future development of the maternal role, but also in terms of mother child attachment. This review of the literature will present an overview of Thailand, domestic violence during pregnancy, abused women living in a shelter, and becoming a mother.

Overview of Thailand

The Kingdom of Thailand is located in the heart of Southeast Asia region and covers an area of 516,115 square kilometers (National Identity Office of the Prime Minister [NIOPM], 2000). Its shape and geography divide the country into four natural regions: the mountains and forests of the North: the vast rice fields of the Central Plains: the semi-arid farm lands of the Northeast Plateau: and the tropical islands and the long coastline of the peninsular South.
The country is divided administratively into 76 provinces that are further spilt into districts, sub-districts, and villages. Bangkok is the capital city and the center of political, commercial, industrial, and cultural activities. It covers about 1,537 square kilometers (NIOPM, 2000).

Thailand is warm, tropical, and humid in the majority of the country during most of the year. The area of Thailand north of Bangkok has a climate determined by three seasons, whilst the southern peninsular region of Thailand has only two. The climate is monsoonal, marked by a pronounced rainy season lasting from May to November, and a dry season for the remainder of the year. The temperature is highest in March and April and lowest in December and January. The average temperature is approximately 70 degrees Fahrenheit (F). During the summer season, the temperature may climb to as high as 100 F (NIOPM, 2000).

Thailand is governed by a constitutional monarchy, with a bicameral parliamentarian form of government. The official national language is Thai. It is a tonal language, uninflected, and predominantly monosyllabic. English, a mandatory subject in public schools, is widely spoken and understood, particularly in Bangkok and other major cities (NIOPM, 2000).

The structure of the Thai education system is comprised of three years of preschool education (kindergarten- \textit{Anubal}: ages 3-6), six years of primary education (primary school- \textit{Pratom suksa}: ages 7-12), three years of lower-secondary education (middle school- \textit{Matthayom suksa}: ages 13-15), three years of upper-secondary education (high school- \textit{Matthayom suksa}: ages 15-18), and higher education (university). Legally, children must complete at least the six years of primary education (NIOPM, 2000). However, millions of Thai children are unable to obtain the primary education because they may live in a very poor family, or there may be a lack of a teacher willing to work in remote areas. Girls in rural areas are also unable to achieve a high
level of education because there is a traditional belief that girls do not need to study as high as boys because girls should get married, stay home, and be a wife and a mother (Wisikasin, 2003).

The total population of Thailand was approximately 67 million in 2009 (The Thailand National Statistic Office, 2009). The population includes descendents of ethnic Chinese, Khmer, Lao, Vietnamese, Indians, and other groups. Ninety-five percent of the population is Buddhist. Christianity, Islam, and a number of other religions are embraced by the rest of the population. There is absolute religious freedom. The king of Thailand, under the constitution and in practice, is the patron of all major religions embraced by the people and participates in ceremonies conducted by people from many different religious backgrounds (NIOPM, 2000).

Typically, the Thai family is extended, consisting of several generations living under one roof. However, the number of single families is increasing. Many in the younger generation migrate to Bangkok to find a better job or to further their education. The rapid growth of population in the country, especially in Bangkok, has strained its infrastructure and has led to a number of serious problems, such as traffic congestion and pollution—all sources of crime as well as violence (NIOPM, 2000).

Socio-cultural factors affecting becoming a mother in Abused Thai women.

Motherhood and domestic violence in Thailand are influenced by social norms and cultural beliefs, including the following.

(1) The inequality between the genders. Thai families typically value men and view women as subordinate within the family (Friends of Women, 1993). Men have power over women and assume the highest position within the family. A woman is believed to be a piece of property belonging to her parents before marriage, and to her husband after marriage. Moreover,
divorce is not a common and unacceptable practice in the Thai culture. Women usually feel ashamed and embarrassed when they get divorced. Thai society places a high value on a woman being a good housewife and being loyal to only one man after marriage. Thai society also applies a strict standard as to when women are good wives and mothers. It is believed that a woman should bear the sole responsibility for household chores and for maintaining the family well-being, even when a bad situation exists within the family (Chatchawanit, 2008).

(2) Thai families’ beliefs and cultural norms. Many Thai families still believe that domestic violence is a private matter within the family, in which outsiders should not intervene, even when problems are serious (Friends of Women, 1993). Thai women have been taught to keep family problems within the family. When a woman suffers from domestic violence, it is likely that she will keep it to herself. Some women may feel that domestic violence is their own fault for not being a good wife and mother (Friends of women, 1993).

In the Thai culture it is generally believed that the wife should solve problems by giving away her interests and desires in favor of family happiness. In light of Thai cultural norms, the problems of gender inequality and men’s domination are suppressed under the cover of family harmony. Domestic violence is perceived to be acceptable if the wife deviates from her traditional place or roles. This places such women in a position where they are vulnerable to victimization (Chatchawanit, 2008).

(3) Regarding family hierarchy, Thai society values men as breadwinners and leaders, whereas women are considered followers. Women usually have less decision-making power than do men (Chatchawanit, 2008).

(4) The influence of this changing society has led to increases in the occurrence of domestic violence (Benson & Fox, 2004). Thailand is a developing country that is under
transformation from agriculture to an industrial society (Ishizuka, Hisajima, & Macer, 1995). Moreover, the current economic crisis forces women to work outside their home (Benson & Fox, 2004). On the other hand, Thai society also requires women to be good wives and mothers. In Thailand, these changes are believed to have increased the occurrence of family conflicts (Friends of women, 1993). This changing social context should be considered as a factor affecting domestic violence, and motherhood.

**Domestic Violence and Pregnancy**

Abuse during pregnancy is more common than most people think. In a review of domestic violence against women that was implemented by World Health Organization (WHO, 2005), a study was conducted based on interviews with 24,000 women in 10 countries: Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, the United Republic of Tanzania, and Thailand. The study assessed women’s experiences of violence using a questionnaire developed and validated for cross-cultural use. It also studied how violence is associated with health and injury, and the strategies that women use to cope with the violence. In Thailand, the research was conducted by the Institute of Population and Social Research, Mahidol University, and the Friends for Women. A total of 2,818 women were interviewed in Bangkok and Nakhonsawan. The results indicated that domestic violence is widespread in all of these countries. However, the prevalence rate varied from country to country. In Thailand, women who had experienced physical abuse, sexual violence, or both were 23, 30, and 41% respectively. Whereas the proportion of women who had suffered from physical abuse ranged from 13% in Japan to 61% in Peru: sexual violence ranged from 6% in Japan to 59% in Ethiopia: and both ranged from 15% in Japan to 71% in Ethiopia.
Abuse may begin during pregnancy and is likely to continue following the baby’s birth (Campbell, Oliver, & Bullock, 1993). Many studies indicated that pregnancy may be a time of increased risk for violence (Webster, Chandler, & Battistutta, 1996). From the study of Bacchus, Mezey, & Bewley (2006), they examined women’s experiences of domestic violence during pregnancy. The sample consisted of 16 British women who had experienced domestic violence in the previous 12 months. The semi structured interviews were analyzed using content analysis. The findings showed that ten of the 16 women had experienced domestic violence during a recent pregnancy. Four of the ten abused women also had been assaulted in at least one previous pregnancy. Some women reported abuse happened because of the arrival and care of the new baby, financial problems, the decreasing ability of the women to help with household responsibilities during pregnancy, the lack of social support, and the uncertain feelings about parenthood. Another research in study of Maureen (2005) studied the prevalence and correlates of physical abuse during the year of pregnancy and to explore the association between physical abuse and other risk factors for preterm birth. The participants were 680 postpartum women in two tertiary care hospitals in the Canadian province of Manitoba. The instruments included the Abuse Assessment Screen, Prenatal Psychosocial Profile, Perceived Stress Scale, and a questionnaire to collect data on demographic characteristics, complications during pregnancy, and lifestyle behaviors. The finding of this research was 9.4% reported being physically abused during the year of pregnancy.

**Types of Violence**

There are the various forms of abusive behaviors which could be classified into 3 types: (Barnett, Miller-Perrin, & Perrin, 2004, Robert, 2007).
(1) Physical violence is abusive behavior that brings physical injury to women such as slapping, pushing, hitting, kicking, and punching. This form of physical abuse can be fatal to women.

(2) Emotional violence is any action which affects emotion, thoughts, and feelings such as refusal to talk, negligence, ignorance of personal value, and being accused of doing things the women have not done. Some reports have found that women who are physically injured are emotionally injured as well (Barnett, Miller-Perrin, & Perrin, 2004, Thepthongkham, 2002).

(3) Sexual violence is the use of force to compel a woman to have sex against her wishes. The violence can be molestation, compulsion, or coercion into prostitution (Castro et al, 2003).

Studies of domestic violence during pregnancy mostly operationalize violence as physical harm, while few evaluate sexual or emotional violence during pregnancy. The order of domestic violence and pregnancy are not well-established: it remains unclear if pregnancy predicts domestic violence or exacerbates pre-existing violence. In fact, there is mixed evidence regarding domestic violence and pregnancy prevalence rates. Some literature suggests that domestic violence is more prevalent during the postpartum phase than during the pregnancy itself (Gielen, O'Campo, Faden, Kass, & Xue, 1994), and other empirical evidence indicates that physical violence decreases during pregnancy but verbal/emotional abuse escalates (Castro, Peek-Asa, & Ruiz, 2003).

Gielen et al (1994) explored the frequency, severity, perpetrators and psychosocial correlates of violence during the childbearing year. The sample was 275 women who were interviewed 3 times during pregnancy and at 6 months postpartum. The finding showed that 19%
of women reported experiencing moderate or severe violence prenatally, compared to 25% in the postpartum period.

Whether a pregnancy was intended also emerges as a significant factor in understanding the full implications of domestic violence during a pregnancy. Evidence suggests that unintended pregnant women had been physically or sexually abused by their current or most recent partner (Pallitto, & O'Campo, 2004). For example, Pallitto, & O'Campo (2004) explore the relationship between intimate partner violence and unintended pregnancy. The sample comprised of 3,431 ever-married women aged 15-49 who had given birth in the last five years or were currently pregnant. The result showed that 55% of respondents had had at least one unintended pregnancy, and 38% had been physically or sexually abused by their current or most recent partner. Again, the temporal order is uncertain and it remains unclear if domestic violence existed prior to the pregnancy or resulted from an unplanned or unwanted pregnancy.

Domestic violence during a pregnancy is also linked to the health and welfare of the infant during the pregnancy, at delivery, and with bonding immediately postpartum (Huth-Bocks, Levendosky, Bogat, 2002). Some research demonstrates that abused women are more likely to enter prenatal care during the third trimester, have poor maternal weight gain, and are diagnosed more frequently with anemia (Huth-Bocks, Levendosky, Bogat, 2002). Physical abuse also was related to a greater likelihood of premature labor, lower infant birth weight, and more prenatal substance use. For example, the study of Rachana et al. (2002) explored the incidence rate of violence and its complications. The result found that 40% abused women had to be hospitalized prior to delivery for premature contraction, falling or abdominal trauma related to physical violence, including 3 cases of uterine rupture caused by blows to the abdominal region. The study was conducted by Buaboon (2001). She assessed the effects of physical and emotional
abuse on pregnancy outcomes and maternal-child attachment among 230 abused mothers. The study found that mother who were not abused during pregnancy had better infant birth weight, Apgar score, and mother–child attachment higher scores on than those of mothers who were abused.

Research indicates that domestic violence during a pregnancy negatively influences the maternal-child bond and can be displayed as maternal anger and depression in relation to her pregnancy. Furthermore, it also affects the mother’s perception of her ability to care for their children (Hutch-Bocks, Levendosky, Theran, & Bogat, 2004)

**Consequences of domestic violence**

Domestic violence often causes harm from the direct acts of violence and has many physical and psychological implications for the individuals, couples, and families. Direct effects of violence can be described as injury and mortality, while the longer term effects can be categorized into ongoing health and mental health problems (Bacchus et al., 2004). Injuries caused by domestic violence have been noted to range from minor injuries, such as scratches and bruises, to major injuries, such as gun or knife wounds, broken bones, and burns (Tjaden et al., 2000a). The rate of female homicide at the hands of an intimate partner is alarmingly high, remaining remarkably stable for approximately twenty years (U.S. Department of Justice, 2006). Abused women have approximately 60% higher rates of health problems, such as chronic pain (e.g. pelvic, back, and abdominal), vaginal bleeding and infections, sexually transmitted diseases (STDs), headaches, and digestive problems when compared to women that were not abused (Campbell et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000). Women that experience physical and sexual abuse by their partners are more likely to use alcohol or marijuana to cope, and to attempt suicide (Wingood, DiClemente, & Raj, 2000).
Domestic violence also contributes to numerous mental health problems, including depression and anxiety. In the United States, Sutherland, Bybee, and Sullivan (2002) interviewed a community sample of 397 women about their experience of intimate partner violence, stress, depression, and physical health problems. A random sample of women that experienced any adult domestic violence (e.g., physical, sexual, and non-physical) within the previous five years reported a two to three times higher prevalence of depressive symptoms.

Stress has been found to mediate the relationship between domestic violence, depression, and physical health problems. Domestic violence has devastating effects on general health, well-being, and functioning, which clearly has lasting consequences on the mental health and emotional stability of victims (Bacchus et al., 2004). These consequences of violence are further magnified when domestic violence is experienced during a pregnancy.

**Abused women living in a shelter**

The numbers of families living in shelters have grown rapidly over the past two decades. The U.S. Department of Housing and Urban Development (HUD, 2009) estimated that 1.6 million people experienced homelessness in 2008 and 32% of people who became homeless were identified as being a part of a family.

**Definition**

Women living in a shelter are generally classified via the criteria established by the McKinney Homeless Assistance Act of 1987 (Aday, 2001). Based upon these guidelines, study participants may include women:

(a) Lacking a fixed, regular, and adequate nighttime residence.

(b) Having a primary nighttime residence in a publicly- or privately-operated shelter.
(c) Living in temporary accommodations such as a congregate shelter, welfare hotels, and transitional housing for the mentally ill.

(d) Living in a public or private place that is intended to be a temporary residence for people ordinarily institutionalized.

(e) Living in a public or private place not designed for living.

**The history of abused women’s shelters**

The first women’s shelter was established in Britain after “five hundred women and children and a cow marched through an English town” protesting the elimination of free school milk (Dobash & Dobash, 1992), although the date it was established is unavailable. During this era, women started meeting to discuss many subjects relevant to their lives. This sharing brought attention to the voices of those that had encountered husband or partner abuse. The overwhelming demand of this group was for a safe place to hide from their abusers.

In Thailand, battered women’s shelters are sparse. Few shelters have been available to abused women. The main objectives of the temporary shelters in Thailand are (a) to promote equal rights and social justice to women and children by providing shelter, moral support, and training for all disadvantaged people; (b) to enhance women’s professional skills and knowledge, enabling them to contribute to the economic and social development of Thailand, and (c) to support the full and equal participation of women in power structures and decision-making at all levels, thus eliminating gender bias in laws, policies, and practices (The Association for the Promotion of the Status of Women, 2009; The Wild Flower House, nd.).
The theoretical framework of becoming a mother

Ramona T. Mercer first described a theoretical framework for the maternal role in the late 1960s (Mercer, 1985). Mercer’s inspiration came from her professor, Reva Rubin. Rubin is well known for describing maternal role attainment as a process of the attachment between child and mother and maternal role identity (Mercer, 1985). Mercer’s framework clearly reflects Rubin’s key concepts. Rubin’s focus on pregnancy and the first month after delivery was extended by Mercer to include the first year after the birth of the child. She also reported that the theory was based on role theory, knowledge of the infant’s traits, and the factors that influence the maternal role during the first postpartum year (Mercer, 1985).

Maternal role attainment, or becoming a mother, was described as a process “in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set so that she is comfortable with her identity as a mother” (Mercer, 1985). Mercer believed that maternal role attainment was achieved when the women felt internal harmony with the maternal role and all the expectations it includes. Mercer further explained attachment to the infant, gaining competence in maternal behaviors, and expressing pleasure in mother-infant interactions as the major components of the maternal role. Attachment is a process which develops through a mutually satisfying interactive process between a mother and her infant(s) and attachment also identified as the most important caregiver role of mothers (Bowlby, 1969). Attachment has been studied widely in the past three decades (Mercer, 1983) and has been proven to be a highly significant factor in the development of the parent-child relationship (Bowlby, 1969).

Mercer adapted Thornton and Nardi’s role theory to her framework. She described the development of maternal role attainment as progressing over the anticipatory, formal, informal,
and personal stages. This process begins during the prenatal period and expands over a three- to twelve-month postnatal period. Maternal role competence is the “mother’s skill, sensitivity, empathic responses, and nurturing behavior that promote the infant’s health and development” (Mercer, 1995, p. 159). Maternal role competence is a primary component of maternal role attainment.

The anticipatory stage of maternal role attainment occurs during pregnancy. This is described as a time of social and psychological adjustment to the expectations of the role. This stage is characterized as one of replication and fantasy. The formal process of maternal role attainment begins with the birth of the child. During this stage role taking behaviors are created through information from professionals, peers, and the family (Mercer, 1995).

The informal stage takes place when a woman is working in her role, developing knowledge and insights. During this stage the mother begins to develop her own unique style of parenting and performs her role in creative ways. The identity, or personal, stage is successful when a woman has completely integrated her role and expectations into her own life and is secure about her maternal abilities. This stage is reached when a woman feels a sense of harmony, satisfaction, and competence in the role, as well as emotional pleasure in her relationship with her child (Mercer, 1995).

Maternal role attainment is the final product of role development. Some women are able to feel comfortable within the first month, and other women will be successful at some point during the first year. Role attainment is a very complex process that involves the mother, the child, a partner, and the environment.
Variables associated with becoming a mother

The achievement of becoming a mother is related to several variables. These variables are divided into three groups: maternal, infant, and environmental variables (Mercer, 1995). Maternal variables include maternal age, parity, marital status, race, education, income, parenting education, perception of birth experiences, self-esteem, and the psychological states and personality traits of the mother. Maternal competence is related to self-esteem and has been identified as a key variable that affects maternal-infant attachment (Mercer & Ferketich, 1990). Another indicator of maternal competency is breastfeeding. Tarkka (2003) found that breastfeeding led to better maternal competence. She determined factors that contributed to the maternal competence of first-time mothers when the child was 8 months old. The sample consisted of 248 first-time mothers who completed the questionnaires when their child was 8 months old. The structured questionnaires were used to collect data. The data were analyzed using stepwise regression analysis. The result showed that the more balanced the mother’s state of mind, the more easy going the child, the period of breast feeding, and the concrete supports were, the greater was the mother’s competence.

Becoming a mother in Thailand

The maternal role in Thai society is very important. A Thai mother has the primary responsibility for child rearing. Studies of the maternal role in Thailand are predominately focused on mothers who have experienced difficulties with maternal role attainment. For example, Phahuwatanakorn (2003) studied the relationships between social support, maternal employment, postpartum anxiety, and maternal role competency among 124 Thai primiparous postpartum mothers. The results revealed that social support and maternal employment had an
effect on postpartum anxiety, but only support from family and significant persons had an effect on maternal competency.

Jirapaet (2001) used content analysis to explore the factors affecting maternal role attainment during 39 interviews with low-income, Thai, HIV-positive mothers. Interview results indicated that the mothers’ use of internal and external resources to attain their maternal roles was of importance. Six factors that positively impacted maternal role attainment were: (a) setting a purpose in life, that is, focusing on raising their infant; (b) keeping secrets from others; (c) a feeling of normalization; (d) having good quality support from others; (e) having hope for an HIV cure; and (f) receiving accessible, pleasant health services which protect anonymity regarding HIV status.

Soomlek (1995) studied the maternal role in 268 first-time mothers visiting the postpartum unit, Siriraj hospital, Thailand. The study found that the factors affecting the maternal role were social support, marital relation, self esteem, and mothers’ sense of competency. Currently, most Thai mothers have to work outside the home. This might be another factor affecting development of the maternal role. Although there are studies about the maternal role of Thai mothers, there is no research involving becoming a mother among Abused Thai women living in a shelter.

In summary, becoming a mother is described as a significant event in a woman’s life and it is also difficult to clearly explain, especially in abused women living in shelters. This study will extend the research to Abused Thai women by exploring the process of becoming a mother among those Thai women who are living in a shelter. It is hoped that the findings of this study will be beneficial to all abused women living in shelters and will provide some direction for improvements in nursing care, health care policy, and social awareness in Thailand.
Chapter 3
Methodology

Introduction
This chapter outlines a proposed study which will be explored grounded theory. The narrative will include (1) the study’s setting, (2) a description of study participants, (3) human subject assurance, (4) data collection methods, (5) The study’s procedure, and (6) data analysis. The following section will describe how grounded theory will be used as the theoretical root for conducting research through (1) theoretical sensitivity, (2) theoretical sampling, (3) constant comparative analysis, (4) coding and categorizing data, (5) theoretical memos and diagrams, (6) literature as a source of data, and (7) integration of theory.

Research Design
The focus of this dissertation is on generating a detailed, contextually-grounded description and theoretical explanation of the process of becoming a mother in Thai abused mothers residing in shelters. The specific research design for this dissertation is a qualitative approach, specifically, grounded theory. The qualitative method is designed to explore the nature of a woman’s experiences, to explore concepts and relationships that are complex and not yet clearly described, and to generate essential and formal theories (Glaser, 1978: Glaser & Strauss, 1967).

The grounded theory method was chosen for several reasons. First, this idea explores social processes and this method is helpful when the goal is developing a theory that explains human behaviors during interactions with other people in a society (Glaser & Strauss, 1967).
Second, becoming a mother is a transition, and nursing research has shown that grounded theory is suitable for the study of individual behaviors related to developmental transitions and challenging situations. This idea also allows for the analysis of processes rather than static situations. Finally, grounded theory is helpful when less is known about the area of study, as is the case of abused mothers residing in shelters.

**Theoretical perspective: Grounded theory method**

Grounded theory is a leading qualitative method that has its roots in sociology. Glaser and Strauss, sociologists, originally developed the method of grounded theory in 1967 (Glaser & Strauss, 1967). They were interested in studying persons that were dying in hospitals. They noticed that the healthcare providers rarely talked about dying or death with the patients that were near death. They interviewed the people that were dying about their feelings and how they dealt with this critical event. Then, the researchers exchanged their data through communications with each other. Consequently, Glaser and Strauss generated a theory of social organization and temporal order of dying. In addition, discovering analytic ideas from the study contributed to the development of systematic methodological strategies that other researchers could apply to their studies.

Grounded theory is used to explain the social process that is present within human interaction and based on the theoretical fundamentals of symbolic interactionism (Carpenter, 2002). The basic assumption of this philosophy is that people construct their realities through social interactions, in which shared symbols are used to communicate meaning (Kendal, 1999). Grounded theory has been widely used by researchers in the fields of health, nursing, education, and psychological specialties. Grounded theory was introduced to graduate nursing students at
the University of California, San Francisco, by its originators in the early 1970s (Stern & Covan, 2001). Grounded theory has progressively changed since its introduction. Strauss’s approach to grounded theory has been developed over time, and many researchers use grounded theory to generate middle-range theories (Carpenter, 2002). The middle range theories continue to grow rapidly because many nursing researchers use the mid-range level to provide guidance for everyday practice and scholarly research rooted in the discipline of nursing. They use the steps of abstraction to articulate the logic of middle range theory as related to a philosophical perspective and practice/research approaches congruent with theory conceptualization.

Grounded theory involves symbolic interaction theory, which focuses on communication as the process of expressing feelings, desires, needs, opinions, and information exchanges (Strauss, 1987). The purpose of grounded theory methodology is to reflect an inductive mode of analysis or a process of moving from a specific area of study to a general theory. Clark and McCann (2003) explain seven key characteristics of grounded theory: (1) theoretical sensitivity, (2) theoretical sampling, (3) constant comparative analysis, (4) coding and categorizing the data, (5) theoretical memos and diagrams, (6) literature as a source of data, and (7) integration of theory.

Theoretical sensitivity refers to a researchers’ ability to “render theoretically their discovered substantive, grounded categories” (Glaser, 1978, p. 1). It can help researchers to generate actual theory that is grounded in data. In this process, grounded theory researchers use their experiences to conceptualize and interpret data and relate concepts to each other (Glaser, 1978). The researchers use an inductive perspective in order to construct a new theory because it can move from concrete to abstract levels of knowledge.
Theoretical sampling. Before collecting data, researchers determine the inclusion and exclusion criteria for the participants, along with the setting and the methods. These processes are known as purposive sampling. Once the initial data are obtained, the researcher must make a further decision as to how to obtain new data. They might change participants, sample size, a setting, or adjust the data collection method. All adapted procedures are called theoretical sampling (Glaser, 1978). In a grounded theory study, recommended sample sizes are varied and depend upon the characteristics of the domain of inquiry. Determining the sample size is not an important process of theoretical sampling: more important is that theoretical saturation is reached. Theoretical saturation refers to the practice by which researchers continue data collection until no new or relevant data are found in emerging categories. Moreover, researchers must be able to group data into categories or subcategories. The relationships among categories are well-established and validated (Straus & Corbin, 1998). In this process, novice researchers typically enlist experts in grounded theory to help prepare and interpret data and to determine when new data are approaching (Munhall, 2007).

Constant Comparative Analysis refers to the central approach to data analysis. It is the critical method used to achieve a grounded theory. This approach occurs when data collection and data analysis are conducted simultaneously (Strauss & Corbin, 1998). Constant comparative methods are comprised of four stages (Glaser & Strauss, 1967): (1) comparing incidents applicable to each category; (2) integrating categories and their properties; (3) delimiting the theory; and (4) writing the theory. During data collection, data sources come from individual interviews, focus group interviews, and/or participant observations. Qualitative interviews can be conducted using informal conversation interviews, semi-structured interviews, and standardized, open-ended interviews (Patton, 1990). Typically, grounded theory interviews are semi-
structured. An interview guide is developed to provide a direction for researchers conducting interviews. Observation is another form of data collection. Observations enhance research through improved understanding about settings, incidents, activities, and people, and can describe situations and accurately capture contextual information (Creswell, 1998). Using the constant comparative approach, the researcher attempts to analyze data until the new data obtained provide no further insight and a theory is sufficiently generated (McCann & Clark, 2003).

Coding and Categorizing Data. In grounded theory, the first step of data analysis is developing qualitative codes to characterize the data. Coding is the process by which researchers simultaneously categorize and summarize many pieces of data to determine and establish a short name for the segments of data. There are three steps of coding applied to the emerging categories and subcategories: open coding, axial coding, and selective coding.

a) Open coding, also referred to as (Level I) or (substantive) coding, is the process of data expansion. During this process, data set are broken down into discrete parts to be conceptualized and categorized (McCann & Clark, 2003), and researchers create as many codes as needed to reach the goal of open coding (Strauss & Corbin, 1998). The goal of open coding is to establish theory through the steps of conceptualizing, defining categories, and developing categories in terms of the discovery of the properties and dimensions of each concept. There are two types of open coding. The first type is in vivo codes, whereby codes are named using the participants’ exact words. The second type is the sociological construct, a process by which collected data are combined with professional knowledge and expertise to create codes. During this step, researchers keep
data grouped according to codes that occur frequently, while other rarely-occurring ones may eventually be discarded from the analysis.

b) Axial coding, also known as (theoretical) or (Level II) coding, was introduced by Strauss (1987) as a process of relating categories to their subcategories. The purpose of this process is to limit data that were expanded during open coding. Strauss & Corbin (1998) summarized four basic tasks in axial coding:

1. Lay out the properties of categories and their dimensions. This task begins during open coding.
2. Identify the variety of conditions, actions/interactions, and consequences associated with each phenomenon.
3. Group categories to their subcategories through statements denoting how they are related to each other.
4. Search for connections in the data that denote how major categories might relate to each other.

c) Selective (Level III) coding, is the process of integrating and refining the theory (Strauss & Corbin, 1998). In this level, the theoretical sampling is terminated when the data displays richness and no new data emerge. The goal is to identify a central category and to establish links among categories. Strauss (1987) explained the criteria that are used to select a core category:

1. The core category must be central and related to all other categories.
2. The core category is frequently found in the data and can be used to indicate each concept.
(3) The core category can be used to explain the relationship among categories logically and consistently.

(4) The core category is named abstractly in order to be used to conduct other research in several areas and to be used to develop more general theories.

(5) When the concepts are integrated with other concepts, the theory that is generated is a thorough depiction of the process and has a powerful background explanation.

(6) The concept has an ability to explain the importance of the data.

In summary, the three levels of coding provide systematic analysis for emerging grounded theory through the technique of developing categories and subcategories, interconnecting the categories, and integrating and refining theory.

Theoretical Memoing and Diagramming are very useful tools for building theories in the analytical process. Researchers write memos as reflections of their ideas. A record in a memo helps to remind the researcher of important information. Strauss and Corbin (1998) proposed three types of memos: code notes, theoretical notes, and operational notes. Open, axial, and selective coding are found in code notes. Theoretical notes consist of researchers’ thoughts about theoretical conceptualizations. Operational notes determine the direction of further analytic processes and remind researchers not to overlook important information. Diagramming is a tool to help researchers understand the relationships among concepts, categories, or subcategories (Schreiber, 2001). Creating diagrams can enhance the researcher’s ability to create new categories or to cluster them rapidly.

Literature as a Source of Data. Some grounded theorists propose having researchers initially conduct literature reviews. They believe that researchers will gain many benefits from
exploring various literature, including development of more effective theories, or providing important information for theoretical sampling (Munhall, 2007). On the other hand, many grounded theorists are concerned that researchers will begin their studies with fixed ideas from the literature reviews (Glaser, 1978).

**Integration of Theory.** This process includes writing the storyline, making use of diagrams, and reviewing and sorting memos (Strauss & Corbin, 1998). Writing the storyline helps researchers to express their thoughts about the integrated theory. Making use of diagrams is a second technique for integrating theory. Moreover, diagrams assist researchers by facilitating work with concepts instead of data details. The final technique that can be employed is reviewing and sorting memos. Memos include all conceptualizations written during data collection and analysis. They can be sorted by categories or specific themes (Strauss & Corbin, 1998).

**Participants**

A purposive sampling procedure will be used to recruit Thai abused mothers that live in the shelters. These women will be asked to recall any abuse that occurred during pregnancy as well as questions regarding becoming a mother. In a grounded theory study, recommended sample sizes are varied and depend upon theoretical saturation. Saturation refers to the practice by which the researcher continues data collection until no new data are found. It is anticipated that 15-25 interviews will be needed to reach theoretical saturation.

**Inclusion Criteria**

The following are the criteria for selecting the target population.

1. Mothers that are Thai, at least 18 years of age, able to speak and understand Thai.
2. Mothers who give birth to the first child and this child have no significance on health problem.

3. Mothers that have experienced abuse during their current pregnancy.

4. Women that live in shelters for abused mothers.

**Exclusion Criteria**

The following are the exclusion criteria that will be used to exclude women from the target population.

1. Mothers diagnosed by a center as having a mental problem are automatically hospitalized. Such women will be excluded from the study.

2. Mothers those are not cognitively or psychologically able to engage in an interview.

3. Mothers with known postpartum complications requiring medical intervention.

**Research Settings**

This study will take place from four non-profit, charitable shelters in Thailand. Approximately 10-40 women reside in each of the shelters. The four shelters are:

1) The Wild Flower House located in Chiang Mai, Thailand. The shelter was established in 2004 to provide assistance to single mothers with very young children. The goals of this shelter are to provide safe shelter, health care, education and emotional support to women coming from difficult situations, to have each woman in a steady job or continuing education after leaving Wildflower Home, and to be assured each child is in a healthy, loving environment after leaving Wildflower Home.

2) The Association for the Promotion of the Status of Women (APSW), Shelter for Battered Women, located in Bangkok, the capital of Thailand. The APSW, under the Royal
Patronage of HRH Princess Soamsawali. It was established in 1980 by a Buddhist nun, Kanittha Wicheanchareon, to provide assistance to women and children who are victims of forced prostitution, HIV/AIDS, unemployment, abandonment, and physical and mental abuse.

3) Ban PraKun was established in 1987 as part of Lutheran Christian Welfare Department. This shelter provides safe, temporary accommodations and support for women and their children who are victims of domestic abuse.

4) Ban Sukhruthai Pakhini Srichumpabal is temporary housing for mothers with children and unwanted pregnant women who are unable to live at home. It was established since 1972. Staff members provide support services to help women and their children find permanent housing, to prepare women to live independently.

**Protection of Human Subjects**

Prior to conducting of the study, the research proposal must be reviewed and approved by the committee for the Protection of the Human Subjects Department at The Catholic University of America. Written permission for conducting this study will be obtained from the administrative director from each shelter.

Informed consent will be obtained from each participant in this study. The participants will be informed that they can refuse to answer any question or to withdraw from this study at any time.

To protect the privacy of the participants, all of the answers will be coded with a number. Confidentiality will be maintained by separating the names on all record forms. Psychological support services are available at the shelters if participants have expressed distress while participating in this research.
Data collection instruments

Prior to data collection, the investigator constructed interview guides containing major questions to be ask during participants’ interviews. This interview guided was reviewed by advisors.

Demographic data (appendix B) will be collected via the data collection instrument. Semi-structured interviews will be facilitated via the interview guide. Over the course of the interviews, additional questions and probes may be used to clarify responses or to explore themes.

The primary research question is: What is the process of becoming a mother among Thai abused mothers living in shelters?

The central questions guiding this dissertation are as follows:

(1) How would you describe your feelings on becoming a mother?
(2) What made you feel like a successful or unsuccessful mother?
(3) What do you do in order to taking your baby?
(4) What experiences have either made it harder or easier to become a mother?

Research Procedure

The following steps will be used to guide the conduct of the study.

1. The researcher met with the director of the shelter to discuss the research proposal and asked for support and permission to conduct the study. The director or relevant staff will identify potential participants that meet the inclusion criteria.
2. The staff member will inform potential participants about the study through a recruiting flyer (Appendix C). If a woman is interested in participating, she will notify the researcher by means of a telephone number noted on the participant information sheet.

3. Upon first contact with the researcher, the potential participant will be screened to determine if she meets the study inclusion criteria. Once eligibility has been determined, the researcher will explain the purpose of the study and study procedures, including potential risks, potential benefits, and how potential risks will be minimized. Issues regarding participants’ confidentiality and anonymity will be explained to them. Once consent procedures have been completed, if the woman agrees to participate, she will be asked by the researcher to sign the informed consent form.

4. After obtaining informed consent, the researcher will schedule an appointment to interview the participant at her preferred time. A one-on-one interview will be conducted in a private room at the shelter with no other individuals present. The researcher will attempt to develop a sense of trust and respect between her and the participant by asking general questions, inquiring about how she is currently doing and expressing interest in hearing her story. It is anticipated that the interviews will be 60-90 minutes in length, but the exact time will depend on the point at which no new information is forthcoming.

5. During interview, open-ended questions will be used to elicit responses from the participants. Demographic data will be collected to obtain a rich description of the study participants (Appendix B- Demographic data). The participant will be asked about her experiences of becoming a mother (Appendix B– Interview Guide).

6. The conversations between the participants and the researcher will be audio recorded with a digital recorder and will be transcribed verbatim. The researcher is the only person that
will transcribe interviews. Pseudonyms will be used to code each transcript. The researcher will review the transcripts with her dissertation advisor. All data and documents will be retained in a locked and secured area in the researcher’s home and on a password-protected computer.

**Data Analysis**

All interviews will be transcribed verbatim in the Thai language and translated into English. The transcripts and demographic information will then be back-translated by a colleague who is fluent in both Thai and English. Only coded information will be shared with a colleague. Demographic data will be analyzed via descriptive statistics in order to describe general characteristics of the sample. Theme data will be analyzed by using the grounded theory technique of constant comparative analysis described by Glaser and Strauss (1967).

**Establishing Trustworthiness**

The four criteria of trustworthiness in this study are Lincoln & Guba’s technique: the concepts of credibility, transferability, auditability, and confirmability (Lincoln & Guba, 1985; Sandelowski, 1986).

Credibility is the first technique for establishing the trustworthiness of this study and will be used to determine the validity of the study. Lincoln & Guba (1985) suggest peer debriefing, negative case analysis, and member checks to examine the credibility of the study:

First, in grounded theory the researcher is the primary instrument for data collection. It is important to address the potential for problems in researcher bias. In the proposed research, the researcher will keep a record of all participant interviews and discuss any concerns with her advisor. The researcher will also identify her biases and feelings about becoming a mother.
Second, the researcher will use peer debriefing to provide an external check on the research process. The researcher’s biases are probed, explored, and clarified during this phase (Sandelowski, 1986). Debriefing provides an initial opportunity to test the code categories that have arisen from the interviews. Discussion with the major advisor and committee will provide feedback on the researcher’s interview transcriptions and coding themes on a regular basis throughout the research process to ensure that the researcher has remained as unbiased as possible.

Transferability is the second technique for establishing the trustworthiness of this study and the method to determine the applicability of the study. Lincoln & Guba (1985) explained that the researcher is responsible for providing a rich description of the information to reach an overall detail of the study.

Auditability is the third technique for establishing the trustworthiness of the study. With respect to audibility, this study will be auditable when other researchers can follow the decision trail and draw similar conclusions (Sandelowski, 1986). Auditability will begin with careful attention to development of an audit trail. It will include the audio recording of interviews and organization of all data, including tapes, transcripts, field notes, memos, codes, categories, and all other forms of documentation.

Dependability is the third technique for establishing the trustworthiness of this study. Dependability is the way to determine the reliability of this study. Lincoln & Guba (1985) suggest that the researcher should have an auditor to establish the reliability of the study. A major advisor and committee will be tasked with examining the process and the product of the study. Examining the process of the study is the way to maintain the fairness of the data from the subject. Examining the product of the study is the method to evaluate accuracy of the data with
replicated subjects. In this study, it is important to be concerned with the trustworthiness and honesty of participants’ responses. The researcher will improve trustworthiness by offering the participants’ confidentiality in their participation, making the study completely voluntary, and trying to improve the investigator-participant relationship during the interview. The researcher will use active listening skills during the interviews and allow the mothers to do most of the talking. It is also important to ensure research representativeness. The researcher will interview mothers and continue participant interviews until reaching the point of data saturation (Strauss & Cobin, 1998).

Confirmability is the final technique for establishing the trustworthiness of this study. It is considered through the development of a trail of all collected and analyzed data (Lincoln & Guba, 1985). Creditability and auditability help to achieve confirmability. Lincoln & Guba (1985) suggested that confirmability is comprised of two parts: the audit trail and the audit process. The audit trail helps to manage the process of the study through methodology, raw data, data analysis, and findings. The audit process is the method through preentry, determination of auditability, trustworthiness, and closure. In this study, the discussion of transcripts with the dissertation committee is important in establishing confirmability.

**Limitations**

There are several limitations to this study. First, the participants will be obtained from four shelters in Thailand and may not represent the process of becoming a mother of the broader population. Second, all participants are Thai so the data may not be representative of becoming a mother in general.
Summary

In this chapter, the research design of the qualitative study will be guided the emerging categories in order to develop theory by using grounded theory methodology. The participants, settings, instruments will be explained in the detail of the study. The protection of human subjects provided for the human’s rights in this study. Finally, the application of Lincoln and Guba’s technique for establishing of trustworthiness will be discussed with respect to deter the rigor of this study.
Chapter 4

Presentation of Findings

The goal of this study was to describe the process of being a mother as reported by abused Thai women who were residing in shelters. The results consist of the mothers’ perceptions based on their own life experiences. This research employed a grounded theory approach and themes were developed based on the interviews of the women who served as participants in the study. To facilitate a discussion of the findings, this chapter is presented in three parts as follows: part one describes the demographic characteristics of the participants as well as an overview of their families; part two consists of an explanation of the process involved in the generation of the conceptual categories; part three is comprised of a description of the substantive theory which emerged as a consequence of this research. In this study, pseudonyms were used throughout the interview process in order to protect participant confidentiality, and the participants’ actual identifying information was not connected to their transcript.

Demographic Characteristics of the Participants and Their Families

Participants were recruited according to the study criteria through a flyer that was placed at shelters for abused women and through social workers involved with abused women in each shelter. Demographic data were collected to provide a description of the study participants, participants’ partners, and participants’ babies. The demographic interview form that was used to collect their information is attached in Appendix B, “Interview Guide”.

Demographic Characteristics of Participants

Demographic data were collected to provide a description of the participants (see Table 1). Study participants included 21 women who experienced abuse during pregnancy and were residing in shelters with their babies. The age of the participants varied from 18 to 33 years of age, with a mean of 25.29 years of age at the time of the interview.

All participants were Thai. Thirteen (61.90%) participants were Buddhists, five (23.81%) were Catholic, and three (14.29%) were Islamic. The majority had finished high school (42.86%, n = 9) and eight (38.10%) participants had completed their bachelor’s degree.

Most participants were unemployed at the time of the interviews (85.71%, n = 18). All of them experienced an unintended pregnancy (100%, n = 21). Eighteen (85.71%) defined their marital status as a separated relationship and three of them (14.29%) were single.

Most of the participants in this study grew up in a rural area of Thailand (61.90%, n = 13), eight (38.10%) were from Bangkok (the capital city of Thailand). Participants who grew up in rural areas were classified as having lived in the following regions of Thailand: the northern region (23.81%, n=5), the north-eastern region (23.81%, n=5), the southern region (9.52%, n=2), and the eastern region (4.76%, n=1). Thirteen (61.90%) participants had never contemplated terminating their pregnancy, whereas five of them (23.81%) were forced to consider terminating their pregnancy by their husband or parents, and three of them (14.29%) had opted to end their pregnancy but the pregnancy termination was either not successful or they changed their mind when they arrived at the clinic.

Seventeen (80.95%) of the participants reported they were from the extended families and now living independently, but still received some financial assistance from their parents, and four (19.05%) participants were residing with their nuclear family at the time they became
pregnant. The majority of participants (61.90%, n = 13) reported receiving no financial assistance from their families and/or partners during the term of residence in a shelter. These women noted they had thus far resided in a shelter for two to ten (x = 4.86) months.

Table 1 the Demographic Characteristics of Participants (N=21)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (Frequency %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>18-33 (x = 25.29)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Thai</td>
<td>21 (100%)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>13 (61.90%)</td>
</tr>
<tr>
<td>Catholic</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>Islam</td>
<td>3 (14.29%)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3 (14.29%)</td>
</tr>
<tr>
<td>Separated</td>
<td>18 (85.71%)</td>
</tr>
<tr>
<td>Educational Background</td>
<td></td>
</tr>
<tr>
<td>Pratom:(grades 1-6)</td>
<td>2 (9.52%)</td>
</tr>
<tr>
<td>Mattayom ton:(grades 7-9)</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td>Mattayom Plai:(grades 10-12)</td>
<td>9 (42.86%)</td>
</tr>
<tr>
<td>Vocational College</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>8 (38.10%)</td>
</tr>
<tr>
<td>Length of Stay in Shelter (months)</td>
<td>2-10 (x = 4.86)</td>
</tr>
</tbody>
</table>
### Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (Frequency %)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Working status</strong></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>3 (14.29%)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>18 (85.71%)</td>
</tr>
<tr>
<td><strong>Type of Family</strong></td>
<td></td>
</tr>
<tr>
<td>Nuclear family</td>
<td>4 (19.04%)</td>
</tr>
<tr>
<td>Extended family</td>
<td>17 (80.95%)</td>
</tr>
<tr>
<td><strong>Hometown</strong></td>
<td></td>
</tr>
<tr>
<td>Bangkok</td>
<td>8 (38.10%)</td>
</tr>
<tr>
<td>Northern Thailand</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>North-eastern Thailand</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>Southern Thailand</td>
<td>2 (9.52%)</td>
</tr>
<tr>
<td>Eastern Thailand</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td><strong>Pregnancy planning</strong></td>
<td></td>
</tr>
<tr>
<td>Unintended pregnancy</td>
<td>21 (100%)</td>
</tr>
<tr>
<td><strong>Initial Thoughts of Terminating the Pregnancy</strong></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>Being compelled by others</td>
<td>3 (14.29%)</td>
</tr>
<tr>
<td>Decided by themselves</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Support from Family</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8 (38.10%)</td>
</tr>
<tr>
<td>No</td>
<td>13 (61.90%)</td>
</tr>
</tbody>
</table>
Demographic Characteristics of Participants’ Partners

The participants’ partner was not interviewed for this study. All information was given by the abused Thai women. Partner ranged from 18 to 38 years of age ($x=27.90$ years). All of the partners were of Thai ethnic background (100%, n=21). Sixteen partners were Buddhist (76.19%). Sixteen (76.19%) held a bachelor’s degree. Seventeen (80.95%) partners were employed and had a full time job.

The greatest proportion of partners (28.57%, n=6) grew up in Bangkok. Partners were evenly distributed from the northern, north-eastern, and southern regions (23.81%, n=5) of Thailand. The demographic characteristics of participants’ partners are noted in Table Two, below.

Table 2 Demographic Characteristics of Participants’ Partners (N=21)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>18- 38 ($x = 27.90$)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Thai</td>
<td>21 (100%)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>16 (76.19%)</td>
</tr>
<tr>
<td>Islam</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>Educational Background</td>
<td></td>
</tr>
<tr>
<td>Mattayom ton: (grades 7-9)</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td>Mattayom Plai: (grades 10-12)</td>
<td>3 (14.29%)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>16 (76.19%)</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>1 (4.76%)</td>
</tr>
</tbody>
</table>
Demographic Characteristics of Participants’ Babies

The gender of the participants’ babies was approximately equal, 11 were girls (52.38%) and most were born by natural vaginal delivery (n = 19, 90.48%). All of them were born at full term gestational age. Twelve babies (57.14%) had birth weights between 2,500 to 3,000 grams. The age of the babies from birth until the time of the interview varied from 2 to 7 months, with a mean of 3.7 months of age. All babies were in good health at the time of interview session (100%, n= 21)

Table 3 Demographic Characteristics of Participants’ Babies (N=21)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Girl</td>
<td>11 (52.38%)</td>
</tr>
<tr>
<td>Boy</td>
<td>10 (47.62%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hometown</td>
<td></td>
</tr>
<tr>
<td>Bangkok, Thailand</td>
<td>6 (28.57%)</td>
</tr>
<tr>
<td>Northern, Thailand</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>North eastern, Thailand</td>
<td>5 (23.81%)</td>
</tr>
<tr>
<td>Southern, Thailand</td>
<td>5 (23.81%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working status</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>4 (19.05%)</td>
</tr>
<tr>
<td>Employed</td>
<td>17 (80.95%)</td>
</tr>
<tr>
<td>Characteristics</td>
<td>Frequency (%)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Type of delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Vaginal delivery</td>
<td>19 (90.48%)</td>
</tr>
<tr>
<td>Cesarean section</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td>Vacuum extraction</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td><strong>Birth place</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>21 (100%)</td>
</tr>
<tr>
<td><strong>Fetal Birth Weight</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 2,500 grams</td>
<td>1 (4.76%)</td>
</tr>
<tr>
<td>2,500-3000 grams</td>
<td>12 (57.14%)</td>
</tr>
<tr>
<td>&gt; 3,000 grams</td>
<td>8 (38.10%)</td>
</tr>
<tr>
<td><strong>Age (months) at time of interview</strong></td>
<td>2-7 (x =3.7)</td>
</tr>
<tr>
<td><strong>Health status</strong></td>
<td></td>
</tr>
<tr>
<td>Healthy</td>
<td>21 (100%)</td>
</tr>
</tbody>
</table>

**Development of the Conceptual Categories**

The grounded theory approach suggested by Glaser and Strauss (1990) was used in this research. This method is appropriate and useful because it is designed to generate explanatory theory concerning complex social or psychological phenomena and to explain how Thai abused mothers’ process their lives over time and with changes in their circumstances.

Data collection occurred over an eight month period of time. Five major activities were used to generate the theory that was derived from this research: interviewing and transcription;
development and utilization of memos; substantive coding; theoretical categorizing and reduction, and theory development.

1) Interviewing and data transcription. After developing a list of questions that were based on contemporary research in the field (Appendix B, Interview Guide), the researcher interviewed each participant by herself. All of the interviews were conducted in quiet rooms at the shelters, with only the researcher and the participant and her baby present. The researcher conducted the interview after the participant’s baby was fed and sleeping, so the baby was less likely to interrupt the interview. If the baby needed care during the interview, the interview had to stop and allow the mother taking care the baby. Before the interview would be starting again, the researcher would review the major questions with the mother. Even though the researcher had a list of questions, the interview was guided by the participants’ responses. As themes began to develop, the researcher asked for additional information which might not have been included in the interview guide in order to elaborate on themes that occurred during earlier interviews. All interviews were audio tape recorded and transcribed verbatim and then translated to English by the researcher.

2) Development and utilization of memos. After each interview, the researcher left the shelter and generated a memo. Memos are documents that the researcher used to record information on the research process, as well as to analyze and synthesize data. In each of the memos, the researcher included observations, behaviors, feelings, and thoughts that occurred during the interview.

3) Substantive coding. The substantive codes that were developed were based on the words or phrases that were expressed by the participants. In this research, the researcher herself substantively coded all interviews in two ways. First, the researcher read each transcript in
English to get an overall sense of the data. Second, the researcher went over each sentence again to assign substantive codes. A printed copy of the interview was made wherein the participants’ information was typed on left hand side of the paper and the right hand side was used to code data, rather than coding on a separate sheet of paper. The researcher composed a coding system by using all the substantive codes, the verbatim transcripts, and the researcher’s memos.

During each interview, the researcher compared the new data with the previous transcripts to identify and code the new data. Then, the data from all of the transcripts were grouped into subcategories and main categories that had the same meaning. In the beginning, the researcher categorized each theme as broadly as possible in order to avoid neglecting or overlapping data. As more information was collected, the data seemed more manageable; the researcher then sorted themes into smaller categories.

Table 4. Sample of Transcribed Interview with Recorded Codes

<table>
<thead>
<tr>
<th>Transcribed interview</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse: What are the barriers to raising your baby here?</td>
<td>- protecting her baby</td>
</tr>
<tr>
<td>Gung: My barrier is not serious. I didn’t expect everything to be perfect in this</td>
<td>- being concerned about the baby’s health status.</td>
</tr>
<tr>
<td>shelter but I need more privacy.</td>
<td>- Need for more privacy</td>
</tr>
<tr>
<td>Sometimes I want to stay alone with my baby but I can’t. I don’t want some women to</td>
<td></td>
</tr>
<tr>
<td>hold my baby but I can’t refuse them. If I had a private room, I could</td>
<td></td>
</tr>
</tbody>
</table>
Running head: The Process of becoming a Mother

<table>
<thead>
<tr>
<th>Transcribed interview</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>avoid them. I am concerned that my baby might get sick or get some contagious diseases from them.</td>
<td>- stay away from making any trouble.</td>
</tr>
<tr>
<td>Nurse: Can you tell me the reasons why you don’t want them to touch your baby? Gung: I can but I don’t want to have a conflict with my friends. I used to tell a woman who wanted to hold and play with my baby she could not do so. She was so angry and said when I gave my baby to the Saha Thai Foundation, there would be many people to play or touch my baby. I should accept this point. I understand but I want to give him the best care while I am living with him. I can’t control the future but I can control my present.</td>
<td></td>
</tr>
<tr>
<td>- planning for her baby - trying to do her best while she can take care her baby.</td>
<td></td>
</tr>
</tbody>
</table>

The process of becoming a mother in a shelter was described differently by study participants. After analyzing all of the data, many major themes arose. For example: seeking information for herself and her baby, promoting the baby’s physical and emotional health, planning for the baby’s future, the intention to be a good mother, accepting a new life, being concerned about the health status of the infant, fostering religious beliefs, identifying special...
needs of the baby, providing care during an illness, promoting the mother-infant relationship, and including the nuclear family but not including the father of the baby in the care of the baby.

4) Theoretical categorizing and reduction. The process of identification of themes continued until data saturation was obtained and no new information was noted. In this study, no new conceptual labels occurred after the completion of 16 interviews with these Thai mothers. However, the researcher interviewed five additional mothers to confirm that there was indeed complete saturation. After conceptual labels were identified, the researcher compared each label to investigate how they were connected to each other. This process, called data reduction, was used to make sure that the same phenomena were grouped into similar categories. The conceptual labels were organized into four major themes including: preparing to be a mother; struggling to be a good mother; making progress; and being a good mother on my own terms.

Table 5 Cluster of Substantive Codes and Conceptual Categories Explaining the Process of Becoming a Mother in a Thai Shelters for Abused Women.

<table>
<thead>
<tr>
<th>Cluster of Substantive Codes</th>
<th>Conceptual Categories</th>
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<tbody>
<tr>
<td>Beginning to Adopt the Maternal Role by Empowering</td>
<td>Preparing to be a mother</td>
</tr>
<tr>
<td>Themselves and Seeking Supports.</td>
<td></td>
</tr>
<tr>
<td>Getting away from the abusive relationship</td>
<td></td>
</tr>
<tr>
<td>Personal problems: fatigue, fear, anger</td>
<td>Struggling to be a good mother</td>
</tr>
<tr>
<td>Environmental problems: staff, friends, shelter’s rules, people from outside of the shelter.</td>
<td></td>
</tr>
<tr>
<td>Financial problems: no job, no money</td>
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The researcher identified codes from all the data to describe the process of becoming a mother in a shelter for Thai women who have been abused. In table five, a total of four major phases were described:

- First phase. Preparing to be a mother
- Second phase. Struggling to be a good mother
- Third phase. Making progress
- Fourth phase. Being a good mother on their own terms

**The First Phase of the Process of Becoming a Mother: Preparing to be a Mother**

In this first process, these women described two themes that help them to prepare to be a mother as below: Beginning to adopt the maternal role by empowering themselves and seeking supports; and Getting away from the abusive relationship.
Beginning to Adopt the Maternal Role by Empowering Themselves and Seeking Supports.

Nurturing babies in a shelter was viewed as a challenge. Even though many shelters try to provide a home like environment, a shelter is not a home. In a shelter, women and children of all ages live together. They have to cope with an unfamiliar environment, strangers, the shelter’s regulations, and personal stressors (Krane & Davies, 2007). Moreover, the quality of being a good mother is dependent on many factors, such as, age, financial status, mothering attitudes, family functioning, or social and family supports (Mercer, 2004; Ngai, Chan, and Holroyd, 2011). Many women can develop the maternal role effortlessly and without difficulty. In contrast, some women may find it difficult to accomplish maternal tasks and might neglect or abuse their babies (Semaan, Jasinski and Bubriski-McKenzie, 2013). According study conducted by McKinney et al. (2009), mothering behavior is a meaningful criteria of maternal and child attachment. Many studies suggest that the process of maternal role development and maternal and infant attachment begin in pregnancy, and continues during the childbirth period (Çalışır & Karaçam, 2011; Rubin’s study, 1984).

Although the abused Thai women that were interviewed in this study reported feelings of insecurity and tension, most of them demonstrated behaviors, such as feeding their babies, providing clean clothing, or promoting relationships between mother and infant that indicated they were able to transition into a positive maternal role. This is consistent with research that has found most mothers in general population are able to establish positive mother-infant interactions. In the literature, a positive maternal role is explained in terms of holistic care that involves a strong sense of loving without conditions, providing continuous care for babies 24 hours a day and 7 days a week, and protect them from any harm (McDonald-Harker, 2011; Semaan, Jasinsk, & Bubriski-McKenzie, 2013). In this research, the participants reported that the
Running head: The Process of becoming a Mother

process of becoming a mother began outside the shelter when they were pregnant. They decided to get away from their abusive relationship and seek assistance, including a safe place to live and social supports. They stated that the baby was a key factor in their decision to separate from their partners. They had to empower themselves in order to make the big decision to reside in a shelter and to prepare themselves as a mother.

Nan, Nok, Tip, and Rong shared a common history of having decided to become homeless and separate from their abusive relationship to protect their expected babies. Below is an introduction concerning how each woman described her reason to seek care in a shelter.

One of the participants, Nan, was 28 years old and from Chiangmai Province. She spoke of the responsibilities that she should have as the mother of the baby in the following way:

*When I realized that I had almost reached the due date and my baby would be coming soon, I knew I was his [the baby’s] mother shouldn’t let him live in this bad situation, so I started to find information through the internet. I could not talk to anybody and had to keep all of these secrets with me. I was scared that my husband might know my plan and try to ruin my plan. (Have you ever tried to run away before this time?) No, I thought everything would be better and hoped that he might change his behavior, but it never happened. If he only hurt me, I would give him a chance to try to be a good husband, but I can’t let him hurt my baby. I used to question myself as to whether I could hurt him to protect my baby or not. My answer is yes. If he dares to beat my baby, I would kill him, so I decided to run away from him to protect my baby and myself.*

Another participant, Nok, was 26 years old and from Nan Province, She said that her life was punished by karma that she had done in a previous life. When she was abused she just
accepted and ignored it. However, her pregnancy made her change in a big way. She committed herself to start a new life and did not want her baby have ill effects from the violence situation. Nok shared her experience as follows:

After he knew that I was pregnant, he wanted me to terminate it. When I insisted that I would keep my baby, problems started. Luckily, he never beat me physically. He just ignored me and always yelled at me that the baby was not his baby and he really hated my baby. He told me that our situation would get better if I decided to abort my baby. How cruel he was! My baby is innocent. I couldn’t do that because it would be a murder and a bad karma, so I decided to get away from him. First, I told my parents and asked them if I could live with them. They want me to stay with him. My mother said he would change his mind when he saw my baby. I knew it was not true and I didn’t want to live with a stressful situation because it might affect my baby. I felt that my baby was so quiet. She didn’t have any movement when my husband was yelling at me. Then, I called my friend to help me look for a safe place. She suggested this shelter.

Tip was a 26 years old young woman from Bangkok and lived with her partner for two years prior to separation from her partner. She revealed her reasons for leaving her husband in a way that was similar to reports by some of the other women. She tried to remain in her abusive relationship because of hope and love of her husband. However, love of her baby pushed her to change her life. She described:

My bad situation happened for a while before I was pregnant. Every time when he started to fight or get angry, I ran away to my parent’s house. After my mom
passed away, my brother moved into that house. My brother almost killed my husband when he knew that my husband hurt me. Even though my husband beat me, I still love him. I don’t want him to get hurt. When my husband beat me, I couldn’t run away to my brother’s house. I couldn’t talk to my brother. I just pretended that we stopped fighting or he never beat me anymore. When I was pregnant, I moved slowly and it was difficult to hide when he got angry. I still remember Thai New Year’s Day. He got drunk and he punched on my belly. That situation made me quit everything.

Despite the fact I didn’t plan to have a baby, I didn’t want my baby get hurt like me. I really love my baby. I have to protect my baby, so I finally ran to my brother’s house and told him that I wanted to separate from my husband. I asked my brother if I could live with him. My brother suggested that I live in this shelter. He said this shelter is safer than his house because nobody is at home during the day. My husband might come to his house and hurt me again.

Rong, a 29 year old woman from Bangkok, lived with her husband for six years before deciding to separate from him; here is how she related her story:

*I have known him for seven years. He is my brother’s friend. I don’t love him but he raped me when I was 23 years old. He said he really loved me and wanted to marry me. At that time, I was like many Thai women who believe that we can have only one man in our life, so I agreed to marry him. He beat me every time when he got drunk. I was admitted to the hospital four times and he never stopped hurting me. It got more serious and worse. Last year, when I was two months
pregnant, he had a party and was getting drunk. I had a feeling or sixth sense this time it was going to be more serious, so I just ran away from him with nothing. I was scared to death but I just wanted my baby and I was safe. I went to my best friend’s house. She gave me money and told me to live with her friend in Bangkok.

These women not only coped with their abusive partner, but also dealt with other family members because in the Thai culture parents have a large influence on their children, no matter how old are they. Additionally, most participants needed to empower or encourage themselves in order to start being a good mother or prepare to be a good mother. Their babies were the motivation to take on the role of mothering. Seven participants shared their experiences as they began to transition into life in the shelter:

Ying, 22 years old, was studying at the School of Education, Rajchabhat Nakon Ratchasima, and explained the influence of her mother on her life and her maternal role. She told of her experience as follows:

I have known my boyfriend for one year. After that I got pregnant and told him that I was pregnant. First I wanted to have an abortion. He didn’t agree with me. He said it is a tremendous sin to do that. After my mom knew that I was pregnant, she asked my husband to marry me and told me to move out to live with my husband. He told me and my mom that he didn’t want to bother his mom. My mom was very angry and blamed him because he didn’t want to take responsibility. When my mom asked me and my husband about our future plans, I wanted to give my baby to an orphanage home. My husband disagreed with this idea. He said if I put his name on the birth certificate as my baby’s father, he wouldn’t allow me
and my mother to give away my baby but he also said he couldn’t take any responsibility for the baby. He already has a wife and two lovely kids.

After I gave birth, my mom took me to his house. He was very angry. I had never seen his emotions like this. He said if I want to be his wife, I shouldn't come to his house. He didn’t want his wife to know me. He asked me to raise my baby until it was one year of age and said he would then bring my baby to his mother but for now I have to understand and don’t tell anybody that I am his wife. My mom was very angry. She said that she couldn’t allow my baby and me to stay at her home either. My mother is a principal of a high school and she is very well known in our community. She felt ashamed that her daughter got pregnant before she graduated from college. She doesn’t want anybody to know that I’m pregnant. I felt hopeless because nobody wanted me. When I hug my baby, I feel a little hope. I felt that my baby sent her power to me. I felt that I really loved her and needed to protect her as a mother. This shelter came up to my mind. I used to come with my mother to donate my clothes at this shelter, so I asked her if she might allow me to live in this shelter.

Pla, a 28 year old mother of a five month old girl, talked about her tough experience and stated that she did not want her daughter living under control of her mother and her husband. She said:

You know? When my husband hit me, I told my mom about our situation. She told me to be patient with him. She said I am already his wife. It’s a shame on me if I get divorced and how I can stand up in our society? My mother is a teacher and everybody in our village knows her. She doesn’t want her friends or our
neighbors to know that her daughter will get divorced. She can’t accept any embarrassment from me.

After the ultrasonography, my husband and my mom felt disappointed that I had a girl. They thought my first baby should be a boy. That situation made me decide to leave him. I didn’t even tell my mom. I told my best friend that I was going to separate from him. I don’t want my daughter living under the same situation as me. I have to do everything that my mom orders: quitting my studies, getting married with a guy that my mom chose for me. That’s enough. My daughter shouldn’t be in the same situation as me.

Another mother, Namtan, was a 33 year old woman from Nakonratchasima, and described her situation and stated that the responsibilities and roles of being a mother are very important. She illustrated her responsibilities as a mother this way:

My baby is a big support for me. When I felt her movement inside my womb, I felt love. I have to encourage myself that I have to stand up for my baby. Nobody can help me if I don’t help myself. Especially my baby, I am her mother, if I don’t protect my daughter, who is going to do this for me? Before I was pregnant, I thought I could endure every bad behavior that my husband did to me because I really loved him and couldn’t live without him. Now I still love him, but I love my daughter more than him. It was hard to run away from someone that I really loved. I went back and forth many times.
Anyway, I can’t just let everything keep going on. Someday he might not control himself and intend to kill me. If I died, he must go to jail and my daughter would be an orphan. It might be a serious and tough time for her. If I dare to speak up or do something for my daughter and myself, she might not have a father but she still has me.

Similarly, Gung, 23 years old, indicated her thoughts of being a mother were incredibly difficult:

I have to make myself stronger. I have to protect my baby from this violence. It’s hard to getting started but I can do it.

**Getting away from the abusive relationship**

Some women explained that they need to get away from the abusive relationship in order to begin their maternal role.

Another mother, Rong, related a similar thought that she need to leave her abusive relationship to ensure that her baby would be safe:

I was so scared that he might kill me if he knew that I was going to leave him or I might not have enough money to raise my baby. When I thought about my baby’s future, she will grow up with a drunken and cruel father. I have to make a big decision for her.
Keaw, another mother of a two month old girl, explained the reason that she decided to leave an abusive relationship was her baby.

*My baby means everything to me. She is the only important thing in my life. I have to do everything to give her a better life. Getting away from a house that is full of drunken people, drugs, violence is a must do.*

Saijai, a 24 year old mother of a five month old baby, described her story and stated that she could leave everything behind just because of her daughter. She said that:

*Becoming homeless is such a terrible time. As you know when Thais see people living in a shelter, Thais always think those people might have mental disabilities or they are on drugs. In the fact, there are many reasons why they have to be homeless. Like my situation, when I had my baby, I was terrified because I didn’t want her living in a violent situation. I had to leave an abusive relationship and get out of trouble. Being homeless means I will lose everything: home, job, or money but I have to do this as I am her mother.*

In summary, the participants described the process of becoming a mother in an emotional and challenged manner. They explained that being a mother occurred before moving to the shelters. Their babies motivated them to move forward and leave their abusers. In order to end their abusive relationship, they needed to empower themselves and seek help and information.

**The Second Phase of the Process of Becoming a Mother: Struggling To Be a Good Mother**

The second major phase of the process of becoming a mother in abused Thai women living in shelters concerned the struggle to be a good mother. This phase was comprised of three
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major themes: personal, environmental, and financial problems. These women also described how they prepared themselves to get through this process.

Table 6. Indicators and Properties of the Second Phase of the Process of Becoming a Mother:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Properties</th>
</tr>
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<tbody>
<tr>
<td>Trouble, terrible time, hard, unknown, stressful, drained,</td>
<td>Personal Problems</td>
</tr>
<tr>
<td>overwelmed, scared, anger, upset, scared, horrible, blank,</td>
<td></td>
</tr>
<tr>
<td>accepted</td>
<td></td>
</tr>
<tr>
<td>Friends, staffs, the rules of the shelter, people from outside</td>
<td>Environmental Problems</td>
</tr>
<tr>
<td>the shelter.</td>
<td></td>
</tr>
<tr>
<td>No money, no job</td>
<td>Financial Problems</td>
</tr>
</tbody>
</table>

Twelve women served to illustrate the different feelings that arose when they raised their baby in a shelter.

**Personal Problems**

Cat, a 19 year old mother, stated that becoming a mother in a shelter was a terrible time for her, especially during her first two weeks. She attributed this to lack of experience and said:  

\[I \text{ still remember the first-two weeks when I stayed here. It was such a terrible time for me. I was so upset with my life. I don’t know why I had to be here. My fate or God was just kidding me. He is my first baby. He was just screaming. I did not know how to calm down him. I did not know what happened to him. It’s just horrible. The staff taught me how to breastfeed, change diapers, and hold my}\]
baby, but I couldn’t do it. I wish I had someone to help me take care of him.

Anyway, I am getting better as time goes on. Even though, it is difficult I can do it.

Tukta, another participant, simply said that raising a baby in a shelter is full of stress and overwhelming. Stress was described by reviewing the literature (Cheung, 2011; Milligan, 2012) as patterns of physical, emotional, behavioral, or cognitive responses to stimuli while raising her baby in a shelter. There were various variables that were a source of stress in homeless mother such as dangerous environment, financial problems, a lack of social support, a lack of jobs, or medical illness. She described her experience as follows:

It is stressful to be here. Raising my baby in this shelter is overwhelming. I don’t know how to explain. Everybody is so nice. The staff is friendly and willing to help me. My roommate is easy to get along with but I just feel something stuck in my throat.

Three women, Fahsai, Pim, and Gung, described their lives in the shelter as draining. “Drained” was used to describe a feeling of physical or emotional exhaustion whereby the women had no energy left.

Fahsai explained that the crying of babies had an impact on her life in the shelter and made her feel exhausted. She explained her experiences:

I am so fatigued. I can’t sleep well because I heard babies cry a lot. We have many women and babies living in the same room. This baby stopped crying, and then another baby started crying. Raising a baby alone is hard.

Pim had the same feelings as Fahsai and stated that lack of sleep contributed to her feelings of being drained:
I am so exhausted. I have the sleeping difficulty. Babies wake up and cry almost every one hour. I felt like I have no energy left.

Gung supported this feeling as well and further described how raising her baby in shelter affects her daily life:

I felt completely exhausted after the end of the day. I felt that I slept like I was dead every night. I don’t want to watch TV like other women do every night. After my baby went to sleep, one thing that I wanted to do is sleep.

Saijai additionally expressed her feelings that she was so tired but she could not abandon her baby. She said:

Sometimes I am so tired or fatigued, but I still need to take good care or keep an eye on my baby. I can’t ignore or neglect her. Living in a shelter doesn’t mean you can’t be a good mother.

Many women described feeling scared or frightened. This feeling had many causes. For instance, some feared about what would happen in the future, or were scared their partners would bring them back.

Tip shared her thoughts about residing in a shelter and that she felt scared to live there. Even though she was supported by the staff, she still felt insecure:

I am so scared that my husband would know that I stay here and he might come to get me back. The social workers told me that they will not allow him to meet me and my baby without my permission. They affirmed that I would be safe here, but I am still scared.
Rong expressed another concern as an abused woman living in a shelter. That is, fears about the future. She realized that without a job or money she might not be able to raise her baby. From her thoughts, fear of the future might be the one factor that affects mothering.

*I am so scared that I can’t raise baby. I don’t want to put him in foster care. I have no choice. If I could not get a job, I could not raise him. When I thought I will not see him grow up anymore, I feel I lose all energy.*

Furthermore, anger led these women to take action in terms of being a mother in a shelter. Anger was defined as negative mood states that included: being mad, feeling frustrated, feeling frantic or furious, having inappropriate temper behaviors, or violence (Spielberger, 1983).

Ying explained her anger at herself and her husband while living in the shelter:

*S Sometimes I felt angry at myself. I should have the capability to provide at least basic needs for the baby. When I held my baby, I thought I am a bad mother. I couldn’t find a good place for her. My daughter is a good girl and easy to take care of. The easier to nurture she is, the angrier I get at myself. Sometimes I felt angry at my husband. He doesn’t have any responsibility. A gentleman should take responsibility for his family, but my husband is not. He said he still lives with his parents and he has his family to take care of. He can’t allow me and my baby to live with him. How bad he is!*
However, some mothers had the mixed feelings about being a mother in a shelter. Some of them thought they had a good opportunity because they were residing in a shelter. Others thought they were being punished.

Sopa, a 30 year old mother of a three month old girl, explained her religious beliefs in the context of her situation. According to Buddhism, situations in human lives happen due to Karma or are the result of our actions or behaviors. She believed that she was the one who made this problem, so she needed to take responsibility and accept it. She shared her thoughts as below:

*Sometimes I thought it is my Karma that I have to live here. I did not obey my mother when I was a teenager. I never argued or quarreled with her, but I never listened to her. I often resisted my mother’s teaching. I might be punished by Buddha or a God in heaven. Um...I don’t know. It’s kind of mixed feelings. Sometimes I think Buddha might have pity on me so he sent me here. This place is my last straw. When I thought Buddha would sympathize with me by sending me here, I felt I had to be a good mother to pay back.*

Gung, a 23 year old mother of a 2 month old girl, had some beliefs that made her accept being a mother in a shelter. She illustrated her thoughts as follows:

*I deserved to live here. I believe in Karma and fate that I had done in a previous life and recent life. In my previous life, I might be a man who abused my wife. So this life I was abused and am now homeless. Fate or Karma brought him back to me. I have to accept this result and forgive what he did to me and my baby. I don’t want revenge or to curse him. The Karma between us should be finished in this life.*
Tangmo, 18 years old and from Bangkok, who was unsure about her mothering abilities, shared her experiences of becoming a mother as follows:

I don’t know if I am a good or bad mother. It’s kind of mixed feelings, but most of the time I think I am a good mother. I am just only 18 years old. I didn’t put high expectations on myself. I tried to do my best. I feel that I am a bad mother when I can’t deal with my baby or can’t keep my baby calmed down.

Three women had the same feelings that nurturing a baby in the shelter was a hard time for them. Lack of time was mentioned so often and they reported that this affected their maternal role. The examples were as follows,

Manaw, a 22 year old mother, further explained her concerns about getting a job but taking care of her baby could not allow her to do this. She described her maternal role in the shelter as follows:

Nurturing my baby here is tough. I have to do everything by myself. I want to find a job, but I can’t leave my baby here.

Keaw supported that raising a baby in a shelter was difficult and she has no time for herself. She said:

Fostering a baby here is hard for me. I can’t find time to look for a job or join in a training program.

Additionally, Toom indicated that raising a baby in a shelter was hard because of a lack of support. It also made her upset. She said that:
Everything is harder for me because I don’t have any support, I have nothing.

Then I got upset, I felt my life is blank.

Pim and Fahsai concurred with the same thoughts about lacking support. Both of them agreed that supports from family are very important such new mothers. They told that:

I have to raise my baby here alone. Sometimes I wish I had my mother or sister to help me. I’m very tired, especially during the night time. When my baby was crying, I didn’t want to wake up. (Pim)

I wish I had my mother or sister to help me. I’m very tired, especially during the night time. (Fahsai)

**Environmental Problems**

In addition, those participants also defined several environmental obstacles that included: friends, staff, the rules of the shelter, people from outside of the shelter. In this research, friends were defined as other mothers in the shelter; most women defined all women in the shelter as their friends.

Rong stated that she needed more privacy while she lived in the shelter but she could not advocate for herself in this regard because she did not want any problems between residents:

My barrier is not serious. I didn’t expect everything to be perfect in this shelter but I need more privacy. Sometimes I want to stay alone with my baby, but I can’t. I don’t want some women to hold my baby, but I can’t refuse them. If I had my private room, I could avoid them. (You can tell your reasons why you don’t want them to touch your baby.) I can but I don’t want to make a conflict with my friends. I used to tell a woman who wanted to hold and play with my baby. She was so angry and yelled at me.
Mai agreed that she also needed some privacy or separate space for her and her baby and further explained the reason why she needed it:

*I think it is difficult to find quiet or separate place here. I was concerned about my baby illness. (Did your baby get sick?) No, but too many children live in this shelter. Some of them got sick. My baby might be getting a contagious disease from them and I have no money to take her to the hospital.*

Three women described that other women in the shelter were a source of problems for them, for instance:

*I saw some women hitting and cursing at their babies. I wanted to tell the staff but I didn’t want to make any problems in my life. I just kept my eye on her. In case she hit her baby more seriously, I would need to call the staff. (Sigh) My life has enough troubles. I do not need to deal with others’ problems. (Mai)*

*I don’t want to hear about her sex life, needs, or things like that. I don’t want to hear somebody cursing in the community bedroom or cafeteria. Thank God that my baby is too young to understand what they said. Anyway, those women yelled very loud and made my baby cry. (Fahsai)*

*Some women call their babies with profanities in front of the other women. I believe if mothers say some bad things to their children, it will be true. A mother is a person who gives a life to her baby. The curses from a mother are more powerful than other curses. (Tukta)*

In contrast, some women viewed other mothers in their shelter as their support resources.
Toom stated that she learned baby care techniques from other women in shelter:

*Sometimes I don’t know how to deal with my baby. I just observed other women what they did or how they do to their baby. I just learn from them.*

Namtan shared her thoughts that she received positive support from another woman. She explained how social support in a shelter met her needs. She said that:

*I found my best friend here. I don’t know how it happened. We might have the same problem so we tried to help each other. When I felt tired or I wanted to take a nap, she helped me to keep an eye on my baby. Sometimes we discussed our problems and we cried, but after that we felt relieved. I felt that I have someone who understands my problems.*

**Financial Problems**

Financial obstacles seemed to be a serious problem and to be associated with the emotional and physical well-being of abused women and their babies. Abused mothers who encounter financial tension may be at risk for negative maternal behaviors that disturb the overall development of babies. Similarly, research conducted in the United States by Fuertes et al. (2009) and Kobak et al. (2006), indicates that financial strain may have a negative effect on parenting. Those low income parents have difficulty providing for their infants’ basic needs, for example, food, clothes, housing, or health care and it can increase level of stress. Consequently, these factors may have a negative impact on mother and child interactions. Most women in the present study identified struggling with financial problems created higher levels of stress.

Mai was concerned that living with other sick children might cause health problems. Because of financial problem she could not provide her baby with high quality milk. Even though, breast-feeding is promoted to all women the shelters and that they should breastfeed
exclusively for at least 6 months, some women needed formula milk because they could not produce sufficient breast milk, the mother or infant had health problems that precluded breastfeeding, or they believed strongly that formula was of higher quality based on advertisements they had seen. Mai explained that:

My baby might get a contagious disease from others living in the shelter and I have no money to take her to the hospital. I also have no money to buy her good formulated milk powder. She might have low immunity because she can’t have good quality milk. I understand that staff encourage all women in a shelter feed baby with breast milk. I have not enough breast milk and my baby still cry a lot after breast feeding. Staffs give me formula milk but that formula milk is from donation. It might not be the good brand or almost expired.

Saijai explained that money is very crucial. Even though her shelter provided some basic needs, it was not enough or inappropriate to her specific situation.

Money is a big problem in my life. When I stay here, this shelter supports me with almost everything. I have food, clothes for me and my baby, diapers, and formula. When my baby has an appointment with the doctor, they take me and my baby to the hospital. I don’t think that is enough but I can’t ask for any more help. They are so kind to give the opportunity for me to stay here. I want to get a good job, to get my own money, and to buy good foods for a postpartum mother. Sometimes the food here is so spicy: sometimes they put preserved bamboo shoots in curry. I know that is not good for breastfeeding. What else I can do? I have to eat.
Namtan noted that she did not have money or job, so she had no choice and had nowhere else to go:

*I was taught that money is not important in my life. When I have my baby, I thought money is very important. I have no money, so I have to live here. Raising a baby without money is so hard. I want to get something special for my girl but I can’t.*

Rong elucidated that she could not see a bright future. Without money there was only one thing that she can imagine and that was putting her baby in foster care. She explained as below:

*I am concerned about my future. I have no money and job. When I see my baby, I start shaking and feel cold. I am so scared that I can’t raise him. I don’t want to put him in foster care.*

Sopa stated that it was problematic for her to get a good job. She has to work hard which means that she would have no time for her baby. Her story is as below;

*I want to get a job, I want to have money to take good care her. I talk to the staff and she told me that I can leave my baby at the Sahathai organization if I have a job. However, with my knowledge I don’t know how I can get enough money to support me and my daughter. I used to work at the noodle shop. My boss gave me 180 baths (six US dollars) per day and my job was 12 hours from 8am-8pm. That is so stressful.*

Nan was the only participant who got emotional support from her family, but her family was unable to provide any financial support. The discussion of support was as follows:
My family is always with me when I have problems. I can call my parents or my sister any time but my family is so poor. They can’t help me about money. Sometimes, I feel better when I talk to them but my deep feeling is still full of tension about my situation.

Several participants shared their opinions about the rules of the shelters. All of them accepted that these shelters were distinctly different from their homes. Ying explained that she had to follow the shelter’s rules strictly, even though she would not agree with these rules. She said:

The shelter has strict rules. I need to get along with everybody. A woman was very rude and I don’t want to even talk to her. Under the shelter’s rules, I can’t show my reaction that I don’t like her. I was forced to tolerate people who I dislike. I have no choice.

Fah Sai felt that the shelter was too strict and explained her frustration when she wasn’t able to do her own activities:

We must get up at 4.30 am to do Morning Prayer. Then, we start to wash the baby’s clothes or milk bottles, or prepare everything for our baby. Before I had a baby, I woke up at 7 a.m. At some times I am so tired. I couldn’t sleep because my baby got sick and cried all night. She just fell asleep in the early morning. I wanted to sleep with her too, but I couldn’t do it. I must wake up at 4:30 a.m. to do chores. During the day I couldn’t get into the bedroom. There is a rule that we can’t stay in the bedroom unless we get sick. I don’t want to explain to the staff that I am not sick but I am just tired.. tired and I want to take a nap.
Orn, who lived in a shelter that has less strict rules had conflict with their rules as well, stated that:

Every morning I have to get everything ready at 7:30 a.m. We will start breakfast at 7:30. If you come late, you can’t have it [breakfast]. It is hilarious. In the morning everybody is so busy. Sometimes my baby is still sleeping but I have to bring him to the kitchen. I understand they don’t have enough staff to keep an eye on us, but the rules should be flexible in some cases.

Rong further explained that she might not agree with the shelter rules, that there is a lack of privacy and shelters are too rigid. But she emphasized that she needed to follow shelter rules:

I want my son to stay away from others. I don’t want my baby to catch a cold. The shelter’s rules don’t allow us to stay alone. I couldn’t provide any privacy to my son. Even me, sometimes I need a quiet place to think about my future or some space that I can cry without a witness. So, my private area is only in a bathroom. Sometimes I am so frustrated but I have to follow the rules strictly. I don’t want to be kicked out of this shelter.

Besides the stressors that exist inside the shelters, many mothers explained their concerns about people from outside the shelters.

Mai, a 21 year old mother from small village in Nan Province, explained her concern about her neighbor:

I am concerned about my neighbors. If they know my situation, they might say I got what I deserved. When I go to work in Bangkok, some neighbors talked...
without addressing anyone in particular, but I did know they were talking about me. They said I would get pregnant and my baby would not have a father. (Why do they say that?) You know? Many rural old people do not like young women moving to work in Bangkok, especially women with little knowledge like me. Many young women in my village had babies without their husband’s taking responsibility. They bring their babies to their parents and leave them with their parents. If they know I have a baby and have to live in this shelter, I can’t go back to my village again.

Pla clarified that people from outside the shelter made her self-esteem low, although they treated her and her baby gently and kindly. She said:

*I went to the hospital. When the nurse knew that my baby was referred from an abused shelter, I will never forget the faces on her and her assistant. She looked at me with sympathy, held my baby carefully, and touched me softly. It made me feel bad. I don’t want any sympathy.*

Gung described that using a shelter’s facilities is a stigma. She felt that people from outside judge her because she has been living in a shelter:

*When I get off of the shelter’s bus at the hospital, everybody stared at me with curiosity. I knew that they wanted to know what I did wrong, or why I live in the shelter. I hate their staring eyes. I am not a wrongdoer or criminal.*

Namtan agreed with Gung that being a mother in a shelter was a stigma and was viewed as a failure that she needed to hide from society. She explained that:

*Raising a baby in the shelter! It is a stigma. I want nobody to know that I am living here. It is like I am a failure in my life, I am a loser.*
your baby because you have to be here?) No, it’s not her fault. It is my fault
because I am a bad mother. I give her a life but I can’t give her good
opportunities in her life.

Additionally, some women suggested strategies or their life styles that they adopt in order
to cope with the tension of being a mother in a shelter. The strategies focused mainly on religious
beliefs.

Two mothers, Keaw and Sopa, fostered their religious beliefs to help them be a good
mother or release the tension associated with living in the shelters;

*I learned to do meditation. It is helpful. I feel I am so calmed down and more
patient with my baby. Before I practiced meditation, I was a horrid mother. I was
defreaking when I heard a baby’s cry.* (Keaw)

*The nurse at the antenatal care unit gave me a Dharma book by Vashiramethi
and suggested that I read it. When I first heard her advice, I was speechless. I
didn’t think it would help me. Dharma is good for older people or people who are
successful in their lives. Some sentences in this book made me find the light. When
we are hurt, nobody can hurt me. It’s only me that can keep anger, hatred, or
sadness in my mind. My husband doesn’t care about me anymore, so why I do
need to think of him? After I finished that book, I started to practice meditation. I
felt a lot of peace, full acceptance of this situation. When I felt down with myself
or my baby, I just took a deep breath and relaxed for 10 minutes. I felt better.*
(Sopa)
Tukta suggested another coping strategy that she used when she was living in a shelter. She told that she asked for help from the staff or other women:

> When I felt overwhelmed with raising my baby here, I asked my friends or staff to keep an eye on my baby. I just wanted to get outside of the building, take a walk, and relax.

Cat explained that sharing her problems with other women was helpful. When she recognized that her problem was not as bad as other women and if these women could get through these problems, she could do it. She stated:

> I discussed my problems with my friends in this shelter. Some women’s problems are more serious than mine. If they can survive, I can too.

Another strategy that Manaw chose to use was learning from another. Either good or bad examples could help her to develop her maternal capabilities. When she compared her maternal role with other abused women, she was more confident that she was a good mother. She shared her idea that:

> Sometimes I learn how to take care of my baby and I learn what is good or bad for them. Well, I thought some of my friends make me feel that I am a successful mother, some babies are always getting sick but my baby is very healthy and easy to take care of.

In brief, becoming a mother played an important role in women’s lives, especially abused mother. They needed great efforts to balance their maternal roles. They experienced many variables that affected their mothering. The participants described personal, financial, and environmental problems as the barriers of becoming a mother. Some women suggested the strategies that helped them get through this period.
The Third Phase of the Process of Becoming a Mother: Making Progress

The participants in this study had prepared themselves to be good mothers by developing behaviors that promote positive mother-baby interactions.

For example, they sought information on infant care, they learned childcare techniques, they took actions to support their own physical and emotional health, and they engaged in behaviors indicative of positive maternal-infant attachment. As a result, they were generally ready to take care of their babies. Most of them focused on their intention to be a good mother by adjusting emotionally and changing their behaviors.

Intention to Be a Good Mother by Adjusting Emotions and Changing Behaviors

These women intended to be good mother and began their maternal role by adjusting emotions and changing behaviors.

Sopa stated that being a mother could learn and develop over a period of time. She suggested the successful techniques that she used centered on adjustment of her attitudes and beliefs:

The important thing to be a success in being a mother here is attitude. You have to believe in yourself. I don’t believe that the maternal role is about instinct and that every woman has it. We have to learn how to be a good mother and stick to our goals. When I first came here with my baby, I thought I can’t raise my baby alone. I had that emotion only a few days. When I held my baby, she is so adorable. I am her mother and I have to take good care of her. Every morning after I wake up I tell myself that every day. It’s like our emotions control our body. If we always say we can do it, then we can do it.
Tangmo explained that being in a good health is important for raising her baby in a shelter:

*Before I have him, I wake up late around 9 or 10 a.m. Now I change my life style. I wake up early morning, do exercise, and eat healthy foods. I have to have good health to take care of my baby.*

Tip explained that her life totally changed after she raised her baby in the shelter. She had changed her life style and taken good care of herself;

*I am totally changing my life. I love to eat spicy Somtum plara (fermented raw fish with papaya salad). I ate it almost every day. The nurse said it is not good for my baby because she might get diarrhea. When I breastfeed, I must eat healthy food, so I don’t eat it. I stopped smoking and do exercise every day. I don’t want to get sick.*

Nok were so grateful the opportunities that she got from the shelter. She was indebted to the staff and she stated that in order to pay back the staff she was being a good mother for her baby;

*I tried to do my best. The staff at this shelter helps me a lot. They always encourage me to be a good mother. I am so grateful for what they do. We don’t know each other but they tried to help me and my baby. I have no money or gifts to reward them, so I tried to be a good mother as a reward to them.*

**Seeking Information and Supportive Resources**

In order to maintain a positive maternal role, participants tried to seek information and supportive resources to help them achieve a positive maternal role.
Nan shared her experiences that learning from other women and professionals help her develop and maintain good mothering:

*I learn everything from the staff and friends who were living here. This is my first baby and I don’t know how to take care of him. Some women help me and teach me to feed my baby. When I didn’t know why my son was crying, they were very helpful to calm him down.*

Gung further supported that learning from other women were good resources for her.

*I saw one of my friends take good care on her baby, so I just learned from her. I want my baby is healthy like her baby.*

Fahsai shared her experience that she tried to read books and discussed these with professionals. She felt that some other women’s experiences were not always helpful, but she would do these suggested activities if they were not harmful to her baby;

*I read a book and asked nurses on how to take care of my baby. Some women told me how to nurture my baby, but their words look weird to me. (Could you please explain this more?) For example, when I came back from the hospital, one of my friends told me that I should feed my baby with honey for 3 days because it will help the baby get rid of the dark greenish feces. I just accepted her honey and tossed it when she walked away. When my baby was crying, she said JaoTee (a spirit or God who protects a house) is teasing my son. She also told me to pray at the big tree in front of the building. I just followed her suggestion. Actually, I don’t believe it but I don’t want to be faced with any problems. If it isn’t harmful, I just do whatever they advise me.*
Rong indicated that the shelter’s staff provided helpful information for her and other women:

*We have nurses and nursing students come every week to teach us how to nurture our baby. There is the lawyer who comes every month to teach us to know our rights. I thought it is very good and I learn from them a lot.*

Pla described that her mother could not be her role model in order to take care of her baby but she could get useful information from professionals:

*If I were at home, I could ask my mom how to take care of my baby and my mom would help me to raise my baby. If I don’t know what happens to my baby during living here, I just asked the staff and nurses. They have many experiences and the knowledge to help me.*

Pim related that money was not important in order to gain knowledge. She could get information for free from the health care system;

*When my friends take their babies to the hospital, I asked them to pick up some booklets for me. I have no money to buy magazines about babies and mothers, so that is the easy way to get knowledge.*

**Providing Babies’ Basic Needs**

When asked, all of the women in the study, most of them stated they had a good understanding of the maternal role. When asked what it meant to be a good mother, many women suggested that providing basic needs to their babies is one of a mother’s most important jobs. Babies’ basic needs in their viewpoints are allocating food and clothes, promoting babies’ physical and emotional developments, and maintaining a state of well-being.
Toom was concerned about her baby’s health status. She stated that her baby might get sick because of the cold temperature;

*This shelter doesn’t have warm water. Some mornings I just use a towel to clean up my baby. It is too cold to take a bath.*

Fahsai described that there was no play time with her baby while she showered her baby. She said:

*I read the book it said bathing is a good time to play with my baby. Bathing my baby is a terrible time for me. No playing time! I have to rush because everybody must get ready before 7:30 a.m.*

Keaw, who did not have enough breast milk for her baby, expressed concern that:

*When you don’t have a job and money, the expenses for the baby is incredible. I want a good formula for my baby, but I have no money to buy it, so I just get whatever this shelter provided me.*

Rong, who accepted that she might not have the capability to keep her baby with her, explained that she still wanted her baby safe while she took care of him. She said:

*I don’t want some women to hold my baby. They don’t wash their hands before touching my baby and some of them got sick. I don’t want my baby to get sick. I used to tell a woman who wanted to hold and play with my baby. She was so angry and said when I gave my baby to the SahaThai foundation there will be many people coming to play or touch my baby. I should accept it and get used to it. I understand, but I want to give him the best care while I am living with him. I can’t control the future but I can control my present.*
Pla, who believed that formula was of higher quality than breast feeding and was concerned that her baby might get sick if she didn’t provide the baby with good formula, said that she tried of taking care of herself and protecting her baby from others:

* I have no money to buy her good formula. She might have low immunity because she doesn’t have a good quality of formula. (So, what do you do to help your baby?) I tried to take care of myself; exercise, eating good food, or take me baby away from sick children.*

Mook had the same idea as Pla, that providing the best formula is the part of a mother’s duties. She said that:

* I thought my breast milk is not enough for her. I wish I had a lot of money to buy the best formula. I am such a bad mother.*

Tangmo expressed her thoughts that the baby should live in her house with her family. She said that:

* Sometimes I felt I am a bad mother. My baby should live in my house or live with my family.*

**Concern for the Baby and Taking Action to Protect the Baby’s Health**

Another basic need for babies is taking care of the baby’s health. Most women were concerned that the shelter can be a place that could spread disease easily.

Namtan, one of mothers living in the shelter, shared her thoughts about baby’s heath status:

* It is the big problem in this shelter. One person gets sick and she spreads it to others. When she gets well, then somebody else gets it and she gets sick again.*
When I get sick, my baby gets sick too. It has been kind of hard to maintain our good health here.

Moreover, women also believed that babies need both physical and emotional health. In order to meet these basic needs, Tukta explained that following the nurse’s advice was the best way to accomplish these goals. She said:

The nurse told me that the baby needs to develop both physical and emotional health, so I just follow everything that she told me to do. I hold him warmly and talk to him softly every time. I hope my son will be a gentleman when he is grown up.

In addition, Ying showed her concerns that her baby might not have the basic needs because she had no money to provide good food. She said that:

I know that breastfeeding has of high benefit to my baby. If I breastfed, she will have a high level of immunity and it promotes a very special bond between my baby and me. In order to provide breastfeeding, I need to get enough protein in my diet. You know I have no choice to select good foods here. I have little money so I decided to buy eggs and eat one hard-boiled egg every day. That is the only protein source that I can afford and I hope that it might help my baby keep healthy too.

**Promoting the Mother and Infant Relationship.**

In this study, some women did not think that money was important to develop their maternal role. Being a mother in the shelters could not affect their relationships with their babies.
Toom indicated that raising a baby in a shelter was hard because of a lack of support and money, but it could not inhibit their love and relationship between her and her baby. She said that:

*Everything is harder for me because I don’t have any support, I have nothing. Then I got upset, I felt my life is blank.* When I saw my baby, I felt that I had energy and power. I truly love him. Living in a shelter could not affect the relationships between us.

The third phase was a period of making progress of being a mother. The participants intended to be a good mother by changing their daily’s lifestyles and rectifying their emotion. Some women described that seeking supportive resources was very crucial to develop their maternal role. Furthermore, some women narrated that mother must concentrate on nurturing babies. Providing babies’ basic needs and taking care babies’ health were the special job as a mother.

**The Forth Phase of the Process of Becoming a Mother: Being a Good Mother on Their Own Terms.**

The last major theme indicated that these women were achieving their maternal role and gaining confidence in being mothers. Most women believed that they might not be as good a mother as a “general mother”. The idealized role of Thai mothers is to focus on their babies and be the primary caregiver for their babies. Putting babies in foster care or up for adoption is unacceptable in Thai culture; however, they realized that babies might have a better opportunity instead of living with them. While they were residing in a shelter with babies, they tried to do the best as much as they could. In order to achieve the role of being a “good” mother, those women
explained that they needed to live independently, stand on their own feet and go back into the world.

**Standing on their own feet**

Many women wanted to get away from the shelters; however they still wanted some supports from the shelters. Gung shared her thoughts “I might give my baby to the Saha Thai foundation (an orphanage). (Do you mean you want somebody to adopt your baby?) No, I just want them to help me to take care of my baby. After I can get a job and a secure house, I will bring him to live with me.”

Fahsai said that “I plan to leave here as soon as possible. However, I need to keep my baby here. I have no potential to raise my baby outside this shelter. I want this shelter to help me to take care of her until I got a good job. I will bring her back when I have a safe place and enough money.”

Mai described that the following: “I will find a job and get money to raise my baby. I don’t know how I can get a job. I have little knowledge. It’s quite difficult to get a job during this recession. By the way, I need somebody to help me to take care of my baby. I might leave my baby here when I work.”

Nok was only one of a few mothers who had a job. She said that she felt that she was a good and successful mother. She stated that:

*I just got a job. It doesn’t make enough money to provide for a child care but I need to find a part time job. I still remember that feeling the day that I got my first month’s salary, I was so happy. I can survive by myself. I have money, a job, and my little baby. One day I might have my own house.*
Toom explained that she got some help from the staff to achieve what she believed was a positive maternal role and stand on her own feet. She hoped she would give back to them whenever she had a chance. She said that:

*I will be finished my college this semester and I hope I will get a job after my graduation.*

(Could you please tell me more how you can continue your study while you are living here?) When I came here I was a senior in a hospitality college. The supervisor of this shelter wants me to finish my study, so she asks for help from my college. Luckily, they gave me scholarship. When I go to school, all staff and women in this shelter help me to nurture my baby. I got salary 100 baths (3 dollars) per day because I help this shelter to prepare documents and booklets. I keep all money for my study. I talked to the supervisor of this shelter. She will allow me to live here for another three to six months after I got a job. When I go to work, I just pay for the child care. I know she tried to help me to stay on my own feet. I am definitely sure that I will pay them back when I have more money.

Manaw could find a job and her boss would provide food for her and her baby and also allow her baby to stay with her. She realized that she had more opportunity than other women in shelter. She explained her future plans:

*The sister will help me to find a job. She told me I can work as a housemaid. The house owner is so nice they allow me and my baby to live together and will provide food for us. They will pay me 4000 baths (130 U.S. dollars) per month. It is not a high salary, but I can live within my means.*
Love the baby, but let him or her go

Many women stated that they can survive by themselves. However, they had no resources by which they could raise their babies. Three women expressed the emotion that they really loved their babies, but the best choice for the baby was living with somebody who could provide a better future life.

Fah sai said that her baby was the most important person in her life and she preferred to give her baby away to provide her with a better life. She stated that:

*If I can’t take her back after six months, I will give her to the Saha Thai Foundation. I hope it will not happen to me. She is the most important in my life, but I have no choice. Giving her to rich people might be good for my baby.*

Saijai planned to give her baby to her sister’s boss because she hoped that her baby would have a better quality of life.

*I know if he lives with me, he might not get the good things. My sister’s boss will adopt him. I hope he will have a good quality of life. It hurts to give custody of your baby to someone else, but it is more hurt if you see your baby starving.*

Namtan was willing to judge from other people that she was a bad mother because she decided to put her baby in adoption care. She felt that being a good mother in the Thai culture meant to devote one’s life to taking care of their babies and families but she had no competency to care adequately for her baby and did not want her baby to live in bad situation. She stated that she might be the bad mother if she just accepted and allowed this bad situation keep going. She said that:
I let people condemn me as I am a bad mother, but I don’t want to let my baby to live in a bad situation like me. I don’t think I am a bad mother if I can find the best place for my baby. In contrast, I will be the bad mother if I do nothing and let the bad situation happen in our lives.

**Summary**

This chapter described the process of becoming a mother as related by a cohort of abused Thai women living in shelters. The findings of this research identified that such women experienced four temporal periods during the process of becoming a mother: preparing to be a mother, struggling to be a good mother, making progress, and being a good mother in their own terms. Each of these phases is depicted in Figure One, below.
Figure 1 The Process of becoming a Mother in Thai Abused Women Living in a Shelter.

**Preparing to be a Mother**
- Getting away from the abusive relationship
- Beginning to Adopt the Maternal Role by Empowering Themselves and Seeking Supports.

**Struggling to be a good mother**
- Personal problems
- Environmental problems
- Financial problems

**Coping strategies**
- Fostered their religious beliefs
- Asked for help from the staff or other women
- Sharing problems

**Making progress**
- Intention to Be a Good Mother by Adjusting Emotions and Changing Behaviors
- Seeking Information and Supportive Resources
- Providing Babies’ Basic Needs
- Concern for the Baby and Taking Action to Protect the Baby’s Health
- Promoting the Mother and Infant Relationship.

**Being a good mother on their own terms**
- Standing on their own feet
- Love the baby, but let him or her go
Chapter 5

Discussion, Conclusions, and Recommendations

The purpose of this final chapter is to summarize the findings of the study in relationship to prior research and theories concerning the process of becoming a mother. Additionally, conclusions are explained. Finally, recommendations for additional research are suggested.

Summary of Findings

This study proposed to answer the question: What is the process of becoming a mother among abused Thai women living in shelters? Sub questions consisted of the following:

1. How would you describe your feelings on becoming a mother?
2. What made you feel like a successful or unsuccessful mother?
3. What do you do in order to take care of your baby?
4. What experiences have either made it harder or easier to become a mother?

A qualitative approach was utilized to conduct this research. Specifically, the grounded theory design of Glaser and Strauss (1990) was used because it was suitable for clarifying the complex process of becoming a mother among abused Thai women living in shelters. Data were collected from participants by using open-ended questions (appendix B- Interview Guide). The interview guide questions were constructed based upon a review of relevant literature and input from advisors who are experts in this topic. Initial interviews focused on broadly descriptive questions that encouraged the participants to reveal the process of becoming a mother in a shelter. Questions became more focused and specific as categories arose. Interviews were taped recorded, transcribed verbatim, and translated from Thai to English. Memos were made to reflect
the researcher’s impressions and to articulate the themes that were derived throughout data collection.

The sample consisted of 21 abused Thai mothers. Participants’ ages ranged from 18-33 years. The range of time that they had lived in the shelter was from two to ten months. All of them were Thai. Most participants were Buddhist, unemployed, came from extended families, and were educated through high school. All of them experienced an unintended pregnancy. The majority of participants never considered having an abortion or giving the baby up for adoption before they were homeless. The majority of participants reported they did not receive financial assistance from their families and/or partners while they were living in the shelter.

During data analysis, a substantive theory was developed to describe the process of becoming a mother as reported by abused Thai mothers. As will be explained later, this research supported many previous research studies which described becoming a mother as a complex and ongoing process. Four major themes were identified: (a) Preparing to be a mother; (b) Struggling to be a good mother; (c) Making progress; and (d) Being a good mother in their own terms. In the next part of this chapter, each theme will be presented.

**Preparing to Be a Mother**

Most of the abused Thai women who were interviewed in this study reported that the maternal role begins during pregnancy. In order to prepare to be a good mother, these women needed to perform two tasks: getting away from the abusive situation and beginning to adopt the mothering role by empowering themselves and seeking support.
Beginning to Adopt the Maternal Role by Empowering Themselves and Seeking Supports.

Beginning to adopt the maternal role by empowering themselves was another subtheme under the category of “preparing to be a mother.” Based on the responses of these abused women, the main reason that they wanted to terminate their relationships was for the safety or security of their babies. Seeking help from friends, family members, or health care professionals was another step in the maternal role that they took in order to ensure their baby’s safety. The women’s responses showed that they sought help or information on how to get out of their abusive situation and raise their child in a safe environment. The women sought safe places to hide from their abusers and a women’s shelter seemed like an ideal place to get away and stay safe.

Likewise, most women stated that they needed social support. A women’s shelter cannot only provide women with security but some of the shelters also assisted with job training and help such in terms of finding a job and even future housing. Several participants also stated that they received a great deal of emotional and social support from other women in the shelter and from the staff. They further clarified that shelter staff can be a crucial support by providing greater access to many resources such as employment, continuous education, temporary housing, transportation, or counseling. Of note, participants shared their concerns that their abusive partners might be able to discover their babies and them no matter where they lived. The shelter staff needed to educate them about where they could access more help, for example: polices, emergency phone services, health care system, low-income agency staff, lawyers, counselors, and psychologists.
Getting Away from the Abusive Relationship

The participants in this study related that the process of becoming a mother started when they became pregnant. The first task as a mother was finding a safe place and escaping from violent situations. There were many reasons why these women lived with an abusive partner. For example, some women had no income, so they needed to depend on their husband’s or partner’s finances. It was difficult for them to live by themselves. Moreover, when the participants were interviewed as to why they remained in situations where there were threats or if they were in a violent relationship, they reported that they became terrified that the abuser might kill them, their infant, or other family members. The women felt they had to endure these abusive relationships. Additionally, some women reported that they deeply loved their partner and believed that the partner would change his abusive behaviors. The women in this research stated that the main reason that they decided to end their relationship was their baby. They did not want their baby to grow up under an abusive relationship and absorb aggressive behaviors. During pregnancy, they had become concerned that their abusive relationship might be getting dangerous. Their mothering concerns regarding these circumstances become stronger. In this context, it is clear that these mothers were primarily motivated to leave the relationship out of a willingness to protect their baby from violent situations and from their abusive partners. This intention empowered them to end the relationship. Their babies inspired them to leave and provided a source of empowerment.

Struggling to Be a Good Mother

Being a mother residing in a shelter under the Thai family perspective contrasts with being a mother in a western family, since most Thai families were extended families and Thai
postpartum mothers depend on their family’s support. The participants stated problems of becoming a mother in this order: personal problems, environmental problems, and financial problems.

**Personal Problems**

In contemporary Thailand, single mothers are faced with adversity, and it is very difficult for them to nurture their babies alone in shelters without family support. In this research, most women participating in this study defined their status as an obstacle that affected their ability to nurture their babies.

In terms of abuse situations, women are expected to end their relationships in order to protect their babies from violent situations. Mothers who fail to leave their partners are sometimes viewed as being a failure or a bad mother (Johnson, and Sullivan, 2008; Lapierre, 2010). Being a good mother is still described as a person who is focused directly on the baby’s needs and provides for the infant’s physical and emotional needs, guidance, and supervision, even though the abuse situation makes mothering more complicated (Lapierre, 2010). Most mothers participating in this research viewed themselves negatively, feeling they were not providing good mothering. The present study participants further expressed that experiences of being a homeless mother are associated with stress, depression, or anxiety that prohibit them from being good mothers while in a shelter.

Although many women in this study realized that they were to become mothers and they could not postpone or reject their maternal responsibilities, they still reported that they needed more time to prepare themselves in order to attain the maternal role. They stated that they were aware that stress and anxiety have an influence on becoming a good mother and felt this hindered their maternal role attainment. For example, they related that they found it difficult to nurture
their baby in a shelter without family support and noted they were often exhausted and tired. They also stated that they had to live with fear and anger. Many women were scared that the abuser would try to discover them, so they were afraid of going out of the shelter. This finding is consistent with one conducted by Lapierre (2010) wherein participants explained that leaving relationships could not ensure their security. Most women in Lapierre’s research reported the same feelings as the participants in the present, specifically that they were living with fear and needed to develop strategies to protect them and their babies and prevent abusers from taking them back into the previous abusive living arrangement.

**Environmental Problems**

The next subtheme of “struggling with becoming a mother” concerned environmental problems. When examining women’s experiences with abused women’s shelters, most abused mothers answered that they had no choice. Living in a shelter was better than staying on the street. The majority of the abused women specified that they were satisfied with most services offered by the shelters. There were only a few reported needs that staff could not provide, and participants felt they could not ask for any more help. They related that they were very grateful for everything that they had received from the shelter.

In order to obtain more in-depth information, the researcher asked participants whether they might suffer negative consequences from the shelter. It was emphasized that their answers would help to improve the shelter’s services and might better address the needs of abused mothers such as themselves. Some women explained that there are some environmental problems that had influenced their maternal role. For example, they reported negative attitudes by other abused mothers, the shelter’s rules, or people from outside the shelter, such as their friends, their relatives, or people who lived outside the shelters and knew that they lived in the
shelters. Many mothers accepted that living in a shelter was stigmatizing. They were concerned how people from outside the shelter thought about their maternal role. They felt they were judged by the community that they were bad mothers. Those negative feelings lowered their dignity and they reported that they lost the ability of control their lives. Some women further explained that they did not want any sympathy from outside people because it made them depressed and they reported low self-esteem.

Moreover, many women said that being a mother in a shelter had some benefits. They found many good friends and never felt alone in an abused women’s shelter. They also suggested that the shelters need to promote more help with housing, legal assistance, and employment.

**Financial Problem**

In regard to financial problems, most of women in this study had no job and lacked the funds to support their daily lives or provide basic needs to their babies. The participants indicated that the major barrier affecting their parenting was a lack of financial resources. Financial problems also made the problems associated with being a homeless mother worse. This finding is related to the research of Cook-Craig, & Koehly (2011) who studied the impact of social support in 28 homeless mothers residing in a shelter. One variable that related to this study concerned financial well-being. The homeless mothers in Cook-Craig and colleagues research similarly reported that they had financial problems. Indeed, the types of support in their study were significant to stability and included both emotional and personal support. Their results were related to this study in that most women received emotional and personal support from the staff and other women but not financial support.
Making Progress

The third theme that was identified was management of the maternal role. Most women in this study were concerned about their homeless situation and their new lives. Raising a baby in a shelter was viewed as a crisis and not a good choice. They wanted to stand on their own feet and get out of being homeless. In this study, the participants’ babies were an important inspiration to overcome the difficulties associated with mothering. The subthemes described by abused Thai mothers living in a shelter included:

(a) The intention to be a good mother by adjusting emotions and changing behaviors;
(b) Seeking information and supportive resources;
(c) Providing for their baby’s basic needs;
(d) Concern with and taking action to protect the baby’s health;
(e) Promoting the mother and infant relationship.

Intention to Be a Good Mother by Adjusting Emotions and Changing Behaviors

The abused Thai women needed to prepare themselves to be a good mother and to prepare themselves to leave the shelter. However, most women had the same opinion that they were extremely grateful to the community and the shelter that gave them a place to reside and a way to change their lives. In order to be a good mother, they reported that they had to change their lifestyles and adjust their emotions to many kinds of stress. They intended to be a good mother by focusing on their baby and devote time to care for their baby. In this study, stress was described as patterns of personal, environmental, and financial problems while raising the baby in a shelter. Most women realized that nurturing their baby and being homeless mothers were double catastrophes but they could not deny their responsibilities. Some women reported that they had strong religious beliefs and explained that these abusive situations happened because of
Karma, so they just accepted them and tried to develop and maintain their maternal role as much as they could. They changed their life styles by engaging in healthier lifestyle behaviors, such as eating healthy foods, waking up early in the morning to prepare babies’ feedings and belongings, exercising, learning to nurture their babies, or controlling negative emotions.

**Seeking Information and Supportive Resources**

Another subtheme arose with respect to management of the maternal role. Most of the homeless abused women who participated in the study focused on the need to obtain help with securing a good job and a safe place that they could call home. More specifically, they needed longer term residential housing in a location that they could perceive as being safe. Many women explained that they felt safe while they were living in the shelter but they were insecure when they had to go outside the shelter. They further described that their lives at the shelter might not be convenient but the shelter offered a child rearing environment that they felt was secure.

Moreover, this study also revealed that most homeless mothers did not want anybody to know that they were taking their baby into a shelter, and they did not want any sympathy from people outside the shelter because sympathy made them feel distressed and lose their pride.

**Providing Babies’ Basic Needs**

In this study, most mothers were concerned that they could not provide for the baby’s basic needs because of lack of facilities, money, or social supports. Most of women stated that they needed experienced and knowledgeable staff in order to validate their infant care capabilities. Even though participants noted that caring for a baby in a shelter was very stressful, most of these homeless mothers had a clear picture about their primary maternal role and they were focused on taking care of their babies. Nurturing their baby was a first priority for these homeless mothers. They were also concerned about the baby’s environment. The shelter might
be unsafe for them, the staff might not be trusted, or they might be unable to provide for their baby’s basic needs. However, most women tried to stick to their maternal role as much as they could. These findings were consistent with those of a study conducted by Mercer (1990) that determined that maternal tasks during the postpartum period included developing caretaking skills and redefining a woman’s maternal role. The competency of mothering and a mother’s self-confidence were associated with competence in feeding and was achieved when the mothers felt a sense of harmony in their role. Most abused women in the present study defined themselves as a successful mother when they could provide for their baby’s basic needs. However, but some women reported they felt conflicted as to whether they were a good mother because they did not have the financial resources to provide their baby with infant formula rather than breast milk.

Moreover, Mercer’s research described factors that impacted on the degree of role conflict and role strain that new mother’s experience. Such factors as poor maternal or infant health, lack of family support, or dissatisfaction with child care were associated with high levels of role strain and role conflict. The women participating in the present research study reported that the primary factors they found produced high levels of stress and role conflict included having to reside in a shelter, prior experience with domestic abuse, lack of family supports, and concerns regarding the safety of themself and their infant.

**Concern for the Baby and Taking Action to Protect the Baby’s Health**

In terms of the babies’ physical and emotional health, most women were concerned that living in a shelter might affect their babies’ health, for example, getting contagious diseases, not getting enough sleep, or not getting high quality infant formula. Some women were satisfied that they could provide the three basic needs (food, clothing and shelter) to ensure their babies
remained in good health. Other women were also concerned that they could not take good care of their babies because they were unable to meet what they perceived as high quality of care. Additionally, financial problems were an important barrier to access the health care system and to afford baby supplies, such as infant formula, or diapers.

Another concern of these homeless mothers was fear that their baby might become sick. Childbearing in a shelter was viewed as increasing the possibility of negative health outcomes not only for these mothers but also their babies. These concerns voiced by the participants, may be valid, since contemporary research has found that living in unstable or dangerous situations, lack of support, inability to meet basic needs, and difficulty in accessing the health care system have all been associated with negative infant outcomes (Dworsky & Moehan, 2012; Dail, 1990; Hatton, Kleffel, Bennett, & Gaffrey, 2001).

**Promoting the Mother and Infant Relationship.**

In this study, some women did not think that money was important to develop their maternal role. Many women explained that their financial problems could not prevent them from being a good mother; however, they agreed that the shortage of money was the most important source of stress and could affect their relationships with their babies.

Furthermore, all the participants in this research also gave some suggestions to deal with problems they experienced while residing in a shelter. For example, they used meditation, reading books, going outside for a short period, learning from others, exercise, and discussing stressors with friends who had the same situation as strategies to deal with their problems.
Being a Good Mother on Their Own Terms

The last theme that was identified was being a good mother in their own way. Most women in this study indicated that their baby was one of the most important factors in their lives. They described their process of becoming a mother as specific and complicated using the following subthemes: standing on their own feet, loving the baby, but letting him or her go to either foster placement or adoption.

Standing on Their Own Feet

Becoming a mother, included behaviors that indicated they were caring for and loving the baby, and encouraging their sense of responsibility that they had an influence over their baby’s life. Some women described the experience of becoming a mother in a shelter as a huge changing in their own lives. Even though the participants reported they might not have an opportunity to control their own destiny, living in a shelter helped them to adjust to their new life. They are grateful the new lives that the shelters, staff, and society gave them, so they need to pay back by being a good mother and standing on their own feet. In order to stand on their own feet, most women needed supports about preparing a safe house, settling down, and getting a job.

Love the Baby, but Let Him or Her Go

One subtheme that was noted has received little attention in the literature. This was planning for their baby’s life by giving up the baby to foster care or for adoption. Even though these women had faced negative circumstances and critical decisions, they attempted to use every strategy to better their children’s chances for a positive future, including a reluctant willingness to place their baby into foster care or adoption.

Many women stated that although they wanted to place their baby in foster care or adoption care they hoped they could bring their baby back at some later point in time. They
reaffirmed that they truly loved their baby, but they were aware of the negative effects of domestic violence and homelessness.

The themes identified in this research of becoming a mother among abused Thai women were in some respects similar to previous research. However, some major categories in this research were different. The following discussion will compare and contrast the results of the present study to those previous studies.

**Relationship of Research Findings to Prior Research**

**Research on Becoming a Mother**

Many research studies on becoming a mother have described a number of tasks associated with achieving the maternal role, especially, in the particular context of abused mothers living in a shelter. As mirrored in past research, the participants in this study noted that before they became pregnant, they were still living with their abusive partners with hopes that this abuse might lessen or cease. When these abused women participating in the present study became pregnant, they expressed that the baby was the main reason that they decided to end their violent relationship. They noted that their principal maternal responsibility was to protect their babies from any type of harm. This finding is consistent with a related study conducted by Boonzaier (2008), who interviewed fifteen heterosexual couples by using a narrative methodology. Boonzaier examined how women and men characterized the meaning of violence against women. Many women defined themselves as helpless and under the control of an abusive partner; however upon becoming pregnant they developed strategies to end the violent relationship. Their babies became a catalyst for these women to change their lives. Additionally, a longitudinal qualitative study conducted by Ruttan, Laboucane-Benson, and Munro (2012)
investigated the lived experiences of 18 homeless young women. Study findings indicated that the primary motivation for transitioning out of homelessness was pregnancy and the participant’s babies.

Furthermore, several studies have explored the importance of culture and women’s attitudes that keep women in violent relationships. In the Thai society, Thai women are expected to do house chores, including cooking, cleaning house and looking after the children. They are also expected to tolerate any kind of family problems and are not supposed to leave their homes (Chatsuman, 2010; Jirawatkul, 2010). If a woman decides to leave her family, she will be blamed for being irresponsible and will be considered a substandard mother (Baly 2010; Boonzaier, 2008; Chatsuman, 2005; Jirawatkul, 2010). In the present research, most participants reported that they decided to leave their abusive relationship before the birth of the baby. These women reported they felt they were blamed by those in the Thai society as being a bad mother and wife instead of letting their babies stay in the violent situation.

Many studies have reported that women, in general start to adopt their maternal identity before the baby is born (Fouquier, 2011; Levendosky et al., 2011). Specifically, Levendosky et al. (2011) conducted a longitudinal case study to examine the influence of domestic abuse on the attachment between mother and child. The investigators determined that women who experienced domestic violence had difficulty coping but they still adopted their maternal identity during pregnancy. David, Gelberg, and Suchman (2012) also reviewed a preliminary study on the process of parenting young children among homeless women and found that being a parent involved behaviors and feelings toward the baby that began before the baby was born.

The findings of the present research are consistent with those of a study conducted by Baly (2010), who interviewed six women in Paris who were abused by their partners and decided
to leave their abusive relationship. The discourse analysis approach was performed in order to explore how participants constructed strategies to deal with the abusive situation. Baly’s study participants described the great strength that is required for women to come to terms with an abusive situation and then utilize external social supports and their own resources to leave such abuse.

In conjunction their maternal role, participants in the present study sought help and safe places to hide themselves and their babies from their abuser, and a shelter for abused women seemed to be an ultimate place to stay safe. A study of by Aureala (2001) paralleled these participant’s reports. Aureala studied the perceptions of 38 women living in two battered women’s shelters for at least seven days. Participants noted that safety was their most important need. Furthermore, as previously noted Baly (2010) interviewed six women in Paris, who were 18-25 years of age, and of White British/European, Black African, and Black Caribbean ethnic backgrounds, who had left violent relationships. These researchers found that participants’ decisions were influenced by their children. Those women explained that they needed to protect their babies from violent relationships and being a good mother encouraged them to leave an abusive situation.

In the case of inspiration to leave abused circumstances, study participants stated that the well-being of their babies empowered them to move forward. This report supports the assumption of Kelly (2009) who explored the influence of mothering on the decision-making processes of abused immigrant Latino women by using interpretive description. Seventeen mothers who were living in the U.S with their children and had left their abusers at least three months prior to the study were interviewed. This research indicated that abused mothers were confronted with many serious decisions to maintain or leave their abusive relationships and their
mothering was the most important role in their lives. They defined themselves as responsive persons who needed to provide safety for their children. Their children’s security was the main reason that they decided to leave the abuser. The researchers concluded that the decision to leave an abusive situation is associated with women’s thoughts that it is their maternal responsibility to keep their baby away from violent situations.

**Research of Barriers Affecting on the Process of Becoming a Mother**

In this research, most women defined some barriers that affected their ability to nurture their babies such as their maternal competency, financial status, lack of social support, or stress. This outcome is related to the study of Park, Fertig, and Metraux (2011). They examined the influence of being homeless in 2,631 families in terms of maternal health and behavior. The study reported that these women had less supports from their families. It was difficult for them to ask for a loan from other family members. This study further found that experiences of being homeless are associated with stress, depression, and anxiety. Additionally, a study of Finfgeld-Connett (2010) investigated the experiences of 1184 homeless women. Study findings indicated that most women live with the limitation of necessities such as food, shelter, or health care. They struggle with physical and mental health problems including anxiety, low self-esteem, and mood disorders. All of these problems have influences on motherhood and support Mercer’s (1990) research that suggests that most mothers generally move into maternal roles with good intentions but there are some situations that inhibit their achievement of the tasks of motherhood or their willingness to become a good mother.

Another barrier that seemed to be a big concern for this group was living with fear and anger. Aureala (2001) studied the perceptions of 38 women living in two abused shelters. She focused on abused women’s thoughts about living in a shelter. Many women reported that they
were scared that the abuser would try to discover them, so they were afraid of going out of the shelter.

Additionally, the participants spoke of the attitudes of people from outside the shelter as affecting their maternal role. Most women stated they did not want any sympathy from outside people because decreased their self-esteem. A review of the literature was rather scant in the area of the relationship between being a mother in a shelter and lower self-esteem. Most studies explained that daily life stressors and the external environment reportedly had negative effects on the maternal role. Mothering under negative life situations caused more depression and lower self-esteem (Meadows-Oliver, M., et al. 2007; Rich, 1990)

Participants’ reports of financial problems parallel those of a study by Swick and Williams (2010) who studied the voices of four single parent mothers who were homeless. Research findings indicated that the major barrier affecting parenting were a lack of financial resources. Financial problems also made the problems associated with being homeless worse. Moreover, the study of National Center on Family Homelessness (2007) supports the finding that single mothers are often not able to provide their babies’ basic needs without sufficient financial resources.

Another finding in this research was that most homeless mothers wanted to keep their homeless lives secret and they felt that living in a shelter was a stigma. Congruent with these findings, researched by Finfgeld-Connett (2010) investigated the experiences of 1,184 young homeless mothers via a qualitative meta-synthesis methodology. This meta-synthesis found that homeless women needed to move from stressful situations to stable houses. In order to move from a stressful situation, these women needed to take action from being passive to actively seeking assistance. Additional research indicated that most participants visualized themselves as
aberrant and they experienced discrimination and stigmatization while they nurtured their baby in a shelter. The study of Finfgeld-Connett supports the present study that determined that most homeless mothers did not want anybody to know that they were taking care of their baby in a shelter and they did not want any sympathy from people outside the shelter.

**Research on a Good Maternal Being**

Dworsky & Meehan (2012) studied the life experiences of 27 adolescent residents in a short-term shelter in Lakeview, Chicago. Participants identified two responsibilities of a mother, which included providing for their baby’s basic needs and managing their baby’s behaviors. They described a “good” maternal role while they are living in a shelter as follows:

1) Promoting their babies’ physical and emotion health by feeding high quality milk, diapering, thorough sanitation, and obtaining a safe sleeping environment. Some women were satisfied that they could provide these three basic needs for their babies. Other women were also concerned that they could not take good care of their babies because they were unable to meet what they perceived as high quality of care. Additionally, financial problems were an important barrier to access the health care system and to afford babies’ supplies, such as infant formula, diaper, or clothes.

2) The second responsibility as a mother was that mothers should discipline their children to learn the difference between acceptable and unacceptable behavior. This finding of Dworsky & Meehan (2012) supported the present study that adolescent mothers participating in this study understood that their babies were too young to understand appropriate manners but they expected their children to learn and follow rules.

Another concern of these homeless mothers in my study was fear that their babies might become sick. Childbearing in a shelter was viewed as increasing the possibility of negative
health outcomes not only for these mothers but also their babies. Participants reported concerns about living in an unstable or dangerous situation, lacking support and basic needs, and difficulty accessing the health care system. Only a few studies focused on homeless infant's health. Further, Hatton, Kleffel, Bennett, & Gaffrey (2001) reported that homeless children who living in a shelter experienced higher rates of negative health outcomes such as ear infections, respiratory tract infections, and behavior disorders.

In this study, most women, but not all, were concerned about their babies’ nutrition. They could not provide their infants with high quality milk, so they were concerned that their babies might be getting sick. Their concerns are related to the review of David, Gelberg, & Suchman, (2012), reviewed about families under the circumstances of homelessness. The review accounted that homeless infants are at risk for various problems, such as hunger, asthma, ear infections, stomach problems, and speech problems.

Moreover, Marelic Jonas, Elza (2009) explored fifteen homeless African-American mothers and their children’s health status and health management. The findings indicated that most participants experienced coughing, sneezing, wheezing, and vomiting while they were living in a shelter. For them, repeated exposure to infectious diseases became a regular way of life. They were anxious that sick children had to engage in activities together with well children. This situation made them feel helpless and powerless.

In terms of promoting the mother-infant relationship, Williams (2008) described four single mothers’ perceptions of mothering while they were residing in a shelter. They found that the mothers agreed that lack of financial resources and self-control are vital barriers impacting on the development of good relationships between mothers and children. This finding related to the
present study that some women agreed that the shortage of money was the most important stress and can affect the relationships between mothers and infants.

**Research on the Adoption Idea**

The one subtheme was planning for their babies’ lives by giving up the baby to foster care or for adoption. These women had faced negative circumstances and critical decisions that they attempted to use to better their child’s chances for a positive future, including a reluctant willingness to place their babies up for foster care or for adoption. Some women described that giving up their babies means a new future for their babies. They restated that they truly loved their babies, but they were aware of the negative effects of domestic violence, poverty, and homelessness. Schen (2005) studied the effect of separation between mothers and their children by examining previous literature in this regard. It was found that homeless mothers reported that they had to separate from their children to ensure that their children would obtain security and education.

Kallen, Griffore, Popovich, and Powell (1990) compared a group of 105 adolescent mothers who chose to bear their babies and 17 young mothers who decided to release their babies for adoption. The reasons that these women decided to keep or release the babies might be influenced by their own decisions or their mother’s attitudes. Adolescent mothers who put their babies up for adoption were more positive on the idea of adoption than adolescent mothers who kept their babies.

The women participating in this research described their adoption plan positively. They hoped their babies would benefit from adoption. This result was related to the study of Christine & Christine (2000), who recruited eleven pregnant women who were moving into a maternity home in Texas. The sample in this study include six women who were white, three who were
Hispanic, one African-American, and one multiracial woman. All planned to release their babies for adoption. The reasons that they planned for adoption were hoping that the baby would have a better home, hoping that the baby would have better parents, and having no choice.

**Empowerment Theory**

In this present study, most women described the need to empower themselves in order to get started being a mother. The concept of empowerment has been studied widely in disciplines, including nursing. Even though the concept of empowerment was known and broadly used, empowerment conceptualizations are still not clear (Cattaneo & Chapman, 2010; Rappaport, 1987). Empowerment gained prominence in the 1980s. At that time, community psychology introduced empowerment as a multidimensional process to strengthen personal and community ability (Jacobs, 2010; Rappaport, 1987). Empowerment is defined as an individual’s, organizations’, and community’s capacity to control their affairs (Jacobs, 2010; Rappaport, 1987). Additionally, feminists have pointed out that empowerment is the central concept to understanding inequities and improve the well-being of human lives (Cattaneo & Chapman, 2010).

In the case of abused Thai mothers living in a shelter, empowerment is particularly relevant, since these women have to live with the limitations of resources and power. Such situations can cause them to lose control over their lives. Additionally, the stigmatization of being a mother in a shelter may result in feelings of defeat of personal and social authority. In a study by Cosgrove & Flynn conducted in 2005, the researchers described these homeless women often feel criticized, discriminated against, and abandoned. Empowerment theory may be one avenue where these women can increase their personal power and promote their maternal competency.
Implications for Policy Makers, Nursing Practice, Education, and Research.

Implications for Policy Makers

Policy makers have a most important role in terms of the problem of domestic violence. As indicated in this study as well as in a review of the literature, it is clear that the current system in Thailand supports abused women and children who remain quite powerless and it appears that the current system is too lenient toward men. There are only a few public shelters for abused women that are run by the government. Most of the participants in the study had never heard about these types of shelter services before they were abused. Policy makers need to expand shelter opportunities for abused women and provide sufficient funding to such support shelters. They should advocate throughout Thailand for these types of services so that abused women will have more choices to leave or take legal action with their abusive partners. Furthermore, in Thai society there is an incomplete understanding and awareness about the area of domestic violence. Domestic violence is not only a family problem, but also it is a crime that should not be ignored. Policy makers should promote effective and continuous campaigns to support abused mothers and their babies. Such measures may include: (1) enacting laws which hold fathers at least partially responsible for child support; (2) encouraging services that minimize the stigma such women report; (3) offering more flexibility in terms of when women must participate in shelter activities. (4) segregating sick infants or mothers from the general population to decrease the risk of disease transmission; (5) ensuring adequate educational or job training programs for women who experience DV, and (6) establishing systems where mothers who place their child up for adoption or foster care are able to maintain a relationship with their infant.
Implications for Nursing Practice

This study provides ideas for nurses who are working with mothers and babies in shelters, home health care, or hospitals. Working with this vulnerable group is challenging for nurses, and nurses need strategies to screen, assist, treat, and evaluate abused women. There is a big gap between this vulnerable group and other mothers, so nurses need to take a significant role as healthcare professionals. Currently, health care systems and nurses in Thailand only focus on mothering and diseases. There are only a few Thai health care systems that have a clear picture of domestic abuse care for abused women. As we know, domestic violence has a highly negative impact on mothering and mother-child relationships. Consequently it is imperative that nurses develop nursing care to support these women and help them improve their lives. The present research reveals that abused mothers who are residing in a shelter are single, poor, and lack social supports. Nursing care systems in Thailand need to develop programs that help to empower and support these women. Nurses who are working with abused mothers should screen women to identify those who are experiencing abuse. Further, offering supports and treatment options for such women is needed. Providing nursing care for such women should address the needs of abused mothers and babies rather than focusing on a deficit-oriented model (Marelic Jonas, 2009).

Implications for Nursing Education

Domestic violence occurs in all populations and age groups, from babies to the elderly, from rich to poor people. In order to provide positive interventions to abused women and babies, nurses do not require any advanced technologies, but personal experience to routinely screen or identify the signs of the domestic violence. Moreover, attitudes toward domestic violence need to change. Most Thai people, including many health care providers, still think that domestic
violence is a family problem and that family members should keep this problem in their family. Nursing students, as future nursing health care providers, should be educated that domestic violence is a social problem. We need to bring this dilemma to the forefront. Every nursing student and nurse regardless of their area of specialization should be informed in this regard and should practice how to assess, counsel, and refer those who are at risk. Knowledge of counseling, nursing care for physical and emotional health, strategies for coping with stress, and the importance of relationships between mothers and children are crucial curricula in every nursing school.

**Implications for Nursing Research**

Future research is warranted on the study of abused mothers in shelters who have defined themselves as successful mothers to help us understand factors that can assist abused women in moving past the difficult time in a shelter. Additionally, comparing the mothering of abused women in a shelter and versus those women who remain in their own houses would help nurses understand mothering in different social contexts.

Most research on abused mothers has been investigated by using qualitative methodologies. Future research should examine how abused mothers develop their maternal roles by using other research methodologies, such as quantitative research that has enough amount of sample because the small sample size might view as limiting any type of generalizability.

This research only focuses on abused women and their maternal role while they are living in a shelter. It would be useful to expand this study to their extended roles when they left the shelter. This research might help providers comprehend how the experience of being homeless influences the maternal role.
Unfortunately, in the current Thai health care system, providers rarely screen for DV in women seeking health care, with providers frequently attributing this lapse to job overload. Consequently, it is suggested that nurses and others in the health care system consider utilization of the Abuse Assessment Screen (AAS) developed by Macfarlane, Parker, Soeken, & Bullock (1992) to determine whether utilization of the instrument is appropriate to Thai population. This tool holds particular promise because it takes only few minutes to administer and can be used to assess abuse in women and children.

**Recommendations for Future Research**

During the interviewing process, it was difficult for abused Thai women to tell their stories, especially women who gave up their babies. Throughout the interview, they stated that it was quite difficult to tell someone that they wanted to put their babies on an adoption path. However, some mothers admitted that they felt relieved about telling their stories and excited to know that their stories might be valuable to other abused mothers. It might be useful to conduct a longitudinal study on mothers who decided to give up their babies. The longitudinal research could follow these mothers in order to investigate whether releasing the baby for adoption resulted in positive outcomes for these women and for their children.

The second recommendation for future study would be to conduct a mixed methods longitudinal study on the impact of becoming a mother in homeless Thai mothers, because being a mother in shelter could have long term effects on both mother and their babies. Examination the condition of homeless and coping strategies could be help to better support these abused women.
Additionally, the findings of this research indicated that poverty is the big problem for these abused mothers. It appears that adult education and job training might be helpful to these women to get them away from the streets or homelessness. Future research could be conducted regarding the feasibility and benefits of job training or adult education, since such measures could reduce the incidence of homeless mothers and families and provide them with a better life.

**Conclusion**

Based on the theory of Glaser and Strauss, this study utilized theoretical issues regarding the process of becoming mother in abused Thai mothers residing in a shelter. The researcher determined that many abused Thai mothers have conflicts that resolve around being a mother in a shelter. It seems imperative that as a profession nurses should encourage these women to develop strategies to assist them with coping and developing empowerment. This final chapter described a summary of the research results and compared the results to the previous research on becoming a mother in abused Thai mothers residing in a shelter. Moreover, this chapter provided a discussion of implications for nursing education, nursing practice, and policy. At the end, conclusions and recommendations for future research were presented.
Appendix A

INFORMED CONSENT
INFORMED CONSENT FORM

Name of study: Abused Thai Women Living in a Shelter: The Process of Becoming a Mother

Investigator: Natthapat Buaboon, MNS, RN

Supervisor: Dr. Patricia C. McMullen, PhD, JD, CRNP, Associate Professor and Dean.

Contact Information if Questions Arise: If you have questions about this study, you should call or email the investigator, Natthapat Buaboon, R.N. at (081) 684-6208. Her email is dbuaboon@hotmail.com. You may also contact her supervisor, Dr. Patricia C. McMullen at (202) 319-5252.

Description and purpose of the study:
I understand that I am being asked to participate in this research study, which is designed to describe the experience of becoming a mother in Thai women who have been in an abusive relationship, are now living in a shelter, and who have had a baby. Prior studies conducted in the United States and other countries have shown the process of becoming a mother may be different in women from different countries and cultures. There is very little, if any, research that describes the process of becoming a mother in Thai women living in a shelter. I understand that this study is being carried out to fulfill partial requirements for a doctoral dissertation in nursing (PhD) at The Catholic University of America.

Detail description of the procedures to be followed:
If I agree to participate in this study, I will be interviewed about my experiences as a woman who has been in an abusive relationship, has recently had a baby and is now living in a shelter. One interview, approximately 60-90 minutes in length, will be required and will be scheduled three to six months after I have given birth. During this interview, I will be asked about my level of education, my religion, and my experiences as a woman who has been in an abusive relationship, has recently had a baby and is now living in a shelter. I may be asked to answer questions about before, during and after I came to the shelter. A series of open-ended questions will be asked to allow me to explain in greater detail my experiences. With my permission, the interview will be audio-taped. I understand that after approximately five years, and the findings have been reported, the audio-tape will be destroyed by the investigator, who will cut the tape into 6 inch strips and then shred the tape.

Risks, inconveniences, and/or discomfort that may arise:
No medical risks are expected for persons who agree to participate in this study. I may choose not to answer any of the study questions. Also, if the questions make me uncomfortable, I can
stop the study at any time, and/or request that the audio tape recorder be turned off at any time. If I should become upset during the interview, the investigator, who has a master’s degree in nursing and more than 10 years experience caring for patients and their family members, will offer nursing support. If I should remain distressed, the interview will be halted and I will be referred to the charge nurse in the shelter, who will make an appointment for me to be seen by the psychologist who works in the shelter.

Benefits that may occur:
There are no direct benefits to me by joining this study but it may help others who find themselves in my circumstances. While the questions that are asked may sometimes be unpleasant or painful, it may also help bring up questions that can help me understand what is happening to me and how I can work through becoming a mother. This study will assist in the exploration of becoming a mother process in Thai women living in a shelter and may improve the quality of care offered to abused mothers like myself. I understand there is no monetary compensation for my participation; however, I will receive a t-shirt as a token of appreciation with no cost.

Confidentiality of research records:
I understand that a study code number will be assigned to my responses so that my name will not appear on any of the study tools. The audiotapes and written notes will be secured in a locked file cabinet in the office of the investigator. The tape recording will be erased when investigator reviews the audiotape and it has been transcribed onto paper and analyzed; no identifying information will be included on transcriptions except a code number. Audiotapes will be destroyed after analysis and reports of findings are completed. Written transcripts, flyers and other written materials will be kept for five years and then destroyed by the investigator. In order to protect my confidentiality, anything I report will not mention my name.

Assurances:
I understand that my participation in this study is entirely voluntary. I understand that I may refuse to participate or discontinue my participation at any time during the study without penalty or loss of benefits to which I am entitled.

I understand that any information about me obtained as a result of my participation in this research will be kept as confidential as legally possible.

I understand that my research records just like hospital records may be subpoenaed by court order or may be inspected by federal regulatory authorities.

I have had an opportunity to ask any questions about the research and/or my participation in the research, and these have been answered to my satisfaction.

I understand that I will receive a signed copy of this consent form.
I volunteer to participate in this study.

------------------------------------------  ------------------------------------------
Subject’s signature                       Investigator’s signature

------------------------------------------  ------------------------------------------
Date                                       Date

Any complaints or comments about your participation in this research project should be directed to Secretary, Committee for the protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, DC. 20064; Telephone (202) 3195281, or to Dr. Siriporn Kampalikit, Dean of Faculty of Nursing, Thammasat University at (02) 9869213 ext 7314 in Bangkok, Thailand if you have complaints or comments.
แบบฟอร์มยินยอมเข้าร่วมการวิจัย

ชื่องานวิจัย: ขบวนการเข้าสู่การเป็นมารดา: ศึกษาในหญิงไทยที่ถูกทารุณกรรมที่พักอาศัยในบ้านพักชั่วคราว

ผู้วิจัย: ณัฐพัชร์ บัวบุญ, MNS, RN

อาจารย์ที่ปรึกษา: รศ. ดร. พทริเมีย มคมูทเทิน, PhD, JD, CRNP

สถานที่ติดต่อในการมีข้อสงสัย: ในการที่คุณมีข้อสงสัยเกี่ยวกับงานวิจัยชิ้นนี้ คุณสามารถโทรหรืออีเมล์ไปยังผู้วิจัยหรืออาจารย์ที่ปรึกษาได้โดยตรงที่ ณัฐพัชร์ บัวบุญ โทร: (081) 684-6208 และ อีเมล์ dbuaboon@hotmail.com หรือ รศ. ดร. พทริเมีย มคมูทเทิน โทร: (202) 319-5252

รายละเอียดและวัตถุประสงค์ของงานวิจัย: ท่านเข้าใจว่าได้ถูกเชิญให้เข้าร่วมการวิจัยครั้งนี้ งานวิจัยจะศึกษาเกี่ยวกับขบวนการเข้าสู่การเป็นมารดาของหญิงไทยที่ถูกทารุณกรรมในขณะที่พักอาศัยในบ้านพักชั่วคราวพร้อมกับบุตร ท่านจะมีการให้ข้อมูลเป็นหลักฐานในการศึกษาวิจัยและเปรียบเทียบในแง่ของวัฒนธรรม วัฒนธรรมข้อมูลนี้ ผลการวิจัยพบว่า บทบาทการเป็นมารดาจะมีความแตกต่างกัน ในแต่ละประเทศและต่างวัฒนธรรม ในส่วนของประเทศไทยมีการศึกษาเรื่องนี้น้อยมาก ท่านเข้าใจว่างานวิจัยชิ้นนี้เป็นส่วนหนึ่งของการศึกษาวิจัยในระดับปริญญาเอก สาขาการพยาบาลที่มหาวิทยาลัยแคนBlockly แห่งประเทศสหรัฐอเมริกา

รายละเอียดของขบวนการดำเนินการวิจัย: ท่านเข้าใจว่าในการวิจัยครั้งนี้ ท่านจะถูกติ่งเกี่ยวกับการศึกษาวิจัย ที่มีการคัดเลือกข้อมูลที่ใช้ในผลการวิจัย 60-90 นาที ให้ข้อมูลต่างๆ อาทิเช่น ระดับการศึกษา ศาสนา ประสบการณ์การถูกทำร้าย การพักอาศัยในบ้านพักชั่วคราว ค่าเป้าหมายจะถูก


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นํามาใช้ในการสัมภาษณ์ ด้านนี้ยอมให้มีการบันทึกในระหว่างการสัมภาษณ์ ด้านเข้าใจว่า ผลการวิจัยจะถูกเก็บรักษาไว้เป็นเวลาประมาณ 5 ปี โดยผู้วิจัยจะทำลายข้อมูลนี้ทันทีหลังการรายงานผล

ความเสี่ยง ความไม่สะดวก ที่อาจเกิดขึ้น: ผู้เข้าร่วมวิจัยจะไม่มีปัจจัยเสี่ยงหรือผลกระทบทางด้านการแพทย์ใดๆ ด้านอาจจะเลือกไม่ตอบคำถาม ด้านคำถามนี้ทำให้ฉันไม่สบายใจ ฉันสามารถขอสุทธิการเข้าสู่งานวิจัยครั้งนี้หรือขอให้หยุดการบันทึกเทปได้ตลอดเวลา ด้านมีข้อกังวลหรือความกังวลในการรวมสัมภาษณ์ ผู้วิจัยจะชี้แจงสำหรับการศึกษาในระดับปริญญาโท และมีประสบการณ์ในการดูแลผู้ป่วยและครอบครัว ถ้ามีสิ่งใดทำให้การช่วยเหลือไม่อาจดำเนินได้ หากฉันยังมีการวิจัย การสัมภาษณ์ครั้งนี้จะสิ้นสุด และฉันจะต้องถูกส่งต่อไปยังแพทย์ประจำสุขภาพ หรือนักจิตวิทยา

ประโยชน์ที่อาจจะได้รับ: ฉันจะไม่ได้รับผลประโยชน์ใดๆจากผลของการวิจัยครั้งนี้ บางคำถามบางคำถามอาจจะทำให้ฉันรู้สึกไม่สบายใจ หรือข้อสัมพันธ์ แต่การทำวิจัยครั้งนี้จะช่วยให้ฉันได้รับการศึกษา หรืออาจจะช่วยให้ฉันมีการมีประสบการณ์ เทปอาจถูกเก็บไว้ในที่ทำงานของผู้วิจัย หรือที่ทำการที่มีความสมบูรณ์ในกระดาษ ซึ่งจะสิ้นสุดการวิจัยหรือการเก็บข้อมูลครั้งนี้

การมีการรับรอง: ฉันเข้าใจว่า การเข้าร่วมครั้งนี้ เป็นโดยความสมัครใจ ด้านเข้าใจว่า ด้านอาจจะปฏิเสธการเข้าร่วมการวิจัยครั้งนี้ได้ตลอดเวลา และฉันจะไม่มีความผิดหวังหรือสูญเสียประโยชน์ใดๆ ด้านเข้าใจว่าข้อมูลทุกอย่างที่ให้ไว้
ต่อผู้วิจัยจะถูกเก็บเป็นความลับมากที่จะเป็นไปได้ ดังนั้นเข้าใจว่าการบันทึกในงานวิจัย หลักเกณฑ์การบันทึกของโรงพยาบาลที่อาจถูกขอให้เปิดเผยได้ตามคำสั่งของรัฐ
dันได้วิวัฒน์โอกาสที่จะถามคำถามหรือข้อสงสัยเกี่ยวกับงานวิจัยหรือการเข้าร่วมการวิจัย และได้รับข้อมูลด้วยความพอใจ

ข้อติดความหรือข้อคิดเห็นเกี่ยวกับงานวิจัยครั้งนี้ สามารถติดต่อโดยตรงที่ Secretary, Committee for the protection of Human Subjects, Office of Sponsored Programs and Research Services, The Catholic University of America, Washington, DC. 20064; Telephone (202) 3195281 หรือ รศ.ดร.ศิริพร ขัมภทิขิต คณบดี คณะพยาบาทศาสตร์ มหาวิทยาลัยธรรมศาสตร์ โทร. (02) 9869213 ต่อ 7314
Appendix B

Study Instrument

Section A: Demographics

Section B: Theme based Questions
Study Instrument

Section A: Demographics

Introduction: Hello. Thank you for being a part in this study. This study is to gain information about the process of becoming a mother while you are living in a shelter. First, let me get some background information on you.

1. Age
   How old are you?
2. Length of homelessness
   How long have you been homeless?
3. Length of stay in this shelter
   How long have you been living in this shelter?
4. Gender of children
   What is the gender of your child?
5. Age of children
   What is the age of your children?
6. Marital status
   What is your marital status?
7. Level of education
   What is your highest level of education?
8. Employee status
   Are you currently employed?
9. Monthly household income
   What is your monthly household income?
10. Question about the father of the baby
    How old is he?
    What is his highest level of education?
    How often do you see him?
    How often does he see the baby?
Section B: Theme based Questions

Let’s begin by discussing about issue related to becoming a mother.

(1) Can you tell me what brought you to this shelter?

(2) How would you describe your level of satisfaction in terms of becoming a mother?

(3) What made you feel like a successful or unsuccessful mother?

(4) What strategies do you use when interacting with your baby?
   - What do you do when you take care of your baby?
   - Who helps meet your needs?
   - What worried you the most? Give me some example of this.

(5) What experiences of living in shelter either helped or hindered how you viewed yourself as a mother?
   - What supports do you need in your crisis?
   - Describe how you deal with an emergency situation in a shelter.
   - What type of help do you receive during living in a shelter?
   - What changes would you recommend to a shelter in order to provide help for women with baby or young child?
แบบสัมภาษณ์
แนะน าตัว: สวัสดีคะ ก่อนอื่นต้องขอขอบคุณอีกครั้งนะคะ ที่กรุณาเข้าร่วมการวิจัยครั้งนี้ วัตถุประสงค์ของการวิจัยครั้งนี้ เพื่อรวบรวมข้อมูลเกี่ยวกับการดำเนินการเป็นมารดาในระหว่างที่พักอาศัยในบ้านพักชั่วคราว ก่อนย้ายขอก่อนย้ายสู่บ้านพักชั่วคราวต่อ

ข้อมูลของผู้รับบริการ
1. ตอนนี้คุณอายุเท่าไร
2. มาอยู่ที่บ้านพักแห่งนี้มานานหรือยัง
3. ก่อนที่จะมาอยู่ที่บ้านพักแห่งนี้เคยอยู่บ้านพักชั่วคราวที่ไหนมาก่อนหรือไม่
4. การศึกษาสูงสุด ระดับไหน
5. สถานภาพสมรสเป็นอย่างไร
6. การคลอดครั้งล่าสุด ได้ทำประกันหรือไม่
7. ปัจจุบัน ได้ทำงานหรือไม่ ถ้าทำงาน ทำอย่างไรบ้าง
8. รายได้ส่วนตัวและครอบครัวเป็นอย่างไร

ข้อมูลของทารก
9. บุตร อายุเท่าไร
10. เพศอะไร
11. ภาวะสุขภาพเป็นอย่างไร

ข้อมูลของสามี
12. ตอนนี้สามีอายุเท่าไร
13. การศึกษาสูงสุด ระดับไหน
14. ในระหว่างที่พักที่บ้านพักแห่งนี้สามีมาอยู่บ้างหรือไม่ บ่อยเพียงใด

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ข้อมูลด้านการดำเนินบทบาทการเป็นมารดาและการถูกทารุณกรรม
t่อไปนี้ขอสอบถามข้อมูลการเลี้ยงลูกได้และการปรับบทบาทการเป็นมารดา รวมถึงการถูกทารุณกรรมที่มีผลต่อ
บทบาทการเป็นมารดา
1. อะไรเป็นสาเหตุที่ทำให้มาใช้บริการที่นี่ รู้จักทางบ้านพักที่ใดอย่างไร คุณได้รับความช่วยเหลือ
อย่างไรบ้าง
2. คุณมีความพึงพอใจในการดำเนินบทบาทการเป็นมารดา ในการเลี้ยงลูกในบ้านพักแห่งนี้หรือไม่ และ
อย่างไร
3. การเลี้ยงลูกที่ดีในความคิดของคุณ ประกอบด้วยอะไรบ้าง
4. ซึ่งจะทำให้คุณประสบความสำเร็จ หรือไม่ประสบความสำเร็จในการเลี้ยงลูกได้ คุณต้องการ
ในการเลี้ยงลูก
5. คุณมีวิธีการเลี้ยงลูกอย่างไรบ้าง แตกต่างจากคนอื่นๆหรือไม่ อย่างไร
6. ในกรณีที่คุณเคยพักในบ้านพักแห่งนี้ คุณมีความพึงพอใจอย่างไรบ้าง
7. คุณต้องการความช่วยเหลือในการเลี้ยงลูกได้อย่างไรบ้าง
8. การพักในบ้านพักที่นี้มีผลต่อการสร้างเสริมสุขภาพหรือไม่ ถ้ามี มีอย่างไร
9. เวลาที่คุณมีปัญหาในการเลี้ยงลูก หรือการปรับตัวในการดำเนินบทบาทการเป็นมารดา คุณทำ
อย่างไร
10. มารดาคนอื่นๆที่พักในบ้านพักแห่งนี้ มีผลต่อการดำเนินบทบาทการเป็นมารดาอย่างไร
สุดท้าย นี่ข้อมูลอะไรบ้างที่คุณอยากให้เพิ่มเติม หรือคุณอยากได้รับการช่วยเหลือเพิ่มเติมในการดำเนินบทบาท
การเป็นมารดาในขณะที่พักอาศัยในบ้านพักแห่งนี้
Appendix C
Flyer
Recruitment flyer

Natthapat Buaboon, a doctoral student in Nursing at The Catholic University of America, who is doing research on Thai abused women living in shelters: The process of becoming a mother. I am seeking to discover how Thai abused women process maternal role when they are living in shelter with their children.

You’re invited!!!

To be in this you must be:
- At least 18 years old
- Thai speaking.
- A mother
- Living in a shelter with your child.

If you participate in this research, you most will likely be asked to share your story of the process of becoming a mother only with a researcher. Only coded information will be shared. We will not reveal who you are during this study and your name will not be used.

If you are willing to participate in this research, please contact me at (081) 301-2171. Thank you for help.

If you are a women living in shelters with your children, I need your help!!!!
นางสาวณัฐพัชร์ บัวบุญ นักศึกษาระดับปริญญาเอก คณะพยาบาทศาสตร์ The Catholic University of America ขณะนี้กำลังศึกษาเกี่ยวกับ ขบวนการดำเนินบทความการเป็นมารดาของหญิงไทยที่ถูกทารุณกรรมที่พักอาศัยในบ้านพักชั่วคราว

คุณถูกเชิญให้เข้าร่วมการวิจัยครั้งนี้หากคุณมีคุณสมบัติดังนี้

➤ อายุ 18 ปีขึ้นไป
➤ สามารถพูดและเข้าใจภาษาไทย
➤ พักอาศัยในบ้านพักแห่งนี้พร้อมบุตรที่มีอายุตั้งแต่แรกเกิด-1 ปี

ถ้าคุณสนใจเข้าร่วมการวิจัยครั้งนี้ คุณจะถูกสัมภาษณ์เกี่ยวกับการดำเนินบทความการเป็นมารดา โดยนักวิจัยเพียงคนเดียว ข้อมูลดังกล่าวจะถูกปกปิดเป็นความลับ จะไม่มีการเปิดเผย หรือ ที่มาของข้อมูลใดๆ หากคุณสนใจที่จะร่วมในการวิจัยครั้งนี้ โปรดติดต่อที่ (081) 301-2171.

ขอบคุณสำหรับความร่วมมือ

ถ้าคุณพักอยู่ที่นี่พร้อมบุตร เราต้องการความช่วยเหลือจากคุณ
References
References


