CHAPTER 1

INTRODUCTION

The aims of this study were to understand the perspective and coping process among Thai women during their childbirth in hospital. Background and significance of research problems, objectives of the study, research questions, significance of the study, limitation and scope, and definition of terms are described in this chapter.

Background and Significance of Research Problems

Childbirth is a natural, culturally-based human experience and a transition of woman to a mother in the first-time mother (Callister, 1995; Helman, 2001; Raines & Morgan, 2000). Childbirth experience is far beyond the physiologic process because of various aspects of meaning. The meaning of birth was created by several features, including background and personal characteristics, cultural beliefs and values, personal mastery and control, expectation and environment of birth (Nichols & Gennaro, 2000). In addition, childbirth is so distinctive and unpredictable that a woman has to encounter her birth event as a unique approach (Lavender, Walkinshaw, & Walton, 1999; Lundgren, 2004). Thus, childbirth is a powerful experience for a woman, especially a first-time mother.

During childbirth, women need to cope with physical and emotional alterations as well as the environment of birth. Physical alterations result from persistent and increasing pain and discomfort along the duration of labor (Robertson, 1997). Emotional alterations arise from fear, physical discomfort, and a woman's

interaction (Simkin & Frederick, 2000). Environment of childbirth covers unfamiliar place, equipment, health care providers, climate and interventions in hospitals. These alterations provoke additional fear and anxiety in women (Robertson, 1997).

The incidence of stress during childbirth in the Australian study was 33%, in which the trauma symptoms were contributed to the high level of obstetric intervention and poor maternity care (Creedy, Shochet, & Horsfall, 2000). The study in the United States of America also found high incidence of birth trauma at 34%, whereas birth pain and coping were found as significant predictors of traumatic symptoms after birth (Soet, Brack, & DiIorio, 2003). Consequently, successful coping with childbirth is likely to be a substantial contributor to the personal growth and psychological well-being of the women.

The most common fear of women includes labor pain because of its uniqueness and severity (Niven & Murphy-Black, 2000). Labor pain is the major source of suffering, originating from tissue damage; this involves both reflex and cognition (Lowe, 1996). Nonetheless, women viewed childbirth paradoxically as bittersweet (Callister, Vehvilainen-Julkunen, & Lauri, 2001), joyful but frightening (Hallgren, Kihlgren, Norberg, & Forslin, 1995), and pain and achievement coexisting with (Waldenstrom, Borg, Olsson, Skold, & Wall, 1996). Some women reported that going through birth pain increased their strength and power to handle the duty of motherhood (Lundgren & Dahlberg, 1998). Thus, coping with birth pain is likely to be precious to women.

Besides distress from labor pain and physical alterations, women can be discouraged by fear and emotional alterations. Fear of childbirth shows much individual variation (Melender & Lauri, 1999). It is associated with women's

personal characteristics, such as general anxiety, low self-esteem, depression, and lack of support (Saisto & Halmesmaki, 2003). Most fear related to childbirth is fear about labor pain (Melender & Lauri, 1999; Wichaiditsa, 1997). In Thailand, fear about labor pain is the main reason for deliberate choice of cesarean section (Manager online magazine, 2004; Wichaiditsa, 1997), which shows a similar incidence in Sweden and Finland (Saisto & Halmesmaki, 2003). Such incidence implies women's negative assessment of labor pain. Nevertheless, a current problem regarding childbirth in Thailand includes an increasing rate of cesarean section without national control, as is found in other developing countries (Chanrachakul, Herabutya, & Udomsubpayakul, 2000). The overall cesarean section rate in Thailand increased rapidly from 15.2% in 1990 to 22.4% in 1996 (Tangcharoensathien et al., 1998). Recently, according to the survey from 227 hospitals in 1999, cesarean section rates were 24% in general hospitals, 48% in private hospitals, and 22% in university hospitals (Chanrachakul et al., 2000). Two common reasons for cesarean section were previous cesarean section and a delayed birthing process: whereas the rate of intentional cesarean section was 16% totally, mostly attributable to fear of labor pain and the desire for a favorable birth time of both women and physicians (Chanrachakul et al., 2000). According to the evidence, women are likely to lack adequate knowledge, family support and appropriate birth methods.

Other fears involve unsafe baby, complications of childbirth, husband's absence during birth, and the hospital environment (Melender & Lauri, 1999). Fear provokes adrenaline secretion, which in turn leads to physical stress reactions (Robertson, 1997). Therefore, emotional alterations directly affect physical stress reaction. Another stressor includes the environment of childbirth, involving

unfamiliar place, equipment, language, procedures and interventions, family separation, and limited movement. These characteristics of the birth environment also induce adrenaline excretion (Robertson, 1997). Therefore, childbirth in hospitals or an unfamiliar setting is likely to be a stressful event for women.

In the past, Thai women gave birth at home aided by a traditional birth attendant, a midwife or female relatives (Anumanrajadhon, 1998). Childbirth was meaningful as both a woman's transition to motherhood and a delightful family event. At present, most women give birth in hospital because of safety concerns (Whittaker, 1999). According to the report of the National Statistical Office (1996), in 1996, of a total of 2,730,778 births in Thailand, 82.0% were performed in public hospital, whereas only 7.8% of birth was occurred at home. In Thailand, the family generally has not been permitted to stay with woman in labor, except in some hospitals (Chunuan, 2000; Kerdbangnorn, 1999; Liamputtong, 2004; Whittaker, 1999). This despite the evidence that family support is commonly acknowledged as amazingly helpful to birthing women (Campero, Garcia, Diaz, Ortiz, Reynoso, & Langer, 1998; Carter, 2002; DiMatteo, Kahn, & Berry, 1993; Lavender et al., 1999; Somers-Smith, 1999), and that positive outcomes of fathers result from presence during birth in hospitals in Thailand (Thongchai, 1997). Additionally, childbirth education classes are available only in urban areas (York, Bhuttarowas, & Brown, 1999). Hence, Thai women generally lack family support and childbirth preparation.

Although the World Health Organization (WHO) recommended that childbirth practices should not be treated as illness in 1985 (Wagner, 1994), the routine adoption of unnecessary and useless interventions, and use of high technology have continued to the present (WHO, 2005b). According to WHO recommendations, midwives

should be respected and recommended as skilled professional attendants for optimal safety (WHO, 2005a). This recommendation places an emphasis on the significance of the midwifery role in promoting normalcy and concern for the individual's culture of childbirth. According to a WHO report, in Thailand 99% of births were attended by skilled health personnel in 2002 (WHO, 2005c).

A recent review of Cochrane library demonstrated that having continuous labor support by non-hospital staffs from the beginning of labor, women became less likely to have analgesia, operative birth, or dissatisfaction with childbirth (Hodnett, Gates, Hofmeyr, & Sakala, 2003). It was also found that continuous labor support had greater beneficial outcomes than intermittent labor support (Scott, Berkowitz, & Klaus, 1999). However, staffs' support was rarely reported by women (Hunter, 2002; Sauls, 2002). In Thailand it was found that psychological support enhanced pain-coping behavior during labor and optimistic perception of childbirth experience (Athaseri, Chatpothong, & Serisathean, 1990). The evidence from a number of studies pointed out that interaction between women and health care providers played an important role in fostering a positive birth environment, providing a balance of perceived control and support (Lavender et al., 1999; McCrea & Wright, 1999; Misago, 2000; VandeVusse, 1999; Walker, Hall, & Thomas, 1995), the feeling that the midwife was a friend (Walsh, 1999), and successful coping strategies from childbirth education (Spiby, Henderson, Slade, Escott, & Fraser, 1999). A meta-synthesis found that women in labor perceived a sense of caring or uncaring from the communication styles and behaviors of professional care providers, such as their presence or the reassurance of their being available, and providing words of encouragement, eye contact and smiling at the women (Bowers, 2002).

In stress theory, coping is a management process of psychological stress (Lazarus, 2000). A qualitative study confirmed that women's memories regarding childbirth provided long-term brilliant and precise details (Simkin, 1991, 1992). Successful women reported increasing self-esteem and self-confidence, whereas unsuccessful women reported decreasing self-esteem (Simkin, 1991).

Throughout childbirth, the woman-environment interaction involves a coping process by which women assign meanings to what is going on, subsequently reacting to other persons, events or themselves according to such meanings. A woman's understanding of childbirth leads to coping strategies and is modified continuously by the dynamic of interaction. Psychological stressors, not physical stressors, are the precursor of corticosteroid or stress hormone secretion (Lazarus, 1999). Therefore, women's understanding of childbirth can be either harmful or beneficial to them. Reportedly-used coping strategies in childbirth include breathing techniques, position changes, relaxation (Spiby et al., 1999), focusing, imagery, distraction (Niven & Gijsbers, 1996), but coping process itself was not clearly understood.

The existing knowledge informs the divergence between the context of birth in western studies and that of Thai studies, including childbirth education, family presence, labor support, and pain-relieving techniques. Nevertheless, several previous studies regarding childbirth in the Thai context have only limited reference to childbirth-related factors. The theoretical basis regarding Thai women's perceptions and processes of coping with childbirth in their own words is largely unexplained. The major gaps of knowledge in this respect include how Thai women view childbirth and what the process of coping with or the stresses and alterations of childbirth are. Grounded theory methodology is suitable for studying this process because symbolic

interactionism as a philosophical foundation of grounded theory approach can clarify the process. Therefore, a grounded theory method is necessary for this study. This knowledge will add some understanding and contributions to the theoretical basis regarding midwifery care under Thai context. Childbirth covered only vaginal birth in this study, excluding cesarean section, because vaginal birth is a regular and eligible method for all normal pregnant women.

Objectives of the Study

The objectives of this study included understanding the process of coping with childbirth among Thai women during their first-birth in hospital. The specific objectives were: (a) to understand women's reflection on their childbirth; (b) to explore women's coping process during childbirth.

Research Questions

There are two sequential research questions as follows:

1. What are the perceptions of Thai women about childbirth?
2. How do Thai women cope with childbirth?

Significance of the Study

In spite of the existing literature on women's childbirth experience in global society, women's coping with childbirth as a process in the Thai context is relatively knowledge gained from this study can contribute a theoretical basis to midwifery practice, education and research.

Limitations and Scope

The scope of this study is limited to first-time mothers' vaginal birthing experience in a public hospital in the central region of Thailand. All first-time mothers who expected vaginal birth or had already given birth vaginally to a normal healthy baby during August 2003 to July 2004 were eligible for this study. This study did not include childbirth experiences of woman who had cesarean or multiparous births, gave birth outside hospital or whose baby at birth was dead, sick or deformed.

Definition of Terms

Perception of childbirth refers to women's perspective and meaning regarding to the integrated process of physiological, psychological, and emotional alterations of giving birth to a baby vaginally.

Coping with childbirth refers to the personal handling process that seeks to overcome the stressful circumstances of childbirth.

Thai women refers to those who give childbirth for the first-time vaginally in a hospital in the central region of Thailand.