CHAPTER 2

REVIEW OF LITERATURE

In order to explore issues about Thai women's experience of coping with childbirth in hospitals, the researcher will review literature covering the context of childbirth in Thailand, coping and factors related to coping with childbirth, and coping strategies during childbirth. This review will provide basic knowledge of women's coping with childbirth that we already know in order to identify what needs to be further found out for understanding the process of coping with childbirth by Thai women.

The Context of Childbirth in Thailand

Childbirth practices have changed significantly in Thailand since the Seventh National Economic and Social Developmental Plan in 1992 called for 75% of women to give birth in hospitals (Whittaker, 1999). Therefore, health service improvement in Thailand has moved women's birthplaces from homes to hospitals because of the main focus on safety. Regarding birth place and birth attendant, according to the report of Thailand National Statistical Office (1996) from the survey of fertility in Thailand, the places of birth were mainly in public hospitals, (82.0%) whereas birth at homes occurred only 7.8% of cases. Home birth is mostly preferred in the southern region (16.5%) and secondly in the northeastern region (12.4%). In 1996 the total number of births was 2,730,778. Births were attended by physicians (56.3%), nurse-midwives (30%), midwives (6.5%), traditional birth attendants (5.6%), the women

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themselves (1.0%) and others (0.6%). These figures represent the preference for hospital birth, attended by health care professionals. There were some issues in hospital birth, including cesarean section rate increase, family members attending at birth and sociocultural concerns in hospital births.

Increase in Cesarean Section Rate

In hospital, the rate of operative birth has been increasing. In 1996, the cesarean birth rate was 7.2% in district hospitals, 22.9% in provincial hospitals, 21.2% in other public hospitals and 51.5% in private hospital. The national cesarean birth rate in 1996 was 22.4%, representing an increase from 15.2% in 1990 (Tangcharoensathien et al., 1998). Another study reveals that giving birth in hospitals might increase the likelihood of cesarean section, especially in private hospitals (Chanrachakul et al., 2000). The findings revealed cesarean section rates were 24% in general hospitals, 48% in private hospitals, and 22% in university hospitals. The cesarean section rate has increased during the past 5 years by 78% in general hospitals, 50% in private hospitals, and 66% in university hospitals. The most common indication was repeated cesarean section without standardized control of unnecessary primary cesarean section (Chanrachakul et al., 2000). Fear of labor pain was the most common reason for choosing cesarean birth (Wichaiditsa, 1997). The findings were drawn from 100 elective cesarean birth mothers and 100 normal birth mothers by a questionnaire and an in-depth interview. The results revealed that occupation, education, family income and parity were related to choosing cesarean birth. There were differences between two groups regarding beliefs about birth, obtainable information about cesarean birth, and significant others' consultation. The

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most common reason for choosing cesarean section was fear of labor pain. This finding supported the perception that fearful, higher classed women were more likely to favor cesarean birth than lower classed women.

Family Members at Birth

Family absence during birth is another issue in hospital birth that should be reconsidered (Chunuan, 2002; Liamputtong, 2004; Whittaker, 1999; York et al., 1999). According to the benefit of father's presence with women during birth perceived in western culture, a study regarding the father's role during labor in Thai context has been conducted (Thongchai, 1997). A quasi-experiment determined the effectiveness of fathers' role promotion toward role performance and participative satisfaction during birth. The participants were 60 first-time fathers whose wives planned to have vaginal birth in Maharaj Nakhorn Sri Thammarat hospital. They were purposively sampled and randomly assigned to an experimental or a control group, 30 in each group. The promotion program included information providing, training and motivation during the third trimester. Both groups attended their wife's birth. After birth, they completed two questionnaires: The Fathers' Role Performance during Delivery and the Participative Satisfaction During Delivery. The results reveal that both groups of fathers were satisfied with participation during delivery, but fathers in the experimental group had the fathers' role performance during delivery score higher than those in the control group.

Because family absence during birth in hospitals seems to be common in Thailand, a parturient caring model focusing on family-centered-care has been tried in a community-based hospital in Chantaburi province (Sampao, Theinpichet, and

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Deoisres, 2002). The model has been employed in the experimental group. The finding reveals that the women and family in the experimental group had satisfaction scale higher than the control group. This study implies that family presence and family-centered-care during birth should be more concerned in hospital birth practice.

Chunuan (2002) conducted a cross-sectional study among 525 postpartum giving birth mothers in a hospital in the southern part of Thailand and found that 40% of them wanted to have one of their family members with them during intrapartum and recommended changing the hospital policy related to family member attendance.

Sociocultural Concerns in Hospital Birth

Birth practice in hospital has less concern about sociocultural context (Kerdbangnorn, 1999; Liamputtong, 2004; Whittaker, 1999), such as some communication problems (Liamputtong, 2004; Luecha, Putwatana, Thanooruk, Lauhachinda, Lerdmaleewong, & Leesuwan, 1989), social distance between women and health care providers (Kerdbangnorn, 1999; Liamputtong, 2004; Whittaker, 1999). Luecha, Putwatana, Thanooruk, et al. (1989) studied women's opinions regarding the communication between women and health personnel in the delivery room of a university hospital. The participants were 146 new mothers within 24-48 hours after birth. Data were collected by structured interviews. The results revealed that women perceived both positive and negative communications, but most were positive. Positive communications included friendly tone of voice, eye-contact, facial expression, friendly attitude and gentle touch, whereas negative communications included simultaneously practicing two activities at the same time, leaving women

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alone, and using different tones of voice between public clients and private obstetrician's clients.

Begum, Seguerra, and Hasan (1994) conducted a qualitative study regarding birthing choices in a district of the southern part of Thailand. This report revealed that women were the main agents in decision-making regarding birth, supported by their husbands and relatives. Traditional birth attendants were more favored by Muslim women than Buddhist with increasing age, both religious groups of women had a tendency to choose home birth. More educated women preferred trained health personnel and birth technology in hospital. The most significant reason for choosing hospital birth was safety, defined in terms of birth technology. The most significant reason for choosing home birth was traditional care and safety, defined in terms of family support. Nevertheless, this abstract did not present the detail of participants and data collection. Thus, these findings were more fully described by Kerdbangnorn's (1999) study.

Kerdbangnorn (1999) conducted a qualitative study, using a medical anthropological approach in a village of southern Thailand to examine the survival of the Muslim traditional birth attendants' roles. The participants included one Muslim traditional birth attendant, 14 pregnant women and 32 postpartum mothers. The results revealed that Muslim women preferred traditional birth attendance because they received more continuity of care and cultural care from traditional birth attendants.

Whittaker (1999) found that viewpoints of birth between women and health personnel in hospital were rather different. Women's views about childbirth were cultural expectation of moral support, whereas health personnel's views were routine

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events. She illustrated a variety of issues of hospital birth based upon 18 months ethnographic research on women's health in a village of Northeastern Thailand during 1992 and 1993. Data collection was two structured-interview surveys on pregnancy and birth. Two groups of participants included 67 women aging 20-60 and 57 women giving birth in 1992. Furthermore, in-depth interviews were conducted with 36 women of various ages. Six traditional birth attendants and the nurse-midwives were also interviewed. Eleven births at provincial and district hospitals were observed and obstetric staffs in those settings were also interviewed. The issues of hospital birth included high interventions, the social distance between women and health staff in the hospital birth, and the different viewpoints of birth between women and health staff. The majority of high interventions which were regularly acted upon any women included lithotomy birthing position, augmentation, episiotomy, and family inhibition from birth events. The social distance between women and health staff was maintained through the uniforms of the latter, hospital language, and the hierarchical organization of the public health system.

Chunuan (2002) found that women's educational levels were associated with patient satisfaction with pain control and childbirth care. Well-educated women might want to participate more in decision-making than lower educated women. This cross-sectional study was conducted in a regional hospital in the southern part of Thailand. Data were drawn from 525 postnatal mothers. It was also found that preparation for childbirth such as breathing techniques was not explicated well in prenatal care.

In summary, Thai women's birth experience in hospital was likely to include family absence, less sociocultural concern (Liamputtong, 2004; Whittaker, 1999),

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inadequate childbirth education (Chunuan, 2002) and risk of cesarean section, especially among high classed and well-educated women (Chanrachakul et al., 2000), and also among women who were afraid of childbirth (Wichaiditsa, 1997).

Coping and Factors Related to Coping with Childbirth

Lazarus and Folkman (1984) have defined coping as continuously changing cognitive and behavioral management to handle specific loads that are greater than personal resources. Later Lazarus (1999, 2000) has proposed the transitional view of coping by accepting both conscious and unconscious efforts to manage psychological stress. He accepts two main ways of appraisal: deliberate and largely conscious or "intuitive, automatic and unconscious" (Lazarus, 2000 p.207). He also proposes that "…secondary appraising or coping – must always be based on a full exploration of what is going on in the mind of a particular individual and the context in which the person-environment transaction occurs." (Lazarus, 2000 p.206). Thus, transitional view of coping is similar to symbolic interactionism.

Stress-induced illness called posttraumatic stress disorder (PTSD) has been recognized since after the Vietnam War. The term "posttraumatic stress disorder" indicates the belief that this emotional disorder comes from external cause. Actually, individual differences in personality factors arouse stress from vulnerability. Psychological stress depends on the person-environment relationship and it can occur in both peace and tragedy. Lazarus argues that in order to understand the stress process entirely, it should be explored in the frame of stimulus-response or input-output process, along with a narrative approach (Lazarus, 1999).

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The initial step in person-environment interaction is that a person has primary appraisal for meaning and consequence of whether the happening is relevant to the individual or not, and in what way. The major appraisal dimensions for psychological stress include harm and loss, threat, and challenge. Harm and loss indicate that damage has already happened. Threat indicates that damage is possible to happen in the near future, but it is uncertain. Challenge indicates that the possible benefit is likely to happen after the struggle. Threat and challenge can be alternate to each other, or simultaneous, along with one predominating over the other in some situations (Lazarus, 1999; 2000).

The next step is that the person has secondary appraisal for what she should do. If the event is judged as lacking hazards or relationships, there is nothing to do further. On the contrary, if the event is judged as a harmful and negative, threatening, or challenging, the individual feels stressful and needs to operate something in order to gain release from stress or directly modify or control such events. Then repeated reappraisals occur in order to reconstruct new relational meanings of the constantly changing events (Lazarus, 2000). Lazarus (1999) states the interdependence of stress and emotion. He reasons that all emotions were associated with stress, even such positively-toned emotions as happiness, because an individual might fear happiness departing.

Both individual differences and situational variations result in a uniqueness of each person-environment relationship. Psychological meaning of situation and judgment of what to do are likely to constantly change during the coping process. What a person does to overcome psychological stress, called coping strategy, including emotion-focused and problem-focused strategies (Lazarus, 2000).

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Emotion-focused coping aims at decreasing the emotion without changing the actual stressful situation, such as reconsidering the meaning of problem. Problem-focused coping aims at controlling or acting directly on the environment-personal relationship to correct the situation. The two functions of coping are always used in combination because both are crucial parts of total coping effort and each supports the other (Lazarus, 2000). As previously stated, according to Lazarus (1999, 2000) there is no universally-effective or ineffective coping strategy because life courses diversely change contextually over time. Efficacy of coping depends on personal style, the threatening style, the stage of stressful events and expected outcomes. Despite harmfulness in general, denial may be useful under circumstances where nothing can be performed to amend harm-loss (Lazarus, 1999).

Factors or variables that influence stress and emotion, called antecedent conditions of coping appraisal, comprise environmental and personal factors (Lazarus, 1999). Environmental factors include demands, constraints, opportunities, and culture. Personal factors include goals and goal hierarchies, beliefs about self and world, and personal resources (Lazarus, 1999).

Regarding environmental factors, demands are tensions from environment or obligation from individual's duty, which are internalized subsequently. If the demands and inner goals and beliefs are opposed, conflicts may occur. Constraints are limitations that violate social standards, which have punishment as the consequences. Opportunities are favorable timing, in which the individual can benefit if she realizes and manages the right action at the right moment. Culture is an environmental antecedent of coping appraisal (Lazarus, 1999). The childbirth event is shaped by culture: community culture in home birth and health care providers' culture

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in hospital birth, therefore, women in different cultures give meaning to the demands of childbirth in different ways (Jordan, 1993).

Regarding personal factors of coping appraisal, goals and goal hierarchies are considered and the choice of goals is decided. Beliefs about self and world shape individuals' expectations about events and outcomes, such as what individuals hope for and what to do in respect of certain hope. Personal resources are personal traits or characteristics and support. Personal traits or characteristics include intelligence, education, social skills, money, and supportive family and friends (Lazarus, 1999).

The environmental antecedents of coping appraisal with childbirth include demands, constraints, opportunities, and culture related to childbirth. Personal antecedents of coping appraisal with childbirth include women's goal and goal hierarchy; women's beliefs about self and childbirth; and women's characteristics, women's support: family support and health care provider support. Elaborate explanation of selective factors related to coping can provide a theoretical basis for this understanding individual with women's coping with childbirth.

Demands of the Childbirth Event

Childbirth, especially vaginal birth is an integrated process of bringing forth a baby out of its mother's uterus. Biologically, childbirth is an integrated physiologic process of uterine contracting, cervical opening, and involuntary bearing for the baby emergence (Nichols & Gennaro, 2000). Psychologically, childbirth is a significant and powerful event in a woman's life (Simkin, 1991) that is vividly remembered (Simkin, 1991) and can induce posttraumatic stress disorder in some women (Creedy et al., 2000). Therefore, childbirth may be a period of crisis or growth; a terrible or

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terrific experience, both positive and negative for women. Although the physiological process of childbirth is rather similar in most women, meaning of childbirth is rather different. Especially for a first-time mother, childbirth plays an important role as a transition from a woman to a mother (Helman, 2001).

Because of the strenuous work, childbirth is usually called "labor", bringing a sense of achievement to the mother (Gould, 2000). The warning symptom of childbirth may appear a couple days before actual birth (Robertson, 1997). Uterine contraction is gradually stronger along with timing of the first stage of childbirth. A course of uterine strength alters from 15-40 seconds lasting in every 5-30 minutes at the beginning to 45-90 seconds long in every 90 seconds to three minutes at the end of this stage (Robertson, 1997). In the second stage, uterine contracts 45-70 seconds in every three to five minutes (Robertson, 1997). Basically, it is difficult to notify the accurate onset of childbirth. A course of childbirth may be longer than 24 hours without an obstetrical complication, so the stage of normal labor is difficult to delimit (Gould, 2000). Therefore, the normal physiologic course of childbirth may be perceived as involving psychological stress for a birthing woman.

In general, childbirth is an innate reproductive instinct that many spontaneous hormones play an integrated important role in. These hormones include oxytocin, catecholamines and endorphins. Oxytocin regulates the course of labor and supports uterine contraction. Uterine muscle becomes ischemic, which results in the pain of childbirth. A variety of reported pain from birthing women includes 20% terrible pain, 30% severe pain, 35% moderate pain and 15% minimal pain or no pain (Bonica, 1995). Endorphins liberate the birthing women from severe pain. Catecholamines, especially adrenaline is released automatically from the adrenal gland when an

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individual is frightened, threatened, or fearful, in order to protect the individual from danger (Robertson, 1997). Therefore, the emotions of psychological stress, such as fear and anxiety, can enhance adrenaline release. Subsequent adrenaline inhibits the progress of childbirth and also inhibits endorphins release (Robertson, 1997).

Birth pain is the most common concern for women both in pregnancy and during childbirth because it is related as one of the most intense of all pains (Niven, & Murphy-Black, 2000). Moreover, women can recall birth pain vividly with either positive or negative feelings (Niven, & Murphy-Black, 2000). Although pain is generally somewhat negative in the feeling of individual, birth pain is so extremely unique that woman may feel both positive and negative at the same time as a feeling of bittersweet paradox (Callister et al., 2001).

Kelpin (1984/1992) describes the meanings of birth pain from nine women interviewing in a qualitative study. The assumptions about birth pain are proposed in four themes: (a) pain should be denied; (b) pain must be relieved; (c) pain is only negative, (d) pain can be explained. Then the questions from these assumptions include: (a) What is being denied in the denial of birth pain? (b) What do we take away in relieving the woman from birth pain? (c) Can birth pain be revealed as positive experience? (d) What is the nature of this experiential wholeness? Kelpin (1984/1992) explains that the origin of the word "birth" is bearing in the sense of enduring. The women endure the pain for the reason that pain related to the birth of a child is inevitable. Women report many strategies for enduring pain, such as grunting, screaming, walking, finding a comfortable position, active relaxation, breathing patterns, and the intention to be free from passive suffering. They need support in order to reassure them that the pain is acceptable. A variety of supports

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include back rub, direct advice, sips of water, a gentle touch, words of encouragement, the presence of a support person, and information of what is happening. Women experience an internal pain, such as low back pain and deep pubic pain. Finally, a child is born accompanied with the incredible feeling of a mother becoming. Those feelings are "relief, disbelief, joy, and incredible exhilaration surround the excitement of the baby's presence" (Kelpin, 1984/1992, p.102).

Women deal with birth pain as a paradoxical aspect of childbirth. Pain is defined as "an extremely complex phenomenon with both sensory and emotional components and an ability to command attention dominating other cognitive processes." (Lowe, 2002, p.s16-s17) Pain is a highly abstract and subjective private experience through intensely personal interpretation of noxious sensory stimuli, affected by interaction of multiple psychosocial and cognitive variables. Anxiety associated with increased labor pain and fear of pain has a high correlation with reported pain level in the first stage of labor. Pain frequent induces suffering and discomfort. Suffering has three common aspects: involving perceived threat to the psychosocial self, body or both; relating to an emotional, unpleasant, psychosocial complex; representing an enduring psychological state (Lowe, 2002).

Therefore, pain and positive childbirth experience can be mutually present according to the meaning women assign to birth pain (Kelpin, 1984/1992; Simkin, 2000). For many women, birth pain is related to feelings of accomplishment, a sense of increased self-esteem, and self-confidences (Simkin, 2000).

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Childbirth Care in Hospitals

In the past, when women gave birth at home among familiar surroundings, childbirth was viewed as a natural event and a component of family welfare. Presently, women give birth in hospital; childbirth is viewed as risky event that has been managed by the risk approach (Wagner, 1994). In some hospitals, women receive active management by synthetic oxytocin intravenous infusions, electronic fetal monitoring, membrane-puncturing, being restricted to bed, and other interventions, to prevent possible danger, even though the current reviews indicate possible harm of some interventions, such as increasing cesarean section occasion (Callister & Hobbins-Garbett, 2000; Rooks, 1999a; Wagner, 1994), whereas some simple, clearly beneficial practices, such as continuous labor support or maternal movements during labor, have been disregarded (Callister & Hobbins-Garbett, 2000). The culture of birth care in hospital is the main system of present birth care not only in a developing country such as Thailand, but also widespread in developed countries (Whittaker, 1999). Because of the limitations in hospital birth care, natural birth movement is sought for the balance between technology and humanism. Natural birth is enhanced by midwifery care, which has the objective of protecting the normalcy of childbirth (Kennedy & Shannon, 2004) by continuous presence and providing encouragement, support and comfort to women in labor (Rooks, 1999b).

Birth technology is the main practice in hospital birth. Even though the outcomes of less intervention birth are better than the outcomes of more intervention birth, a majority of women in the United States receive at least one medical intervention during birth, such as electronic fetal monitoring, intravenous drip, epidural analgesia, artificial membrane rupture, oxytocin infusion to strengthen

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contraction, bladder catheterization, suturing to repair an episiotomy or a tear, induced labor, and episiotomy (Declercq, Sakala, Corry, Applebaum, & Risher, 2002). The middle-class women believe hospital birth assures the wellness of themselves and their baby (Lazarus, 1997). Moreover, in some developed countries, such as Canada, midwives just have been accepted in the system of maternity care (Wrede, Benoit, & Sandall, 2001). Therefore, women's preferences or the system of maternity care should be reconsidered based on evidence support.

Whittaker (1999) found that hospital birth issues include high interventions, the social distance between women and health staff in the hospital birth, and the different viewpoint of birth between women and health staff. The interventions that are commonly imposed upon women include lithotomy birthing position, augmentation, episiotomy, and family absence from the birth event. The social distance between women and health staff was symbolized by uniforms, medical language, and the hierarchical organization of the government health system. The viewpoint of birth between women and health staff is totally different. Birth culturally demands moral support in women's view. Conversely, birth is a routine medical event that engaging occasional monitoring of the process of labor in health staff's view.

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Continuity of care is the model of care that a woman is concerned with as the center of childbirth. The concept of continuity of care generally refers to women receiving care from the same small group of health care providers for most care throughout pregnancy, labor, birth, and the postnatal period (Biró, Waldenstrom, & Pannifex, 2000). Continuity of care by the same care providers throughout the childbearing period has been emphasized since the last decade in many countries,

such as England and Australia. In England the Changing Childbirth Policy called for a new midwifery practice as a small team for the continuity of care (Wrede, Benoit, & Sandall, 2001).

Continuity of midwifery care had been correlated to less medical procedures in labor (Biró, Waldenstrom, & Pannifex, 2000) and positive birth experience through women-midwife friendships (Walsh, 1999). The feeling of the midwife as a friend was also found in Green, Coupland, and Kitzinger's (1998) study that women often explained their feeling of the satisfaction of giving birth with a known community midwife who had met women throughout pregnancy. A woman perceived that she was treated as a person, and both woman and husband were treated as a couple. She felt she was being delivered by a friend. However, Green et al.'s (1998) study also found that most women who gave birth with an unknown midwife could recognize the continuity of care during birth if the midwives were friendly early on, and provided support and their presence until the baby was born. Therefore, continuity of care by a known midwife throughout the birth period is valuable for women.

Currently, the hospital is the main choice of birthplace for women in Thailand because of emphasis on safe birth, ensured by environment, professional practice and new technology. In Thailand continuity of maternity care has disappeared from maternity service in hospital. In one study in a hospital in the southern region of Thailand, it is found that continuity of care from the nurses is one of the factors predicting women's satisfaction with birth experience in Thailand hospitals (Chunuan, 2002), which is as the findings from other countries (Fiedler, 1997; Green et al., 1998; Misago, 2000).

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Sociocultural Beliefs About Childbirth

Sociocultural beliefs have profound impacts on women's childbirth experience. Jordan (1993) compared the birth situation in Sweden and Holland in 1979, both countries having the lowest birth-related mortality. The major differences included place of birth and medical intervention consumption. In Sweden, all births were performed by highly trained midwives in hospitals with pain relief medication and medical intervention. In Holland, 55% of births were home births without pain relief medication. In Thailand sociocultural transformation affects women's childbirth experience. Gender role change in a particular culture has an important impact on women's perspective on childbirth. Some Thai women agree to have cesarean birth because they can manage accurate timing for their role as a working woman (Wichaiditsa, 1997). Occupation, education, family income and parity were related to choosing cesarean birth. It was found that higher classed women were more likely to favor cesarean birth than lower classed women. In the southern region of Thailand, most Muslim women in the rural area preferred home birth, performed by a Muslim traditional birth attendant because hospital practices were entirely different from cultural beliefs in their religion (Kerdbangnorn, 1999). Therefore, sociocultural concern is an essential variable that relates to women's childbirth care.

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Women's Goals and Goal Hierarchy

The goals of women relate to their concerns, then lead to coping appraisals and coping strategies. Several studies revealed the ultimate goal of women in labor focuses on the health of the baby and safe birth (Kantaruksa, 2001; Melender, 2002; Melender & Lauri, 1999; Riewpaiboon et al., 2005; Srikanjanapert et al., 1999).

Kantaruksa's (2001) study about the transition experience of Thai women during their first pregnancy reveals that late pregnant women were concerned about the well-being of their baby and themselves and the expected birth. Their strategies during pregnancy served these concerns.

According to Melender (2002), and the studies by Melender and Lauri's (1999) about experiences of fears associated with pregnancy and childbirth in Finland, the two major concerns among the women included the course of childbirth as well as the well-being of both children and mothers. These concerns imply women's goals of safety and achievement of childbirth experiences.

In Bangkok, Thailand Riewpaiboon et al. (2005) found that the major concerns and aspirations included risk and uncertainty of childbirth. These concerns imply women's appraisal of childbirth as risk, against which their goal is safety. Choosing private obstetrician care by providing more money to the obstetrician is the strategy to reach that goal. A qualitative study in northeastern Thai pregnant women reveals that women in late pregnancy are concerned about baby, self, birth climate, and family. Women's concerns emphasize their goals of baby's health and childbirth smoothness. Due to these goals, women seek for childbirth perception (Srikanjanapert et al., 1999).

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Women's Beliefs About Self and Childbirth

Women's beliefs about self and childbirth can influence the actual birth event and coping. Beliefs about self are usually discussed in terms of self-confidence or self-efficacy; including persons' senses of ability to control affected events (Lazarus, 2000; Siela & Wieseke, 2000). Self-efficacy is identified by efficacy expectations

and outcome expectations (Siela & Wieseke, 2000). Efficacy expectations refer to beliefs about the person's capability to achieve an expected outcome. Outcome expectations refer to beliefs about the determined outcomes as the consequences of certain behaviors. For example, if a woman believes that she can overcome the obstacles of birth, she is likely to appraise birth as a challenge rather than a threat (Lazarus, 2000). Another concept related to the individual's belief is called sense of coherence, or the degree to which the individual expects an event to be comprehensible, manageable, and meaningful (Antonovsky, 1998; Horsburgh, 2000). The concepts related to the individual's belief are helpful for understanding how women appraise and cope with childbirth.

Belief about childbirth is created through a diversity of childbirth definitions combined with women's cultural beliefs (Callister, 1995). Social class and education may also influence women's beliefs and expectations about childbirth, and can be reflected in their choices of birth care (Lazarus, 1997). Individuals who define birth as risky and requiring medical technology are likely to choose obstetric care, whereas those who define birth as natural and normal are likely to choose midwifery care (Howell-White, 1997). Also women's ability to cope with labor has a powerful relationship in decreasing pain perception and medication use (Lowe, 2002). Therefore, women's beliefs regarding childbirth indicate the decision-making model of birth care and birth care providers.

Hallgren et al. (1995) found that during birth women perceive the event differently. Women who had perceived birth as a threatening event anticipated being out of control. In contrast, those who had perceived birth as a challenge anticipated

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maintaining a sense of mastery. This finding demonstrates the importance of beliefs about self and events to coping.

There is a very high rate of cesarean birth in Brazil. Osis, Padua, Duarte, Souza, and Faundes (2001) compared the opinions between the 230 women who had experience of both vaginal birth and cesarean birth and the 426 women who had only cesarean birth. Women's opinions in two groups were totally different. The majority of women in both groups argued that vaginal birth was the best, but vaginal birth experienced women had preferred vaginal birth rather than those who experienced only cesarean birth. The women's reasons for cesarean birth were also different. Women with vaginal birth mentioned the baby's health, whereas women with cesarean birth referred to narrow pelvis. The results confirmed that the difference of previous birth experiences differentiates women's beliefs about birth.

Melender and Lauri (1999) conducted a qualitative study to describe fear related to pregnancy and birth in hospital. Twenty women were interviewed two or three days after birth. The women's most important fear was about the baby's well-being. The causes of fear about birth were pain and complications of birth and fear of the husband's absence during their birthing. Many women accepted that even though no evidence of fear has been present, fear was essential in a protective role by arousing the women to prepare themselves for birth.

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Family Support

Childbirth is not only the individual woman's experience, but also the family's experience. The word 'birthing' implies a physiologic process in which the woman or couple actively takes part in giving birth (Larimore, 1995). Hence, family-centered

birthing models have been proposed. Family-centered birth care places an emphasis on the natural process of childbirth, enhances active involvement of fathers during childbirth process, and also promotes family clarification of their own values, needs, and priorities (Tomlinson & Bryan, 1996). Nonetheless, family-centered birth care seems to be simply idealistic because some hospitals distribute services of family-centered care among the environment of high technology (Larimore, 1995). The process of change from the traditional model of birth care to family-centered birth care requires problem identification by staff and timing for change process (Ecenroad & Zwelling, 2000). Regarding family-centered birth care in Thailand, Whittaker's (1999) study in the northeast region revealed that women decided to give birth at hospitals to ensure the safety of women and baby. They intended to tolerate loneliness for the safety promised by modern birth technology. Basically, separation from the family is rather common in some birth hospitals in Thailand, similarly to in some countries, like the urban hospitals in Mexico (Campero et al., 1998), in Lebanon (Kabakian-Khasholian, Campbell, Shediac-Rizkallah, & Ghorayeb, 2000), and in Egypt (El-Nemar, Downe, & Small, 2006). However, family presence during labor is common in some eastern cultures, such as in Taiwan (Chen, Wang, & Chang, 2001) and in Hong Kong (Ip, Chien, & Chan, 2003).

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Family support is associated with the birthplace. Carter (2002) studied husbands' involvement during pregnancy and birth in rural Guatemala. This study employed both qualitative and quantitative methods. The survey from 1,786 women by semi-structure interviews revealed that 83% of birth was home birth, in which the husband was more likely to attend birth, than hospital birth. Mothers and mothers-in-law also attended birth for both home birth and non-home birth. Family present

during birth is common, but birthplace played an important role for the husband-attended birth.

In England, approximately 95% of fathers attend their babies' birth (Somers-Smith, 1995). Family support during childbirth is common in many countries, such as the United States, Sweden, Finland, the Netherlands, and Japan. Both women and partners confirmed the need and usefulness of family support during birth (Hollgren et al., 1995; Somers-Smith, 1998). Women were very grateful for the support of their partners. The supportive behaviors included holding the wife's hand, helping her with relaxation, bathing her, being someone to lean on, making her tea, massaging her back, and reminding her how to cope with pain (Somers-Smith, 1998). The fathers perceived that they were very helpful to their wives during the labor period.

In Thailand Thongchai (1997) conducted a quasi-experiment, determining the effectiveness of the fathers' role promotion toward role performance and participative satisfaction during birth. The participants were 60 first-time fathers whose wives planned to have vaginal birth in Maharaj Nakhorn Sri Thammarat hospital. They were purposively sampled and randomly assigned to either an experimental or a control group, 30 fathers each group. The promotion program included information providing, training and motivation during the third trimester. The experimental group was trained to give labor support through this program, whereas the control group did not receive the training. Both groups attended their wife during birth. After birth, they completed two questionnaires: (1) Fathers' Role Performance during Delivery and (2) Participative Satisfaction during Delivery. The findings revealed that the experimental group had higher scores for the role performance than the control group. However, both groups similarly appreciated being present at their wife's birth. The

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results of this study have confirmed that both prepared and unprepared husbands similarly appreciated being present at their wife's birth during hospital birth in Thai culture. Therefore, husband support in hospital birth should be encouraged. At present, public hospitals permit family presence in labor more than in the past.

Support from Health Care Providers

The evidence from three meta-analysis studies have found that continuous labor support has the most important positive effect on obstetrical outcomes and decreasing anxiety (Klaus & Kennell, 1997; Scott et al., 1999; Zhang, Bernasko, Leybovich, Fahs, & Hatch, 1996). The specific labor supports contributing to positive birth outcomes include continuous emotional support during childbirth, ambulating, position change, hydrotherapy, eating and drinking, pushing, and squatting or side-lying birth position. Labor support from a trained person is most important to birth outcomes (Callister et al., 2000). From these studies, simple labor support such as hot-wet compression, positioning, massage, and sympathetic care are recognized as coping resources for birthing women.

Maher and Souter (2002) interviewed 18 midwives in order to describe birth support in Melbourne, Australia. Midwives mentioned their birth support as rather a friend than a midwife. They also described birth support as assisting birthing women to develop and negotiate satisfactory birth narratives, including the difficult experience of birth. Therefore, birth support also reflects the women-caregiver friendship. Bausoung and Rungroengsri (1994) found that both the relaxation touch as well as the caring touch was beneficial to the first-time mothers' perception of childbirth experience and pain coping in a study in the Thai context.

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The similarity from several studies revealed an emphasis on the interaction between a birthing woman and her caregiver or birth companion (Fiedler, 1997; Green et al., 1998; Kennedy, 1995; Kennedy, 2000; Misago, 2000; VandeVusse, 1999; Waldenstrom, 1999; Walker et al., 1995; Walsh, 1999; Whittaker, 1999), especially the balancing of perceived support and personal control through this interaction (Lavender et al., 1999; McCrea & Wright, 1999; Misago, 2000; VandeVusse, 1999; Walker et al., 1995). The interaction between women and midwives is not simply a professional relationship. Most women described their midwives as friends (Walsh, 1999). Midwives and women partnership is a major aspect to facilitate the positive childbirth experience through continuity of coaching, advocacy, and guidance (Seibold, Miller, & Hall, 1999). It is more important still if women cannot have friends or family members being with them during birth (Campero et al., 1998). Professional support or women-professional interaction is intertwined as a unique environmental coping resource for women. It can reflect the model of care as well as caregivers' perspective of birth. Therefore, caregivers take an imperative part in women's coping with their birth either as a coping resource or a constraint.

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Coping Strategies During Childbirth

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Coping with childbirth initiates in pregnancy because women create goals, expectations, and perceptions on childbirth as demonstrated in previous cited studies. Most pregnant women prepare themselves for childbirth by learning about childbirth from multiple sources. However, it is doubtful whether women can transfer the learned coping strategies to actual birth event.

Antenatal childbirth education is a method that provides anticipatory coping skills and knowledge about childbirth as coping resources for women and their partner. Some women who attended childbirth education felt that they failed to implement those coping techniques from antenatal childbirth education to the actual birth environment (Spiby et al., 1999) and there were differences in women's perception of their birth (Hallgren et al., 1995).

Spiby et al. (1999) studied women's using of coping strategies they had learned from antenatal education in 121 primiparous women in England. All of the participants had a birth companion during birth. The learned coping strategies included breathing technique, position change, and relaxation. The preference included breathing technique (88% of women), position change (51%) and relaxation (40%). Most women used more than one coping strategy as in the result from the study of Niven and Gijsbers (1996) and Byrne-Lynch (1991). The most popular strategy was breathing by sighing out slowly. Encouragement from their birth companion was associated with the use of both breathing and relaxation. The women felt that their birth companions helped in using coping strategies more than midwives. Because of failure in using coping strategies during birth, some women suggested that midwives should demonstrate coping strategies upon early admission.

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There are many types of childbirth education programs for women and partners in order to provide knowledge about pregnancy and birth, as well as promote practicing coping skills for coping with birth. These programs purport to maintain maternal self-confidence and personal control. Utilizing personal coping procedures, such as breathing exercises, and relaxation, can help women cope with labor pain by increasing personal control (McCrea & Wright, 1999). Although each childbirth

education program has been accepted as helpful to clients, it has not been common implemented in Thailand yet.

Regarding coping strategies, results from many studies (Green, 1993; Spiby et al., 1999) found that breathing as well as relaxation is the most useful coping strategy women reported. Other useful coping strategies are postural change, distraction, imagery, focusing, therapeutic touch, acupuncture, music, biofeedback, hydrotherapy, massage, touch relaxation, and hot-wet compression.

Childbirth is a stressor for which each woman activates all of her strength to overcome the stress. According to the review, coping strategies most women used during childbirth included breathing techniques, position change, and relaxation (Spilby et al., 1999), as also atypical strategies, focusing, imagery, and distraction (Niven & Gijsbers, 1996). It was remarkable that most women used more than one coping strategy (Niven & Gijsbers, 1996).

Byrne-Lynch (1991) studied childbirth coping strategies in 60 first-time mothers during the first three days after birth, using a semi-structured interview and qualitative analysis. Only 20% of the participants had attended antenatal education and 35 of 60 women had a birth companion. Coping strategies were divided into four groups: movement and position change, breathing exercise or relaxation techniques, gripping/squeezing and back-rub by others.

Niven and Gijsbers (1996) found that women usually used more than one coping strategy and levels of labor pain were negatively correlated with the numbers of coping strategies women used. This prospective study was conducted initially in 101 British women, but the final sample was only 51 women. The women were interviewed three times: during the active phase of labor, 24-48 hours after birth, and

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three month postpartum. This study explored the nature, origin, and effectiveness of pain coping strategies women used during birth. The instruments were visual analogue scales and the McGill Pain Questionnaire. Although the sample was small, tape-recorded interviews were also conducted for the detail of coping strategies. The results revealed that women usually used both formal coping strategies they learned from childbirth education, and idiosyncratic strategies by focusing their mind on pain. Breathing technique was the most used strategy by 34 women. Although the sample was small, it found that the more coping strategies were used, the less the pain. However, any medication for pain relief was not presented in this report.

In spite of the extensive literatures related to women's childbirth and coping strategies from global society, they do not illustrate coping with childbirth as a process. Furthermore, the discrepancy between Thai and other countries' contexts of childbirth in hospital shows a difference in women's childbirth experiences. We have already seen that childbirth is mainly shifted from home to hospital, which from the health care providers' perspective is risk approach, and that rates for cesarean section, are increasing. Also that birth technology is increasing accompanied family absence. The missing critical evidence-based knowledge of childbirth includes the understanding of what a woman perceives of childbirth and how she has been interacting in that situation as an interactive process between herself and environment. There are major gaps in our knowledge regarding Thai women's thinking of vaginal birth and coping process during vaginal birth. This knowledge holds potential to contribute to the refinement of midwifery theory, education, and practical guidelines for optimal birth care in the Thai context.

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