CHAPTER 4

FINDINGS AND DISCUSSION

This chapter will explicate what the perception of Thai women about childbirth is and how Thai women cope with childbirth, accompanied by discussion of the findings. Scope of this study is limited to coping process of women who expect vaginal birth. This chapter will be divided into three parts. Part 1 will describe the characteristics of participants. Part 2 will describe the qualitative findings. Part 3 will describe the discussion of the findings.

Part 1 Characteristics of Participants

In this section, the personal background, demographic characteristics and pregnancy and childbirth characteristics of participants are presented as follows.

Demographic Characteristics of Participants

The participants in this study were 20 first-time mothers. The demographic characteristics of participants are presented in Table 4-1. The range of participants' age was 18 to 29 years ($\overline{X}$ =21; S.D.= 3.7). Seventeen of them (85%) were less than 25 years old. All participants lived with their husbands. Sixteen couples (80%) lived in an extended family with their parents, whereas only four couples had a nuclear family. Eleven women had finished secondary education. Five had a bachelor degree. Three had a diploma and another had primary education. Eighteen women (90%) were Buddhists and two were Muslims. Fourteen participants (70%) were

housewives, five were employees, and one was a vender. Only six women had their own income, with a range from 5,000 - 35,000 baht ($\overline{X}$ =3,668). Fifteen participants (75%) were cohabitant whereas the rest were married.

Table 4-1

Demographic Characteristics of Participants (N=20)

Characteristics		Number	Percentage
Age (years)			
	18-20	8	40
	21-25	9	45
	26-29	3	15
	($\overline{X}$ =21; S.D.=3.6)		
Religion			
	Buddhism	18	90
	Islam	2	10
Education			
	Primary	1	5
	Secondary	11	55
	Diploma	3	15
	Bachelor degree	5	25
Occupation			
	Housewife	14	70
	Employee	5	25
	Vender	1	5
Personal income (Thai baht)			
	No income	14	70
	< 10,000	3	15
	10,001– 20,000	2	10
	20,001– 30,000	0	0
	30,001– 40,000	1	5
	($\overline{X}$ =3,668)		
Marital status			
	Cohabitant	15	75
	Marriage	5	25
Status of living with husband			
	Yes	20	100

Table 4-1 (continued)

Demographic Characteristics of Participants (N=20)

Characteristics	Number	Percentage
Type of family		
Extended	16	80
Nuclear	4	20
Duration of living with husband (years)		
< 2	12	60
2-4	8	40
Couple's relationship		
Excellent	12	60
Good	7	35
Fair	1	5

The demographic characteristics of participants' husbands are presented in Table 4-2. The range of participant's husband age was 18 to 34 years ($\overline{X}$ = 25; S.D.=4.6). Thirteen participants' husbands (65%) had secondary education. Six husbands had primary education and one had a bachelor degree. Eighteen husbands (90%) were Buddhists and two were Muslims. Fifteen husbands (75%) were employees. Four of them were venders and another was a soldier. The range of the husbands' income was 3,000 – 50,000 Thai baht ($\overline{X}$ =9,727). Twelve couples (60%) had lived together for less than two years. The rest had lived together for two to four years. Twelve couples (60%) reported excellent marital relationship. Seven couples (35%) reported good relationship and another reported fair relationship.

Table 4-2

Demographic Characteristics of Participants' Husbands (N=20)

Characteristics		Number	Percentage
Age (years)			
	18-20	5	25
	21-25	4	20
	26-30	10	50
	31-34	1	5
	($\overline{X}$ =25; S.D.=4.6)		
Religion			
	Buddhism	18	90
	Islam	2	10
Education			
	Primary	6	30
	Secondary	13	65
	Bachelor degree	1	5
Occupation			
	Employee	15	75
	Vender	4	20
	Soldier	1	5
Personal income (Thai baht)			
	3,000– 10,000	14	70
	10,001– 20,000	5	25
	20,001– 30,000	0	0
	30,001– 40,000	0	0
	40,001– 50,000	1	5
	($\overline{X}$ =9,727)		

Pregnancy and Childbearing Characteristics of Participants

The pregnancy characteristics of participants are presented in Table 4-3. Eighteen participants realized their pregnancy within eight weeks of gestational age. Another two realized their pregnancy at 16 and 20 weeks. All of them received

prenatal care from health care providers; 10 in hospital, nine in obstetrician's clinics and one in both hospital and clinic. Three participants had prenatal visits to private clinics and were personal clients of an obstetrician. Thirteen participants (65%) had their first antenatal visit within the first trimester of gestational age. The rest had their first prenatal visit during the second trimester. All participants had prenatal visits more than four times and nine of them had prenatal visits ten times or more. All couples wanted a baby. Twelve participants (60%) had ultrasonographic scanning tests at least one time.

The main resources of childbirth knowledge and information included their mothers, relatives and friends. Only four participants (case 3, 4, 8, 11) reported that they bought some books and magazine about childbirth for self-preparing. Three participants (case 3, 8, 11) who reported self-preparing by reading books had a bachelor degree, whereas another had primary education. Two participants prepared themselves by following the booklet provided by hospital. One of them (case 18) was successful in coping with pain of childbirth while another (case 5) failed. Three participants (case 7, 10, 14) reported so extreme fear of anticipatory childbirth that they could not listen to others' birth stories in pregnancy. One participant (case13) feared because of her friend's fearful birth story, but her mother told her her natural birth story. Two participants (case 12, 16) had heard from their friends and mothers that childbirth was natural, thus they did not prepare themselves at all for labor pain whereas one participant (case 19) had no fear because she expected pain-relieving medication the same as her relatives' childbirth experience. Thirteen participants could not relieve their birth pain despite learning about childbirth from other experienced women. Three participants, who perceived childbirth as a natural and

easy event, did not prepare themselves at all. Some participants fortunately created their own strategies for pain relieving by trial and error, whereas some could not and felt terrible. One participant was extremely anxious when a friend told her about her difficult labor experience. Six participants reported well self-preparation; ten reported average self-preparation and four mentioned no self-preparation.

Table 4-3

Pregnancy Characteristics of Participants (N=20)

Characteristics	Number	Percentage
First realization of pregnancy (gestational age)		
4-8 weeks	18	90
16-20 weeks	2	10
Place of prenatal visit		
Hospital	10	50
Private clinic	9	45
Hospital and private clinic	1	5
Gestational age at first prenatal visit (weeks)		
First trimester	13	65
Second trimester	7	35
Number of prenatal visits (time)		
4 - 9	11	55
> 10	9	45
Wanted pregnancy		
Yes	20	100
Ultrasonographic scanning (time)		
none	8	40
1	11	55
2	1	5
Main resource of childbirth knowledge & information		
Mother	8	40
Relatives and friends	6	30
Books & magazines	4	20
Hospital booklet	2	10

Table 4-3 (continued)

Pregnancy Characteristics of Participants (N=20)

Characteristics	Number	Percentage
Perceived fear of childbirth before birth		
None	3	15
Normal	13	65
Horror	4	20
Perceived childbirth self-preparation		
None	4	20
Average	6	30
Well	10	50

The childbearing characteristics of participants are presented in Table 4-4. Twelve participants had spontaneous labor pain, whereas eight participants had medical induction. All participants had spontaneous delivery. Seventeen participants were delivered by nurse-midwives. Three participants were delivered by their personal hired obstetricians. Duration of labor pain lasted from 3 hour 20 minutes to 17 hours 30 minutes, with an average of 9 hours 16 minutes. Duration of the pushing stage varied from six to 45 minutes ($\overline{X}$ =24.5) and thirteen participants pushed no longer than 30 minutes. All babies were healthy and heavier than 2,500 grams. Half of them weighed between 2,500 to 3,000 grams. Only one baby was heavier than 3,500 grams.

Table 4-4

Childbearing Characteristics of Participants (N=20)

Characteristics		Number	Percentage
Onset of labor pain			
	Spontaneous	12	60
	Medical induction	8	40
Type of delivery			
	Spontaneous	20	100
Type of service			
	Public client	17	85
	Private client	3	15
Type of health care provider during birth			
	Nurse-midwife	17	85
	Obstetrician	3	15
Duration of labor pain (hours)			
	3.3 – 8.0	9	45
	8.1 -16.0	9	45
	16.1 - 17.5	2	10
	($\overline{X}$ =9.2; S.D.= 0.01)		
Duration of pushing stage (minutes)			
	6.0 -30.0	13	65
	31.0 – 60.0	7	35
	($\overline{X}$ =24.2; S.D.=12.0)		
Weight of baby (grams)			
	2,500-3,000	10	50
	3,001-3,500	9	45
	3,501-4,000	1	5
	($\overline{X}$ =3072; S.D.= 262)		

Part 2 Qualitative Findings

The specific objectives of this study were to understand women's reflections of their childbirth and to explore women's coping processes during vaginal birth. The qualitative findings include (1) Process of coping with childbirth by loving baby and being loved, (2) women's perceptions about childbirth, (3) coping with childbirth, and (4) self-fulfillment. Women's perception about childbirth gave an answer to the first objective. Overall findings gave an answer to the second objective.

1. Process of Coping with Childbirth by Loving Baby and Being Loved

The core category of this grounded theory study illuminated the process of women's coping with childbirth by loving baby and being loved. The basic social process of coping with childbirth was initiated by women perceiving and assigning meaning to dynamic events during childbirth as fearful events and suffering. Then women employed several coping interactions to certain events according to certain perceptions. Finally, self-fulfillment came as the consequence of this process.

"Loving baby and being loved" was indicated as the central category of the process of coping with childbirth. All participants articulated both kinds of love: loving the unborn baby and being loved by anyone. Loving baby was indicated by all participants' reflection of maternal bonding and concern for their unborn baby. Being loved was indicated by participants' reflection of being encouraged and cared for by anyone. The sense of being loved by husband and relatives was indicated by all participants whereas the sense of being loved by health care providers was indicated by fourteen participants. Both emotional senses had nurtured participants throughout

the process of giving birth. Participants indicated that a healthy and normal baby was the ultimate goal of pregnancy and childbirth, so loving baby was a vital underpinning goal of women's interaction to childbirth. Since women were discouraged by the stressful alterations of childbirth, they expressed the need of encouragement and help as the sense of being loved. Being loved during labor could be compatible to labor support. The data reflected that both loving baby and being loved generated internal strength of participants so that they could tolerate the stressful alterations of childbirth.

Women perceived childbirth as a fearful event. The issues of fear included *"fear for baby's health"* and *"fear of pain and difficult birth."* They also perceived childbirth as suffering, mainly caused by labor pain. The issues of suffering were illustrated in terms of *"characteristics of labor pain"* and *"reactions to labor pain."* Despite the same perceptions, they gave meaning to fear and suffering in different ways. When participants viewed childbirth as a challenging fearful event and a meaningful suffering, they coped with childbirth in a more positive way. These positive meanings came from loving baby and being loved. For example, some participants indicated that they were pleased to be suffering to give life to baby, so they continued using the coping strategies for successful vaginal birth. In contrast, when women viewed childbirth as threatening fearful and dreadful suffering, they gave up coping with childbirth and then asked to escape from vaginal birth by cesarean birth. Active interacting during childbirth altered women's perception and coping actions whereas loving baby and being loved, triggered by encouragement, nurtured the coping process.

To cope with perceived fear and suffering, the women employed five major strategies. The first strategy was *"building hope for a normal healthy baby and a*

natural birth." Secondly, the women prepared themselves for childbirth by *"learning about childbirth," "mind-preparing"* and *"seeking assurance."* Thirdly, self-encouraging, including *"adhering to baby and family members," "positive thinking," "enduring," "thinking of supernatural powers"* and *"comparing with other parturient women,"* were employed. The fourth strategy was self-managing with labor pain, including *"moving and changing positions," "holding objects," "effleurage, compression and massage," "breathing techniques and concentration,"* as well as *"crying."* Finally, in addition to self-coping resources, the women sought encouragement and help from their husband and family, other parturient women and health care providers.

They were able to endure to pain when the sense of loving baby remained. They expressed emotional words of loving unborn baby, including *"feeling attached to baby", "wishing the baby to be physically normal the same as other babies",* and *"wishing to see baby's face."* When participants forgot the baby, they gave up and asked for a cesarean birth. They expected familiar persons staying with them in labor to encourage and help, but family presence was inhibited by hospital rules. Due to family separation, encouragement and help from health care providers was the great expectation. Women who received encouragement and help from nurse-midwives, expressed their satisfaction with the childbirth experience in spite of physical suffering and family absence. These incidences reflected the significance of being loved in the presence of a trustful person was more than physical care.

Women regularly adhered to babies and contemplated husband and family members when they were severely painful. The suffering from prolonged severe pain discouraged women whereas loving baby and being loved enhanced women to

tolerate to pain and an unsatisfactory situation. Because of being discouraged by suffering and social isolation from their beloved family members, the encouragement by attentively verbal support and physical care from health care providers was sought. Participants rationalized that the health care provider was *"our single expert helper in this place."* They accepted the sense of being loved through encouragement by health care providers maintained their endurance during childbirth. However, some participants attempted to meet their family members to gain encouragement and help.

Following these coping strategies, the women achieved self-fulfillment, including feeling glad, released and proud. Feeling glad came from *"giving birth to a normal baby"* and *"giving birth to a healthy baby."* Feeling released came from *"getting over from pain"* and *"feeling free."* Feeling proud came from *"overcoming difficulty," "having ability"* and *"giving life."*

The illustration of women's perception, interaction and consequence in the process of coping with childbirth by loving baby and being loved is portrayed in illustration 4-1.

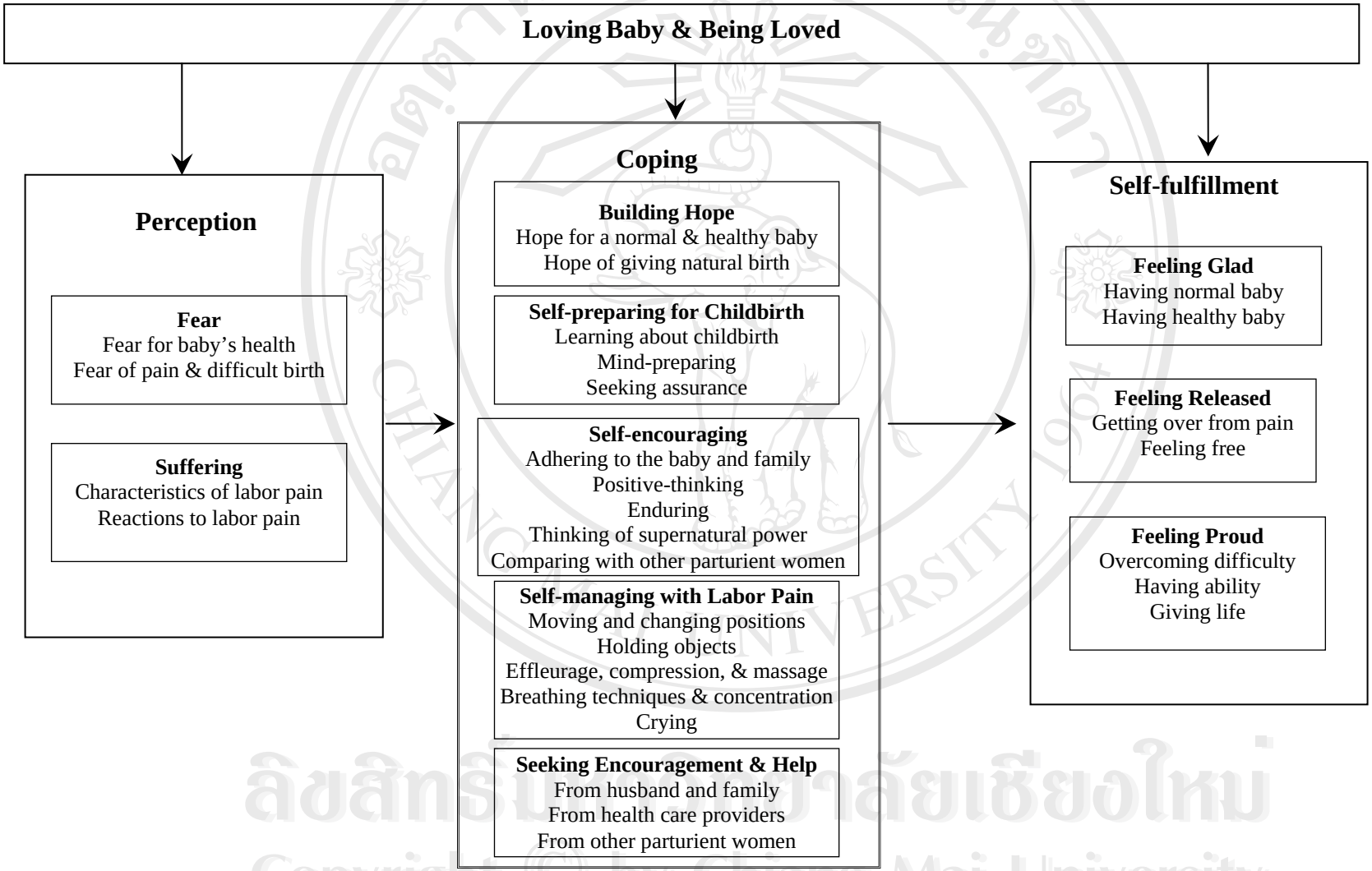

Illustration 4-1 Process of Coping with Childbirth by Loving Baby and Being Loved

2. Women's Perception About Childbirth

Participants perceived childbirth as fear and a suffering. The major reasons of fear were caused by listening to the experienced women's birth stories and their bonding with and loving baby. The issues of fear included (a) fear about baby's well-being, and (b) fear about pain and difficulty of childbirth. Ranges of fear varied from no fear, moderate fear and awful fear. The different ranges of fear led to the different coping strategies. The major reason of suffering came from characteristics of labor pain, including discomfort of pain, increasing pain intensity along the period of labor, prolonged duration of labor pain. Although perceiving characteristics of childbirth as suffering, participants gave different meanings to suffering. Some gave meaning to suffering as a challenge, whereas some gave meaning to it as threatening. Different meanings also led to different coping strategies.

2.1 Fear

Fear in pregnant women implied their safety concern or hope of a healthy outcome. Women's hope or goal about childbirth included two points: baby's physically normality and healthy *"the same as other babies,"* and their ability to give birth by themselves *"the same as other women."* This hope induced women's actively seeking self-preparation for childbirth. They avoided listening to the others' birth stories and learning about childbirth.

2.1.1 Fear for baby's health. All participants expressed their fear about baby in term of an unhealthy and malformed baby. They hoped that their unborn baby would be both normal and healthy. A 29 year-old employee who had prenatal check-

ups by two obstetricians and gave birth with an obstetrician expressed her fear about baby's health,

> *I fearful...how about my baby? I was not worried, but I was rather afraid of malformation or unhealthiness. I was afraid that the baby would be abnormal. It made me anxious. (1: 808-10)*[*]

The mothers' fear of health problems and malformation of baby was triggered by maternal bonding to baby. A participant who accidental saw a figure of an abnormal baby on television said that a certain awful picture aroused great anxiety about the baby's health. She said,

> *When I saw pictures of other babies from the television or anywhere, I was anxious about my baby's health. (15: 220-1)*

A 21 year-old participant who deliberately took a poisonous drug in pregnancy was very anxious about her baby's health. She would be guilt if the baby was abnormal. Her fear was also stimulated from hearing about a couple of mother-baby's prenatal death. It was remarkable that this woman's fear was a spontaneous negative reaction. She said,

> *I feared that the baby would be foolish or idiotic. I was anxious that the baby might be malformation because of the poisonous drug… I heard that another baby was dead together with its mother. I was afraid of being like that. (5: 380; 672-3)*

Some participants were afraid of harm to babies due to prolonged labor. They thought if the baby was in the mother's womb too long, the placenta might degenerate.

> *I thought that if the baby was too long in my womb, he or she would lack of oxygen. The respiration process might be damaged when the baby was coming out or the baby might die as a result of an amniotic fluid problem I had heard about. (8:217-9)*

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[*] (1: 808-10) indicates that this excerpt was quoted from line number 808 to 810 of case 1. This format is employed for quotations throughout this paper.

2.1.2 Fear of pain and difficult birth. Natural childbirth is generally talked about as a tremendously painful event in women's lives. A number of interventions for pain relief in labor are conducted in the modern obstetric practice in hospital, despite their being known to cause some side-effects in the baby. Participants demonstrated common fear of birth pain and fear of the childbirth situation as follows:

> *I was afraid of a difficult birth because I had no experience of birth. (4: 691)*

> *I was afraid that my birth might be so difficult that I would need a cesarean birth. I was afraid of exhaustion…I was afraid of pain from being cut. I feared that it would be painful after birth. (6: 573-4; 832)*

Despite fear of birth pain, a participant preferred vaginal birth because of perceiving more benefit from natural birth than cesarean section, such as less pain postnatally. Information about childbirth from their mothers determined the level of fear, and their beliefs and decisions about childbirth.

> *I never thought about cesarean birth because my mother told me about the pain after cesarean section. I believed that it was terrible after surgery. If I had a natural birth, it would be painful only before birth. So I decided to have natural birth. (2: 297-9)*

Despite being a natural event, childbirth was perceived as a possible risk. Some participants were afraid of the death of the baby and themselves. The causes of fear related to the participation of the childbirth situation as composed of characteristic pain and reaction to pain. Two participants were afraid that they would die because of severe pain.

> *I was afraid. I just feared that I might die…If I were dead, what would happen. My baby would not come out. Childbirth looked like a fateful event of life that I had to face. I thought about it. (5: 157-8; 654-6)*

Some participants were afraid of the environment of birth, such as being left alone, being disliked by relatives, being blamed by nurses.

She (a nurse) told me that she would turn off the light and leave me alone. I was frightened because I did not want to be alone. I needed someone to help me… I was rather afraid of being alone. (10: 639-41; 451)

Two participants were extremely fearful because they had prolonged labor pain and unexpected medical intervention.

I was afraid of the injection needle. It was my greatest fear because I had never had a saline infusion before…I was extremely fearful. I did not want any more pain. It was the most terrible pain that I had had. (10: 20-1; 584)

Another fear related to the childbirth situation was fear of hospital staff's uncaring behavior. Some participants revealed that they were afraid of an unsatisfactory interaction with health care providers, resulting in neglecting, verbal abusiveness and uncaring practices. They said,

I was afraid that hospital staff would be angry. I was just a patient so I could not ask or complain about anything. I was afraid of the hospital staff's abusiveness. (4: 526)

I was afraid that they would not treat me appropriately. I was afraid they would be abusive. (8: 1457-8)

2.2 Suffering

Suffering was specified in terms of labor pain and women's reaction to pain. Because of their first-time birth experience, women could not imagine the actuality of labor pain. When they faced the unexpected severe pain of labor, they assigned a particular meaning to certain pains as having positive or negative aspects according to their personal and environmental factors. As a result they reacted to labor pain according to that self-assigned meaning. When the severity of labor pain increased during the process of labor, the meaning of the pain was reassigned and their strategies of coping with childbirth were modified. Most women reported labor pain

as unbearable suffering. The range of suffering varied with the assigned meaning of the event and with the consequences of actions. One participant who perceived labor pain as a valuable pain for giving a baby life suffered less than those who perceived labor pain as leading to death.

> *Birthing pain was the hurt that offered the most precious life of our baby. It had value and meaning. (8:1202-4)*

Most of participants accepted that labor pain was more rigorous than they had expected and was difficult to describe. Additionally, they found that labor pain was the most terrible pain in their life. On the other hand, after birth many participants described childbirth with positive feelings.

> *The suffering was temporary, but the happiness is permanent." (5: 728)*

2.2.1 Characteristics of pain. The characteristics of pain that caused suffering included the severity of pain, the location of pain, the recurrence of pain and the prolonged duration of labor pain. The outstanding characteristic of labor pain that caused most suffering to the participants included the severity of the pain. Labor pain was perceived as the most painful experience in their life and more intense than expected.

> *Others told me that childbirth was not so painful so I did not prepare myself... I guessed it would not be very painful. But my experience was totally different. It was such a difficult birth... The pain was acutely stressful… I had cramps because of stiffness from pushing out the baby. (16: 55-6; 58-9; 125; 258)*

The severity of the pain was perceived as an unbearable suffering, which was intensified by the feeling that the body would brake down.

> *It was painful, as if each part of my body was being broken or torn apart... Well, it was terrible pain as if I was dying... At the beginning the pain was not so great, but when birth was taking place it was so extreme agonizing that I could hardly bear it. (2:64; 91-2; 687-8)*

A participant compared the severity of labor pain as of being in hell.

It was true that being in labor pain felt like being in the hell. I felt tormented. (17: 325-6)

The location of the pain was perceived differently by each woman. Some women were painful in specific parts of the body whereas others felt pain throughout the body. Most participants had backache instead of abdominal pain. Some women were painful in the area of the lower abdomen, lower back and throughout the body.

In the beginning it was ordinary; afterward I had terrible backache that was thoroughly different. (17: 95-7)

The pain at the lower abdomen made me feel as if my waist would be separated from my body. (12: 33-4)

The unique characteristics of labor pain included intermittent recurrence in addition to the more rigorous pain of the duration of labor.

The pain sometimes gave way to a painless feeling… but I could not rest. While I was sleepy, it was painful. (19: 22; 221)

Pain intensity increased with the duration of labor so they were anxious about the time taken to give birth. Many participants perceived the period of labor pain as prolonged. They wished they would be painful for only one or two hours.

When I asked for knock-out medication, was feeling the greatest pain. And I asked for cesarean birth or any kind of birth… It was the most terrible pain, awful suffering. I wanted to get away… It was the awful most suffering of my life and wanted to get away from it. (10: 471-2; 587; 1070-1)

However, most participants perceived labor pain as impossible or difficult to describe.

I can't explain about the extreme pain. It is difficult to give a true picture of. (10: 1515-6)

2.2.2 Reaction to labor pain. Many participants displayed a negative reaction to labor pain, including both physical and emotional reactions. As a life course is

dynamic, it is rather differentiate between perception, meaning and experience in an emotional event such as childbirth. All participants perceived their birth as a suffering. They assigned a different meaning to suffering as positive, negative or both. Finally, they experienced the event by interacting and reflecting on the event. While women's perceptions were clarified, some women's experiences were also mixed because of their closely evolving characteristics.

Physical reactions included exhaustion and terrible body reactions. Some participants perceived suffering as exhaustion and so bad they thought would die in the final stage of labor.

> *I was suffering as if I would die in of labor pain…It was terrible suffering as if I would be die even while breathing. I would dead although I was breathing. (5:23-4; 319-20)*

> *I was exhausted and trembling… I became worse and worse, distracted and furious from the severe pain. (15: 47; 342)*

Most participants had emotional reactions to labor pain, such as great stressfulness and irritability.

> *When it was painful, I had to wriggle… The more I push the baby out, the more pain I felt. It was stressful and the pain was unbearable so that I wished I would give birth very quickly. (10: 1270; 37-8)*

Emotional reactions also included being discouraged, lonely and frightened. As a result of their emotional reactions, being discouraged forced some participants to ask for the cesarean birth to be performed just to be free from pain.

> *I wanted to have cesarean section. I wanted to give birth very quickly so that I would be free from backache… I focused only on the pain. I wanted to give birth very quickly. (17: 179-81; 211-2)*

Another reason of being discouraged by suffering involved prolonged pain.

> *In the beginning I was alone and discouraged… The more painful, the more discouraged. It was a pain that had no relief. It was suffering. (7: 261; 266)*

Even one determined participant reflected on being discouraged by pain and exhaustion.

> *When I was in such pain, I wondered if I could give birth by myself as I could not tolerate the pain. If they did not help me with the natural birth, I would ask for cesarean birth. I thought like this for a while. (8: 498-500)*

The participants expected help and encouragement by hospital staff, whom they recognized as experts. Conversely, they felt painfully alone in the labor room. Hospital staff members were not as much available as they had expected. In addition, family members were not allowed to remain with them in the labor room. Lack of encouragement involved being more suffering and discouragement.

> *When I was alone and in pain, I wondered why they did not help me. It seemed I was alone. I was not sure I would give naturally birth. I thought it would be better to have cesarean birth. (5: 1258-9)*

Physical and emotional reactions were related. One participant forgot everything even her baby because of severe pain. She moaned because she wanted to gain release from the tension of physical pain.

> *Pain forced me to forget everything. Just wanted to quit such pain, to be free from pain immediately… Anyway I did not really want to have cesarean birth. When I asked for it, I wanted only to be free from pain… I wanted to show my pain. I wanted others to know that I was in great pain. (10: 591-2; 374-5; 631-2)*

Suffering as an uncontrollable state was the most common reaction in the late and pushing stage of labor; both feeling forced to push and feeling unbearable pain. Most participants felt extreme fear and suffering while approaching giving birth. Being alone was unpleasant because they were afraid of giving birth alone. They could not fully understand what was happening to them and what to do while the baby was coming out. They were afraid of the danger to the baby and self if nobody stayed with them.

It was an extreme feeling. It forced me to push the baby out...I could not stop pushing. The nurse asked me stop, but I could not stop. (7: 769; 340-1)

3. Coping with Childbirth

Coping interaction during childbirth was performed according to the primary appraisal of the event and the assigned relational meaning. The process of perceiving, assigning a relational meaning and interacting continuously evolved throughout the birth process. By perceiving childbirth as both fearful and involving suffering, women coped with childbirth by building hope and self-preparing for the natural birth, self-encouraging, self-managing labor pain, and seeking for encouragement and help. These strategies were explicated as follows.

3.1 Building Hope

All participants spoke of building hope against fear because of love of their baby. Women's hope included (1) Hope for a normal and healthy baby, and (2) Hope for giving natural birth.

3.1.1 Hope for a normal and healthy baby. The most significant hope included having a normal and healthy baby. Women took very good care of themselves for their baby's health and also prayed for a normal and healthy baby because they loved their baby.

It was my bonding to the baby since I knew that I was pregnant so I was interested to take care of myself for my baby… I hoped that the baby would come out safely. The great expectation was that the baby would be normal and healthy. I expected that my baby would be healthy and would not have any deformity. (1: 84-5; 79-81)

3.1.2 Hope for giving natural birth. Women preferred natural birth because they perceived more benefits from natural birth than from cesarean birth and anticipated their ability to overcome birth pain as other women did. In fact, they could not imagine the severity of labor pain they would have from the experiences of others. Building hope was a precursor of the decision to give birth naturally. Whenever women had hope for natural birth, they kept thinking positively about childbirth.

> *I never thought about cesarean birth because my mother told me about the pain after cesarean section. I believed that it was terrible after surgery. If I had a natural birth, it would be painful only before birth. So I decided to have natural birth. (2: 297-9)*

Hope to give birth naturally came from comparing self to other women. The most significant role-model for women was their mother. Other role-models were relatives and friends. Some participants learned about childbirth from booklets and documents provided by the hospital.

> *But I read a book that said others could give birth naturally, so I felt I would be able to do as the others had done. (5: 659-60)*

Some participants built hope for normal birth by seeking mental supports, such as eating magic bananas and having a holy shower, thinking of the Buddha's image, and self-hypnosis. A 25 year-old participant practiced a religious rite by praying to have a normal and healthy baby. These mental supports were suggested by their relatives, so they enjoyed the sense of being loved by family members.

> *My husband's sister advised me to sprinkle myself with holy water, and to eat magic bananas in order to give birth easily… I sprinkled myself and took anything she suggested hoping for an easy birth. (10: 229-30; 733-4)*

Another point, the baby's size, could build hope to give birth vaginally. A mother was rather confident of giving birth naturally if the baby was not too big.

My abdomen was so big that I was not sure (of giving birth naturally). I was afraid that I would not be able to give birth naturally. I would be exhausted during the pushing. (17: 624-5)

A 22 year-old determined participant reflected the sense of discouragement when she had false labor pains during pregnancy. It reduced her confidence in the ability to give birth naturally. Intermittent discouragement might be common in anticipation of the unique experience such as childbirth.

When I had false labor pains, I felt discouraged and was not sure whether I could give birth by myself. I wondered if I would be able to do it. It looked like something discouraged me. (8: 495-7)

Hope for natural birth called for self-preparing for childbirth. The data in this study demonstrates that all women actively built hope for natural birth in several ways. Finally, women who hoped to have a natural birth trusted in their own ability. Nevertheless, discouragement and encouragement were alternate throughout pregnancy, according to their perception.

3.2 Self-preparing for Childbirth

Participants prepared themselves for childbirth by learning about childbirth, mind-preparing and seeking assurance. Assurance was achieved when participants had the sense of being ready to give birth or of having self-confidence for giving birth.

3.2.1 Learning about natural birth. Participants learned about childbirth from their mothers, relatives, friends and public resources, especially those who had birth experiences. It was notable that they learned anything scarcely about childbirth from health care providers. Most participants learned about childbirth from other persons who had had birth experiences.

I learned by hearing from others who had experience. They told me about their experience. I did not learn from the clinic. (1: 568-70)

Besides persons, participants learned about childbirth from public resources such as books and magazines, television and video compact discs.

> *I knew how to push from a booklet…I was not afraid because the book from hospital taught me to be conscious during birth pain and to believe in my ability to give birth. (18: 260; 802-5)*

The participants' knowledge from what they had learned included birth pain, pushing out, and cutting and stitching up the perineum.

> *They told me about cutting and the pain of stitching up, but they did not mention anything about suffering before birth. (12: 61-3)*

No participants attended formal childbirth preparation in a hospital or clinic. However, they learned about childbirth from the booklets of the hospital.

> *I practiced self-awareness and read booklets from hospital...The childbirth preparation from the hospital booklet kept me relaxed and awake… I read only booklets from hospital. It had quite a lot…When I got the booklet from hospital, I frequently read it. I started reading and practice myself after five months of pregnancy. I practiced breathing and pushing... I read the booklet from hospital frequently when I had free time. (18:247; 395; 1055-9; 808-15; 251)*

On the other hand, at least three participants perceived childbirth as an easy natural event so they did not prepare for giving birth by reading.

> *A wife of my husband's friend who told me about birth did not mention about the terrible pain. She told me that childbirth was just ordinary. (12: 58-9)*

One participant whose mother gave birth easily did not self-prepare for childbirth because she believed that she would have easy birth the same as her mother did. However, she was disappointed.

> *Others told me that childbirth was not so painful so I did not prepare myself... I guessed it would not be very painful. But my experience was totally different. It was a very difficult birth. (16: 55-6; 58-59)*

Another participant who did not prepare herself revealed that she was not concerned about childbirth until the expected date of birth was approaching, when she became fearful about birth pain.

> *I was not afraid of childbirth at the beginning, but fear emerged when birth was approaching. I was worried about terrible pain of birth and wondered what it would be like. I thought of pain again and again.... I did not expect anything about birth. I did not know anything because I did not ask anybody how to do things or how to push the baby out. (20: 592-4; 701-2)*

Only one determined participant learned from her mother that childbirth was instinctive. Her mother also suggested how to deal with hospital staff by adopting a positive manner. Her birth was rather easy because of her positive thinking as she followed her mother's advice.

> *My mother told me that these would be pulling pain. I could understand because it was an instinct... My mother suggested that I should be patient. I had to tolerate the pain. (8: 409-11; 514-5)*

Each participant prepared herself for childbirth in some way, such as learning from the experience of others, reading books and magazines, reading booklets from the hospital, and learning from television or VCDs. Evidence from the interview indicated that the women's mother was the most significant person for childbirth preparation, whereas bonding with the baby or loving the baby stimulated women to think about childbirth and seek for safe birth and a healthy baby. Available information shaped women's perceptions about childbirth. Such perceptions guided self-preparing for childbirth. Fear aroused self-preparing, whereas the less the fear, the less the preparation. Excessive fear also inhibited self-preparing.

3.2.2 Mind-preparing. Mind-preparing was a strategy to create self-confidence and courage to give birth naturally or self-encourage. One woman expressed mind-preparing as courage to face the future.

I was fearful…but the fear was not great. But I had mind-prepared that I would give birth when it was time for birth. If it was time for birth, I would give birth. (1: 697-9)

A common mind-preparing method included comparing with others and thinking of other women's achievements.

Others could give birth naturally, so could I. Well, I thought like this. (3: 399-400)

A 27 year-old participant who was well-prepared had practiced the mindfulness program during pregnancy for easy birth. She said,

The mindfulness program promoted easy birth. During pregnancy I told myself that I would have an easy birth and both of us would be healthy. (11: 23-4)

One woman expected a positive meaning to birth pain and prepared her mind by keeping thinking positively about birth pain.

Birth pain was hurt that would create the most precious life of our baby. It was worth it... I tried to be calm when I heard about birth. It was a common event. If it was painful, I would be as quiet as if it was not painful. (8: 1202-4; 618-9)

One woman reflected on the importance of the mother's mental health after birth.

The mother should have good mental health from the beginning of pregnancy, because both physical and mental health would affect childbirth and the mother's health after birth… (11: 210-1)

3.2.3 Seeking assurance for giving natural birth. Some participants asked the physician to confirm their ability to give birth. Such confirmation helped them have more confidence about natural birth.

I was checked my vagina and pelvis for confirmation of the ability to give natural birth. The doctor told me that I could simply give birth by myself… The doctor told me that my baby was not too big or too small. (3: 1212-3; 1226)

One woman asked her doctor about health and the position of the baby because she would give birth naturally if the baby was in the normal position.

> *I asked the doctor if my baby was normal or not, whether he or she moved normally or not. Was he or she getting ready for birth? During the last visit I asked the doctor whether my baby was in the appropriate position for normal birth… I wondered if I should have natural birth or cesarean birth. Would I be strong enough to push the baby out? I was quite worried about this point. (8: 336-8; 1103-5)*

3.3 Self-encouraging

Self-encouraging referred to mental strategies that participants employed in order to keep positive feelings or to maintain hope. These strategies included adhering to the baby and family, building up positive thinking, enduring, and comparing to other parturient women. By these strategies, participants attempted to implement mental strength to diminish fear and emotional suffering.

3.3.1 Adhering to the baby and family. Baby was the major concern or ultimate goal of pregnancy and childbirth for a mother. All participants reported that they desired to see their baby's face. This inspiration came from maternal bonding to the baby. Adhering to the baby and family members encouraged participants to endure the fear and emotional suffering of childbirth. Thus, participants' adhering to their babies reflected the significance to coping with suffering from childbirth.

One 18-year-old woman adhered to her baby in order to tolerate pain, said:

> *I thought of my baby both before and after birth... Sometimes I touched my abdomen and talked to my baby. I asked my kid not hurt me. It was almost unbearable. It was painful...When it was painful, I wanted to see my baby's face. When the baby was born, I wanted to see her. How about her face? (7: 555; 101-2; 559-60)*

Three women expressed the inspiration the thought of their baby gave them. They thought that they needed to be alive for their unborn baby. They had to do anything to protect their baby from being in trouble.

> *Inspiration for my baby's life made me patient...I was encouraged by the baby. I wanted my baby safe. I thought only of the baby... I wanted to see and hug him... I thought of him. I wanted him to be alive. I had been pregnant for nine months so I did not want to lose my baby so I had to tolerate the pain. (14: 774-5; 808-9; 850; 486-7)*

One woman thought of her baby to pass the final step of pushing.

> *I thought that if I died, my baby would die too... I needed to go through the pain of birth as the final task. I would see the baby very soon. (2: 196; 348-9)*

One woman reflected that she could regain self-confidence by thinking of her baby and motherhood.

> *Although I was discouraged, I thought of my baby so that I would try as many methods as I could... I thought that I would be a mother within a few hours. So I was proud of motherhood. (13:59-60; 270-1)*

Participants kept thinking of their beloved relatives, mainly husband and mother for encouragement and help to balance the emotional suffering. Thought of verbal encouragement from husband was very helpful. A woman said,

> *I was successful in childbirth because of my husband's verbal encouragement prior to birth. He told me to be patient for our baby. (13:268-9)*

One participant had extreme suffering that made her forget about the baby; just wanted to escape from pain. She thought of and wished for death without thinking of the baby. It was not uncommon that mothers could forget the unborn baby. Therefore, this cry for death might signify that the mother needed urgent supportive care or some kind of pain relief.

> *It hurt terribly and I suffered during labor pain so I forgot my baby. I only wanted to get rid of the pain…When I was asked about my baby; I said that my husband would take care of him or her. Then I just realized that my baby*

would not survive if I died. But I still wanted to die. It was unbearably painful. (10: 1081-2; 381-3)

3.3.2 Positive thinking. Positive thinking was compared to emotional-focused coping. Individuals interacted to the event according to the assigned meaning. When women assigned positive meaning to pain and birth events, they were full of hope and had less suffering. One woman was calm because she thought that pain was for the baby's life.

I was glad that it was painful. It meant that baby would be coming out soon… Later, birth pain was a wonderful feeling of ability to give life to our baby by ourselves… Positive thinking to childbirth helped me be powerful. (8:678-9; 392-3; 1002)

When participants were more frequently painful, they thought that they would give birth very soon.

It was painful again; I had to pretend that it was not painful and thought that it was nearly the time of giving birth…I was not afraid of danger because I thought it was extremely painful because it was close to giving birth. (3: 186-7; 1198-9)

Positive thinking included self-support while hearing other women crying. One woman used many strategies, including distraction, giving positive meaning to pain, thinking of the baby and smiling.

When others cried, I tried to distract myself from pain to be relieved from anxiety… I thought that it would be okay. I would be a mother very soon. I would see my baby's face… Someone cried. But I would not be self-discouraged. I kept smiling. (11: 35-6; 49-50; 101)

When participants had positive thinking about hospital staff's manner, they suffered less. Although pain and suffering was over, one participant suffered after birth because of later negative thinking about childbirth. In the first interview she reported satisfaction because she received help from the nurses during childbirth, despite severe pain. Later she became dissatisfied with her birth experience because

she compared her experience to another participant who received excellent birth care from nurses. The sense of being loved promoted the individual's happiness. An individual was either happy or sad according to her own thinking.

> *I had extreme pain, but the nurses helped me. (15: 19 first interview)*
>
> *I walked to relieve the pain. When birth was approaching, nurses set me up on the birth table and asked me to push. They did not look at me. They were writing down at the table and I pushed out alone. (15: 681-2 second interview)*
>
> *If I were the private case of a doctor, I would have had better care. They seemed to neglect me because I was not a private case. (15: 686-7 second interview)*

Two participants who had positive thinking about the nurse-midwives and family members reflected positive childbirth experiences. Positive thinking induced thinking of others and events in a positive way. When an individual loved others, he or she was happy and reacted to others in a positive way. Positive thinking reflected that what happened to people was less important than their thoughts and reactions to such happenings. Both well-being and emotional suffering were shaped by an individual's perception of events.

> *It looked like they were not ready to work as their voices were so impolite. But I was polite to them by smiling. I gave them a smile first… Although they talked to me inappropriately, I talked to them very nicely. I wanted them talk to me nicely too… I gave them positive feelings so I said thanks to them after birth for their help. (8: 584-6; 978-9; 179-80)*

One participant also responded to the love of husband and mother by hiding her pain from their sight. This circumstance was rather different from most participants. She demonstrated the meaning of loving other by keeping the beloved happy.

> *I tried to hide my pain from their eyes (husband and mother). I wanted them to think that I was not experiencing such unbearable pain. (8: 682-4)*

One participant who feared being stitched up encouraged herself.

I thought that it was near being the end. My baby would come out so I would not feel fear any more. (3: 421-2)

Some participants encouraged themselves by focusing on the safety of the baby. Actually, the sense of encouragement and discouragement were intermittent, and alternated.

First of all I smiled and told myself it would be okay. I told myself not to be afraid… I thought that I had to push immediately for the safety of both mother and baby. (11: 47-8; 64-5)

Entry into the birth room also encouraged participants to have hope of approaching an end.

I thought in a positive way that it was nearly birth time as nurse was saying… Coming into birth room gave me hope the end was coming… I was full of hope of giving birth when entered the birth room. It would be better than waiting outside the birth room. When someone entered this room, they would quickly give birth and be healed from pain. (16: 819-20; 215; 198-200)

Some participants were encouraged by the success of other women. They compared themselves to those women and gained hope of their own success, as the following dialog shows:

I told myself that she was already free (from pain after birth). I watched her with her baby and tried to tolerate (her laughing). I felt like I would give birth very soon. (6:288-90)

3.3.3 Enduring. All participants reflected their patience with the physical and emotional reaction of intense labor pain. Women also thought of the baby for endurance. Enduring came from women's internal strength.

I had to be strong and patient. It was very important. I had to help myself as much as I could. (1: 280-1)

I had to be patient. The baby had to come out of my womb so I had to be patient. When I heard the baby's cry, I was very glad. (15: 517-8)

3.3.4 Thinking of supernatural power. Some participants talked about thinking of supernatural power and some used it accompanied with deep breathing. They were encouraged by the supernatural power.

> *I thought of supernatural power and breathed deeply many times. Pain was relieved a little. (5: 1031-2)*
>
> *I thought of Luang Phor… (name of the Buddha image). I asked for less suffering and easy birth. (7: 92-3)*
>
> *I asked my mother's spirit to help me to give birth easily. My mother died in this hospital. (17: 259)*

3.3.5 Comparing with other parturient women's situation. When participants felt the need for encouragement, they thought of others for comparison. Participants compared themselves to others' experiences for negotiating their needs and concerns, such as others also had no relatives in the labor room like them. Two participants compared their birth to experiences of the elderly women in the past for soothing themselves.

> *One elderly woman told that there was no doctor when she gave birth in her time. She gave birth with a traditional birth attendant. She said it was much better that there were some doctors at present. (7: 380-3)*

The successful birth event of others induced self-encouragement. Some participants reported that they gained hope when they saw the happiness of a new mother in the labor room.

> *I saw others that had no relatives the same as me. So I thought I was not the only one. (1: 193-6)*

3.4 Self-managing with Labor Pain

Self-managing labor pain was the physical action that women implemented for pain relieving. Self-managing strategies were mostly discovered by trial and error

and varied among persons. The method that was helpful to many participants, such as walking, might not fit some participants. Pain relieving methods were specific to each participant. They realized such methods by trying them out. When pain was advanced and available methods failed, participants tried another one by trial and error. Some participants observed and followed others' behavior. Preferred pain relieving methods included moving and changing position, effleurage, compression and massage, breathing techniques and concentration, holding objects, and crying. Holding objects and crying seemed to be the reaction to pain and suffering. However, some participants argued that both holding objects and crying were helpful.

3.4.1 Moving and changing positions. Nine participants preferred walking for pain relieving. Most participants preferred walking for pain relief after they experienced greater comfort by trial and error.

> *It was so terrible painful that I could not lie down on the bed. So I walked around… I guessed that walking relieved pain because it was shaken. When it was shaken, pain stopped. So I tried to walk. (15: 15-6; 232-3)*

Some participants walked around because they could not sit or lie down.

> *Nothing was helpful, except standing up and walking around…While walking, I was almost fainted. But I had to walk because I could not sit. (1:727-8; 44-5)*

Some participants preferred walking because they realized the benefits.

> *When I walked around, it was more comfortable than lying or sitting...Walking could speed up the cervix and it was less painful on the back. (6: 79; 508-9*

Some participants preferred walking because they perceived the benefits from trial and error. They could not lie down on their back. They discovered the benefit of movement.

The effective method was walking. It was very helpful…It was so painful that I could not lie down, just walked and walked… Walking could reduce pain. (17: 264-5; 14-5; 26)

Seven participants preferred side-lying and rolling from side to side because they could not sit or walk. When they lay down, most of them had to roll from side to side.

I had to lie down and roll from side to side, but was not restless… I had to sit up when it was very painful. (3: 179-80; 219)

Some participants preferred sitting for pain relief because they realized it was comfortable.

I walked around and sat down because I could not lie down. It was more painful when I lay down. (15: 83)

Some participants preferred uncommon positions for pain relief, such as squatting, taking the all-four position, and bending.

I shifted to all-fours. Nurses told me that I could choose any comfortable position by myself. (6: 186-7)

They moved to the most comfortable position for a while and shifted to another position.

I shifted to many positions, bending, dropping down and lying down. I found that side-lying was the best position. (8: 309-10)

They moved to more than one position from sitting to lying down and walking. Seven participants preferred sitting and only one preferred squatting. However, most participants used more than one positions to manage pain by trial and error.

I sat down and bent the body forward or sat in a meditative attitude… I sat in a meditative attitude and twisted the body, but it was less helpful. It was unbearable because I felt I was being pressed… I lifted one leg very high… I bent the body by standing beside the bed then putting my face on the bed. (15: 235-7; 246-9; 79; 195)

Positions and movement for pain relief were spontaneously realized by trial and error.

> *I did not know any method for pain relief. I tried naturally… I tried many methods for pain relief. (15: 225; 951)*

They just tried and chose the most comfortable position or movement. When it did not fit any more, they shifted to another movement.

> *Most pain relieving methods were spontaneously created by trial and error. If I found a position that helped me be comfortable, I moved to that position because other positions would hurt me. (14: 685-7)*

3.4.2 Holding objects. Several participants reacted to pain by holding or squeezing some objects. They reported that it could decrease birth pain. It was a spontaneous reaction.

> *I seized the bed. I grasped something (for pain relief). (5: 1474)*

> *I clenched my teeth and held the bed tightly because I had no idea how to relieve the pain. And I held that (pointed at the curtain). (13: 164-5)*

3.4.3 Effleurage, compression and massage. Touching is a common reaction to pain because it reduces the pain sensation. Most participants touched themselves for pain relief by effleurage, gentle rubbing on the abdomen, massage and compressing the painful location.

> *I decided to do something so I pressed and massaged my back. When nobody massaged me, I pressed myself. When it was very painful, I pressed and walked around... I gently stroked my abdomen. I sat down on the bed and leaned against the bed, then stroked the abdomen. (7: 688-9; 102-3)*

They spontaneously applied these methods by trial and error and chose some favorable methods because it gave comfort.

> *I pressed on my legs and back, applied self-massage and inhaled the vapor... I pressed on my painful abdomen for pain relief... I lay down on one side and rubbed the abdomen, then held on and breathed deeply. I found that it was the most comfortable thing to do. (8: 835; 310-1; 315-316)*

Some use effleurage from the hospital booklet.

I stroked my abdomen until pushing the baby out. I stroked my abdomen from home to hospital...I use effleurage, side-lying and sitting for pain relieving…I sat up and stroked on the painful location. I felt relief. (18: 863; 608; 166)

3.4.4 Breathing techniques and concentration. Deep breathing induced concentration naturally. When participants employed deep breathing, they were calmed by concentration on both inhalation and exhalation. Seven participants learned this technique from nurse-midwives in the labor room. Three participants learn this technique from prenatal care booklets. Four participants learned this technique from the books they bought themselves. One participant learned this technique from her sister. One participant spontaneously took to deep breathing by herself. Four participants did not know this technique. Most participants reported greater benefit from deep breathing at the beginning. However, they accepted that birth pain could not be completely relieved by any strategy.

I did not know how to relieve pain. The nurse taught me to try deep breathing and slow exhalation. Then I followed this technique. (10: 829-30)

I took deep breathing and it was better…In the beginning I took deep breathing and I felt relief from pain. (17: 190; 491-2)

One participant felt more comfortable by deep breathing accompanied by getting massage from the hospital staff.

I took deep inhalation, and then I slow exhaled. I first felt relief and then pain returned again. When the nurse massaged me, I was very well and felt less pain. (10:1278-9)

One participant concluded that deep breathing could not relieve pain. It only reduced anxiety. She considered that none of the pain relieving techniques was effective.

Deep breathing was just a little help, but the pain was not less…Deep breathing only reduced anxiety. There was no technique for actual pain relief. (16: 45-6; 178-9)

Concentration mostly occurred when women used the deep breathing technique. It seemed to distract women from the labor pain. One woman reported concentration occurred when she held objects or grasped something.

I took slowly inhalation and exhalation as if I meditated on Bud-Toh-Bud-Toh-Bud-Toh…I used deep breathing until I pushed the baby out. After birth I used this method when I felt short of breath. It was helpful… I warned myself before doing anything… When I was in labor pain, concentration was best for pain relieving. (5: 83-4; 337-8; 1324; 668-9)

Some participants used several methods.

For a while, I practiced meditation by deep breathing. It was a little helpful…I switched the method to, self-massage and deep breathing and vaporous inhalation. (7: 105-6; 704-5)

One participant preferred panting to distract from the pain.

When I used panting, I concentrated on breathing and forgot the pain…I naturally knew that I had to breathe slowly for pain relief. (2: 200-1; 80-1)

3.4.5 Crying. Most participants could not cry even though they wanted to because they were afraid that they would be rejected by the nurse-midwives. However, crying was a method for pain relief for most participants.

It could decrease some degree of pain. We could not get rid of pain so I cried for relieve it. (6: 564-5)

Many participants reported that they cried when they felt extreme pain. Hence, crying is likely to be an alarm signal of increasing pain.

I cried mentally when there was not much pain. But when pain increased, I had to cry. (10: 448-9)

Participant who got very good care and attention from nurse-midwives did not cry, excluding only two terribly painful participants. They cried because they wanted others to realize their pain. They cried after testing the nurses' reaction to crying.

> *I tested the reaction to my cry. The nurse did not reject me so I could cry. (16:158)*

> *I wanted to show my pain. I wanted others to know that I was feeling pain. (10: 631-2)*

Two participants said that they cried because they were fearing the unknown and lacked in-experience. It was remarkable that a woman who received very good care from a nurse also cried.

> *I cried because it was so painful pushing that I could not control myself. It felt like my body was being broken…I cried very loud because I had no idea what I would do next. It was my first birth. (12: 1025-7; 13-5)*

One participant cried because crying reduced tension for her. She imitated another woman who gave birth before her. In the beginning, she was afraid the nurses would criticize her. After she saw another woman cried before giving birth, she was brave enough to cry.

> *(Crying) could decrease pain, and it depended on each person… I was brave enough to cry because one woman cried and was ashamed. She cried that she would give birth. She could cry so I also could cry. She could give birth so I could too. I thought like this. (5: 255; 1329-31)*

One participant who had cried heavily before birth, talked about the nurses' reaction to her crying. She cried because she could not tolerate the severe pain of labor, which was not what she had expected about childbirth.

> *I was not brave enough to cry in the beginning. When it was terribly painful, I shouted… The pain did not decrease so I had to shout… I shouted and then she (nurse) complained that others did not cry the same as me. She concluded that I myself wanted the baby so nobody could help me…I shouted, so nurses sent me to shout in the labor room. (19: 504; 58; 157-8; 12)*

Crying might be one way of communicating the desire for help and encouragement when a person felt desperate. Participants cried either because they perceived a benefit from crying or as a reaction to pain. It was notable that most participants who learned about childbirth from books could deal with the pain without crying so much.

3.5 Seeking Encouragement and Help

Participants sought encouragement and help as the last resource after they had exercised all their internal resources in the beginning. They were rather confident in the skill and knowledge of hospital staff to provide good care and attention. When the actual birth began, they were lonely in the labor room. Although they needed encouragement and help, communication was inhibited by their own fear and the staff's manner. Therefore, self-encouragement and self-management were employed firstly to release fear and suffering from pain. Later, encouragement and help from others were sought for.

The dimensions of encouragement included the method and the source of encouragement. The methods of encouragement from others were expressed by women in the form of verbal and physical encouragement. The sources of encouragement included husband and family, health care providers, and other parturient women. The methods of encouragement were as follows.

(1) Verbal encouragement. Verbal encouragement was identified as anyone saying anything that increased a woman's ability to maintain the process of giving birth naturally or getting hope against discouragement: Verbal encouragement appeared in the data as comfort, hope, praise, and empathy.

An 18 year-old participant who was delivered by a student nurse said that verbal encouragement gave comfort.

> *It was very good that the student nurse delivered my baby because I trusted her. She talked very nicely, behaved well and supported me (6: 110-1)*

A 27 year-old participant who was unprepared for birth described the feeling of hope aroused by verbal encouragement.

> *She comforted me that birth was approaching. Actually, I did not realize that birth was approaching, but her words gave me some hope. I felt better although what she said was not true…The nurse told me that I almost giving birth. I only thought that it was almost time and I had to be patient…She told me that and I felt encouraged… I was going to give birth. But I did not know what time it was. "I was going to give birth" were the most comforting words. (16: 91-4; 815-6; 822-4)*

A 21 year-old housewife participant said verbal encouragement as praise from a nurse made her feel better.

> *I thought I felt better because in the morning a nurse talked with me very nicely. She cheered up me. She said that I pushed very well, and baby's head was almost coming out. It made me feel good. The praise gave me the will-power to push vigorously. (5: 478-80; 291-3)*

A 22 year-old participant who was unprepared for birth described her reaction to receiving sympathy from verbal encouragement as follows:

> *The nurse talked very nicely. She told me to hold on for a while. Then she stayed with me so I could tolerate pain…This nurse was very kind and talked very nicely. She told me not to cry because my baby might be short of oxygen. And she suggested I should take deep breaths, not to sigh. (20: 213-4, 222-3)*

(2) Physical encouragement. Physical encouragement was identified as pain-relieving and helped during pushing, included massage, pain-relieving guidance, being accompanied, positioning, providing physical care, and coaching pushing. These encouragement activities induced positive feelings of comfort and hope as follows:

Massage. Four participants spoke of their feelings after being massaged by nurses. For example:

> *She massaged me by using rolling balls. My back pain decreased…It also decreased anxiety…I asked her to press at my leg-cramps…She was beside me and pressed my legs when I told her that I had cramp. I felt better…She massaged and checked the baby's heart sound. (16:94-5;388; 268-9; 838;71-2)*

By trusting and sensing being loved by the nurses, a participant dared to ask for hand massaging as a preference.

> *When I was sitting, a nurse helped me and massaged me for backache…She pressed my back with a rolling ball that made me feel more painful. So I asked her to massage with her hands…I told her I disliked the rolling ball. It hurt me. Finally, she massaged my back with her hands. (17: 114-5; 115-6;122-3)*

Pain relieving guidance. All participants wanted pain relieving guidance from health care providers. Some participants received it and reported that it was useful.

> *A nurse taught me how to take deep breaths.… She helped me. She advised me if I was in terrible pain, I could walk or sit or do anything for pain relief. (9: 571; 563-4)*

A participant was distracted from pain by being taught about positioning practice by a nurse.

> *She showed me many pictures in the positioning chart and asked me try, but I had so much pain that I was not interested. But I tried when pain decreased. I was in so much pain that I could not do anything....She distracted me from pain. I could talk when the pain decreased. (16: 101-3; 646-7)*

This participant reflected her feeling of being loved as follow.

> *There was only me in the labor room so she gave me special service. She was very kind...She told me to take it easy. When I had backache and abdominal pain, she suggested that I should take deep breaths…She taught me how to relieve pain and also helped me. (17: 156-7; 189-90; 190-1)*

Being accompanied. All participants needed someone to stay with them for safety. These women reflected the happiness of having someone with them.

A 25 year-old participant who got very good care from a nurse said:

When she was going to leave the labor room, I seized her hand and asked her stay with me. I asked her not leave me because I was afraid. When she was not with me, I was full of fear. However, when she was nearby, I was reassured because she paid attention to me…I needed someone to stayed with me…Even if they could not help, it was encouraged and warmed me. (10: 1534-7; 1540-1)

A 27 year-old participant who was unprepared for birth explained her experiences:

It was still painful, but it was better because she helped me. It made me feel better... What I liked best was massage. I thought the best was having someone being with…(Feeling good) came from someone being with me, not just the massage. Even with no massage, I felt better. However, massage could relieve backache… A woman in labor needed someone being with her and talking in order to distract her from pain and have hope that she would see her baby soon. (16: 89-90; 477-8; 480-2; 570-2)

Positioning. Some participants discovered comfortable positions and movement by trial and error, but some could not. Two participants described their experiences of being positioned by a nurse.

A 27 year-old participant who was unprepared for birth said:

She had me sit in a chair as shown in a picture. She suggested the position for pain relief so I tried. But it failed to relieve pain… Another position I tried, I sat on the chair facing the backrest and put a pillow close to the backrest, then I put my head on the pillow and shook my head when it was painful. (16: 97-9; 672-5)

An 18 year-old participant who was taken very good care of by a nurse said of her experiences:

The nurse put a pillow on the bedside table and I rested my head on that pillow. I could rest, but I was kept awake by pain...The nurse helped me walk by pushing the stand of IV fluid. Walking relieved the pain. (17: 37-8; 134-5)

Providing physical care. One participant described nursing care to her as she vomited during labor pain.

I vomited because I had been having heavy morning sickness from the beginning of pregnancy to the labor period. She (the nurse) gave me some water and a basin to vomit into. (10: 107-9)

Pushing coaching. Most women who were first-time mothers wanted some help with pushing. They needed health care providers to guide them how to push.

There was a nurse guided me when I was giving birth. She told me to save energy for pushing so I would not suffer. It gave me power to push the baby. After the baby came out, I felt comfortable and free. (12: 775-7)

Although a participant understood how to push, she was happy to have a nurse coach her during pushing. It gave the sense of being loved.

The nurse told me if I had no urge to push, I might not push because it would be exhausting…The nurse suggested and guided me…She let me push if I had an urge to push, and she would help me…I felt good when the nurse told me my baby's head was coming out and cheered me to push again. (18:749;136-8; 752-3)

Participants indicated three available sources of encouragement and hope: husbands, mothers and family, other parturient women, and health care providers. All participants need to rely on the hospital staff because the family was kept out. However, what they said also reflected the need of family member's presence during labor.

The sources of encouragement included husband and family, health care providers, and other parturient women as follows:

(1) Encouragement and help by husband and family. Most participants thought of husband and mothers for their support and help. Some participants walked out of the labor room to meet husband and relatives at night. Participants sought for massage and back rub from husband and relatives as follows:

I escaped from the labor room by myself. I could open the door because it was not locked. Then I sat outside and asked my husband to massage me…

When I was nearly giving birth, I walked outside and pressed my back because of backache. (6: 640-1; 129-30)

Most relatives provided verbal encouragement and massage.

My back was rubbed (by my mother)…I went outside to talk with grandmother for pain relief, but it failed. (9: 187; 485-86)

Some relatives also taught about breathing.

My sister taught me to take deep breaths. I tried to follow her advice until I could walk. (14: 135-6)

Encouragement, appearing before them or thinking of husband and family members was a powerful way of coping with childbirth, providing the feeling of being loved. They described this as the follows:

(I sat with my husband outside labor room), I felt relaxed when I had someone near me and encouraging me. It strengthened me. (6: 647)

So many participants attempted to meet their family members to cry because of being loved by the family.

I went outside and cried with my husband in front of the labor room. (7: 281)

When a woman could not meet her husband and mother, she looked for them at the door of the labor room. She said,

For encouragement, I would look forward to seeking my husband. I sought for someone outside; my mother or husband. (8: 681-2)

She hesitated to go outside to meet the family because she was not sure if they could walk out of the labor room according to hospital rules. She said,

I wanted to go outside, but nobody told me whether I could go out to meet the family. (8: 697)

However, the women's need of family presence was common.

I wanted my husband to stay with me during the birth for encouragement. (10: 994-6)

Verbal encouragement by the husband was the most valuable encouragement when the women were full of pain and suffering. An 18 year-old participant said,

> *Then I walked out to meet my husband. He soothed me telling me to tolerate the pain. I felt that I needed to tolerate the pain for him. (7: 621-3)*

A 21 year-old mentioned verbal encouragement from her husband.

> *I was successful because of my husband's verbal encouragement prior to birth. He told me to be patient for our baby. (13: 268-9)*

(2) Encouragement and help by health care providers. All participants expected help from health care providers because of their expertise, training and authority. Women had confidence in the practices of health care providers, so they want to be attended by at least one health care provider for safety. So they pleased health care providers and complied with hospital rules, even family-woman separation. Few participants could assertively express their needs. Most participants could not even make requests so they complained or cried when they were suffering from pain. These participants said that they pleased health care providers in order to receive good care.

The first strategy for seeking encouragement and help from health care providers was trying to follow hospital rules and being polite to the health personnel. At least two women said,

> *I was asking for service and help from them so it was imperative to follow their advice… They were in their place, but we entered that place for asking help from them… (8: 970-2; 1016-7)*

> *The place had its rules. We entered that place to ask for help so we had to accept the rules of place. (16: 1020)*

By showing high respect and positive thinking to the nurses, the participants could communicate their needs, and would then receive very good care during birth. Participants' politeness was responded to by positive outcomes as follows:

It seemed to me that they were not ready to work. They had quite strong voices. But I reacted to them very well. I gave them smile… I had a respectful voice and politely talked to everybody: doctors, nurses, even a nurse-aid… Although they talked impolitely to me, I had to talk politely to them because I wanted them to talk politely to me. (8:584-6; 1009-10; 978-9)

The second strategy was following nurses' suggestions.

I realized that politely talking to nurses could change their voice and manner to be more positive… I pushed as they suggested step by step. It was all right. They approved of my performance… I cooperated with them. They suggested that I should push during contraction of the abdomen, and I did as the suggested. (8:611-2; 201-3; 985-7)

Personality and manners of the health care providers was an essential of women's interaction.

I wanted to ask about how to give birth quickly, but I could not ask. They seemed to be hostile. (6: 531-3)

If nurses did not smile, women could not approach or ask for help. When women perceived negative characteristics in the health care providers, seeking for encouragement and help was inhibited.

I could not talk to the nurses. I was afraid of verbal violence. Some nurses did not smile so I could not talk to them. (7: 494-5)

In trouble without anyone, a participant thought of her mother. It showed the need of being loved by someone.

I felt great pain, but I had to be quiet. If I was near my mother, I could cry. I could not cry with the nurses. I was afraid that they would talk roughly to me. (16: 447-8)

A participant wanted a massage, but she could not ask for help. She said,

I was afraid of asking for help because others didn't have massages.(15:354-5)

When one woman complained about her pain, she was criticized so she stayed quiet.

I felt pain so I told a nurse that it was unbearable. She said that everyone was feeling pain the same as me. She asked me whether I could not endure just a little pain. So I stopped talking. (5: 433-5)

Asking for help was directly seeking encouragement and help from health care providers. Most participants asked for help in two conditions: feeling terrible pain and being urged to push. It was common to first-time mothers because they had no experience and were fearful, especially when they were alone.

The baby seemed becoming, so I called the nurses. (6: 142)

I told the nurses that I was unable to tolerate the pain and asked them to check me. (14: 36-7)

Even a woman who was very strong and read some books about childbirth, also needed encouragement and help from health care providers, but she could not call for such help.

I thought the nurses had to attend and support me when I was almost giving birth. They had to talk with me kindly. (3: 386-8)

Participants would ask for help from the health care providers who could help them, such as student nurses or the nurse who cared for them.

I asked a student nurse to give me a massage. (6: 636)

I told the student nurses or student nurse-aids that I had labor pains. (8: 742-3)

Then student nurses asked the nurses to check their conditions.

I asked the student nurses to check the completeness of cervical dilatation. Then they reported to the nurses to check me. (8: 748-50)

One woman admitted that the student nurses were very helpful to her as coordinators.

They (student nurses) didn't tell me much but they were coordinators. If they were not there, I could not talk to anyone. (8:802-4)

The women attempted to please health care providers by compliance and were patient in spite of dissatisfaction with the help they received. They were afraid of

anticipatory verbal abusiveness so they were very polite and quiet. Crying demonstrated intolerable suffering and the need for critical care. Being very polite, crying and complaining were indirect methods of seeking encouragement and help from health care providers. Being very polite was effective, whereas crying and complaints were ineffective.

(3) Encouragement and help by other parturient women. Participants sought for encouragement and help from other parturient women by observing others' behavior and directly asking for help. Comparison with others was common in labor room. Participants learned from others' behavior what they could do or what they could not do. After some parturient women were criticized for crying, other women would be quiet.

> *When I was admitted (into the labor room), a woman was loudly criticized. It made me afraid of being that I should be ashamed. (5: 1319-21)*

Some women imitated others' behavior in labor for trial and error.

> *I saw one suffering woman relaxing after birth. She walked and sat in a wheel chair, then she moved to her bed and watched her baby… I would not cry because I saw another woman was criticized for crying. (3: 398-9; 233-4)*

Two participants talked with a new mother to gain hope and encouragement.

> *I talked to a woman. She told me natural birth was not too painful. (8: 261-2)*
>
> *I talked to a new mother. I was glad to meet her and her baby. I would meet my baby very soon so I could smile. (11: 102-4)*

Three participants sought encouragement by talking to other suffering women or observing their attempts at pain relief.

> *I thought that she was elderly so she would have had birth experience. I observed her behavior, then imitated her. (12: 526-7)*

Then there was a participant who tried to follow other women's methods of pain relieving.

> *I observed other women and tried side-lying, walking, and watched other women. (16: 173-4)*

A participant offered a method of pain relief to other women because they were in the same condition. It was an indication of friendship and love among parturient women, of solidarity.

> *I quietly observed a woman (laughing) and shared with her because we were in pain together. I asked her about her pain and we would help each other (laughing). (15: 87-8)*

4. Self-fulfillment

A sense of self-fulfillment might not be the major goal of the process of giving childbirth in the beginning. All participants reflected some variations of this sense to some degree. Initially, they expected help from expert or skillful personnel and some aspects of birth technology. At the end of the childbirth process, they claimed that they gave birth on their own with some degree of help from the hospital staff. The sense of self-fulfillment included feeling glad, released and proud.

4.1 Feeling Glad

Feeling glad was the result of having a healthy normal baby. Participants were free from pain and felt released as soon as the baby was out. Feeling glad depended on the baby's health. All babies in this study were normal and healthy, except one baby who needed phototherapy on the second day. These expressions of the mothers

confirmed the delighted they felt after giving birth to a normal healthy baby, especially hearing the baby's cry.

> *I was glad at the first meeting with the baby. I asked the nurse whether she was healthy. She said that my baby was healthy…I was satisfied that my baby was healthy…I was released and encouraged because my baby was demonstrated her good health by very loudly crying. (12: 907; 963; 227)*

> *As soon as I heard my baby's cry, I was very glad…I was very pleased to meet my baby…When I saw my baby's face; it was as if I were in heaven. (15: 516-7; 262; 632)*

Mothers asked after the condition of the baby, whether it was normal and healthy. A mother expressed her concern about her baby's condition by saying:

> *The pain was gone. I felt released that my kid was out. But I was not totally released until I knew the baby was normal. (4: 211-2)*

4.2 Feeling Released

Participants expressed the feeling of release at getting over pain and feeling free since the baby had come out of their body. Feeling released was identified with getting over the pain, accompanied by the feeling of being free. Feeling released was starkly contrasted to the terrible pain of the couple of minutes or hours before birth. As soon as the baby was born, and the body of a new life was separated from the mother; such separation and painlessness created a feeling of being free in the mother. All babies in this study were normal and healthy so the maternal outcome was rather similar.

A 29 year-old participant whose birth was conducted by an obstetrician and also received pain-relieving medication even though her labor period was only 5 hours, talked about her feelings after birth:

It seemed like something in my body was released. It was free and healed from suffering…It was free from pain as soon as the baby was out. (1: 67-9; 62-3)

All participants agreed that birth pain was the most serious pain in their life, even those who had not had much pain. It might be a natural aspect of birth that prompted a wonderful feeling of being released, with the baby's life the pain healing of birth.

4.3 Feeling Proud

Each participant expressed the feeling of being proud of herself, with the exception of only one participant who was overwhelmed by fear of pain. Feeling proud of oneself came from reflecting on the overcoming of the difficulty of childbirth, of having been able to give birth by oneself and experiencing giving life.

4.3.1 Overcoming difficulty. In the beginning most participants heard that natural birth was so painful and difficult that some mothers asked for cesarean birth. However, they could not imagine how great the pain and difficulty were. They came to birth with some estimation and expectations, such as the degree of pain, the need for pain relief. Prior to birth most of them had learned about childbirth from the folk sector, and a few had learned from bought books and health-care professional sector. After birth the participant realized childbirth was more difficult and painful than they had imagined before birth. Hence, they were proud of themselves for having the ability to overcome its difficulties.

A participant 21 years old, a secondary educated housewife, seriously prepared herself for childbirth by reading the hospital booklet about childbirth. She expected that she could give birth by herself the same as other women. However, she

thought mistakenly that she would give birth as soon as she arrived at hospital. Her special issue was the fear of her baby's malformation due to drug poisoning in pregnancy. She considered that she did not receive enough support and attention from nurses during labor. She had terrible pain, but had a short pushing stage. The labor stage was about 10 hours long and the pushing stage only 6 minutes. Her normal healthy daughter weighed 3,450 grams. She expressed feelings of being proud, and of having suffering as follows:

> *It (childbirth) was the fate of life that was risky…Everything about the childbirth event depended on me. If I had no force to push, the nurses could not help me…It was not as same as traveling or facing other challenges. Giving birth is the most challenging...I understood that it depended on me. I had to be the supporter of myself…I was so proud that I could be a mother. Err! This was my daughter! It was incredible…But I was proud that I did it. It was incredible that I could push the baby out safely, without any damage…I thought of myself positively because I was proud that I could tolerate that pain. I was very smart…My husband praised me saying I was strong enough to push all of my baby's body out…Suffering was temporary, but happiness was permanent. (5: 653; 346-7; 318-9;348-9; 224-5; 214-5; 631-2; 636-7; 728)*

A participant 18 years old, a secondary educated housewife, was not especially afraid of pain and childbirth during pregnancy. She did not much prepare herself for childbirth. The labor stage was about 7.5 hours long and the pushing stage 11 minutes. Her normal healthy son weighed 2,890 grams. She expressed feelings of pride as follows:

> *(Childbirth) made me think that childbirth was very difficult and more painful than any other experience…I was proud, proud of my ability. (6:873; 891)*

4.3.2 Having ability. To give birth naturally, feeling proud was spontaneously experienced by each participant because she perceived herself as a competent mother. All participants declared that they gave birth by themselves, that others merely provided them encouragement.

A participant 29 years old, bachelor educated, whose income was more than ฿ 10,000 as an employee, had prenatal care from an obstetrician. She had birth pain for 5 hours and had pushed for 33 minutes. She gave birth to a normal healthy boy, whose weight was 3,320 grams, by an obstetrician. In general birth practice in hospitals, nurse-midwives in labor-delivery units attended and conducted normal births, whereas obstetricians treated and conducted abnormal birth. This participant had to pay extra to the obstetrician for conducting her birth. She received special care from an obstetrician because she lacked knowledge and no experience of childbirth, and also feared childbirth and damage to her baby. After birth, she revealed her proud feelings as follows:

> *I was proud and very delighted that I could give birth by myself… I could give birth by myself, I was so proud that I could push him out… Childbirth was not as fearful as many women feared. It was not fearful or terrible if woman could give birth in a constructive environment. (1: 291; 297-8;346-8)*

A 22 year-old participant, a bachelor degree trader, had prepared well for childbirth by learning from her mother and reading many books. She also had positive thinking and showed a positive manner to health care providers, so she could give birth happily. The labor stage was about 6 hours long and the pushing stage 15 minutes. Her normal healthy daughter weighed 2,930 grams. She expressed her proud feelings as follows:

> *I was proud that I could give birth myself…Birthing pain was the hurt that corresponded with the most precious life of our baby. It was worthwhile...Both mother and nurses worked together so that childbirth was successful and safe for both baby and mother. (8: 1103; 1202-4; 175-6)*

A 25 year-old participant, a diploma educated housewife, had preparation for childbirth by hearing from husband's friends. She expected childbirth to be natural as she heard. Although she was not afraid of childbirth, she felt so much pain that she

cried and twisted her body trying to minimize the pain. Later a nurse suggested she should conserve her energy for pushing by staying calm. She said that she had easy birth after she stopped crying. The labor stage was about 10.5 hours long and the pushing stage 28 minutes long. Her normal healthy daughter weighed 2,920 grams. She expressed her feeling of pride and satisfaction with the experience of childbirth as follows:

> *I thought that the birth pain was the most extreme in my life… (Pain) was supposed to be positive as it helped me more patient. When we face problems, we would think about the most terrible pain that we could tolerate…Where there was pain, there was pride… If I was asked about excellence, I thought that I was not specially excellent because every woman could give birth by herself…I thought it was my right to be proud because I could give birth without surgery. (12: 299-300; 295-6; 292-3; 274-5; 263-4)*

4.3.3 Giving life. Giving life to the baby was the most significant goal of childbirth. Some participants realized this significance so they decided to give birth naturally. The sense of self-fulfillment by giving life was implied by relating to pain and the ability to give birth as follows:

> *Birthing pain was the hurt that was the counterpart of the most precious life of our baby. It was invaluable. (8: 1202-4)*

A participant aged 18, a secondary educated housewife, had preparation for childbirth by learning from her mother and received good support from her family. The labor stage was about 17 hours long and the pushing stage 33 minutes. Her normal healthy daughter weighed 2,770 grams. She expressed her experience of giving life as follows:

> *I thought that I was bearing pain for the sake of my baby. The baby would be alive the same as us. Giving birth taught me that becoming a mother of a human being was not easy…When the baby came out, I was so proud that I was able to push her out. (9: 751; 614-5; 433)*

A 18 year-old participant, a primary educated housewife, had preparation for childbirth by learning from relatives and friends and received excellent support from her husband. She was rather worried about the pain and her baby's health. She thought the attention by health care providers was inadequate. Her labor pain was terrible even though it lasted only about 6.5 hours long and the pushing stage only 18 minutes. Her normal healthy son weighed 3,350 grams. She spoke of her sense of giving life by comparing to her mother's giving life to her.

> *I called it (childbirth) a lesson. It taught me how terribly my mother had paid to give birth to my life. This difficulty forced me think of my mother…All the things were done by myself so that I could be patient for my baby. (14: 910-2; 522)*

The sense of fulfillment, including feeling released, glad and proud, was found in most participants whose baby was normal and healthy. Findings from this study revealed women's thoughts about childbirth as both a natural and risky event, because of the complexity of childbirth. The participants employed a variety of strategies in the process of giving birth naturally, including building hope, self-preparing for natural birth, self-encouraging, self-managing labor pain and seeking encouragement and help. Verbal and physical encouragement displayed in the findings confirmed the critical value of nursing implications to the process of giving birth naturally. Even though women argued that they gave birth by themselves, they also expressed their need for encouragement and help by significant others as well.

Part 3: Discussion of Findings

The discussion of the findings will cover two research questions that have been pursued by using grounded theory method, including Thai women's perception about childbirth and the process of coping with childbirth.

Giving birth is a common part of women's physiology and biology, but is always shaped and marked by social issues (Davis-Floyd & Sargent, 1997). At present, birth in the urban areas of Thailand is mostly performed in hospital because parturient women hope that hospital birth will be safer than home birth. Nevertheless, evidence provided by Ina May Gaskin's (2002) experiences of taking care of 2,028 pregnancies on the farm in Tennessee from 1970 to 2000 reveal that completed homebirth was 95.1% with 0% maternal mortality and 1.4% cesarean birth. Jordan (1993) found that women's birth experiences were shaped by cultural belief in each location. She compared the non-intervention attitude of the Dutch and Mayan culture to the medicating systems of the Americans and British. Cultural attitudes about birth pain impacted on women's expression of birthing pain (Jordan, 1993). Therefore, the processes of coping with child birth among women around the world are quite different, reflecting their social context.

Thai Women's Perceptions About Childbirth

Findings from this study reveal that women view childbirth as an event which is both fearful and suffered event. Although they realize that childbirth is a natural event, they also are afraid of the danger and the difficulty in the process of birth. There were some reasons and variations of these perceptions. A variety of relational meanings assigned to certain fears and suffering induced different interactions to deal with childbirth.

Fear. Fear was the most common outstanding feeling of women as found in other studies (Alehagen, Wijma & Wijma, 2001; Melender, 2002). Finding from current studies reveals that major concerns included fear about babies' abnormalities

or poor health and also the difficulties of the process of birth. Thess findings about fear were similar in Kantaruksa (2001) as well as the results from another qualitative study of Thai women (Srikanjanapert et al., 1999).

All women in this study were afraid of unhealthy and abnormal babies and the difficulty during the labor process, to some degree. These women's concerns about the baby's health and the childbirth event were similar to the findings in other studies (Melender, 2002; Melender & Lauri, 1999). Fear resulted from women's characteristics, as also the information received from environmental resources. Participants' fear about childbirth was induced by stories of experienced women. The data indicated three levels of fear: no fear, medium fear and terror. According to Lazarus (1999, 2000), an individual may appraise the event as a challenge, a threat or both. Interaction or coping is employed. Then the consequences lead to reappraisal. The cycle of personal-environmental interaction is recurrent. The findings reflected that fear was a challenge to a determined woman (e.g. case 3, 8, 11) whereas it was a threat for others (e.g. case 7, 10, 14). According to different relational meanings, a challenge induced women to have some hope, to seek information and to self-prepare for childbirth whereas a threat induced women to avoid learning and self-preparing. The data reflected that few women who had no fear (case 12, 16, 19) were inattentive to seriously learning about childbirth and preparing themselves. The few participants who viewed childbirth as terror tried to escape learning and preparing for childbirth. This finding was similar to the findings in a qualitative study regarding concerns and practices related to childbirth among Thai women in late pregnancy (Srikanjanapert et al., 1999). Participants who felt terror were nervous about childbirth so they needed help to alter their perception to a more positive aspect. The level of fear and

relational meanings to fear need to be discussed during pregnancy for the benefit of women coping with childbirth. Medium fear seems to be the most beneficial to women. Women with medium fear cope with childbirth in an appropriate way. However, it was also found that women in this study learned scarcely about childbirth from health care providers, both in pregnancy and labor. Their fear of health care providers' behaviors inhibited communication of their needs.

Women who had no fear with different expectations also coped with childbirth in a different way (case 12 and 19). A woman who had no fear because she expected natural birth did not want pain relief medication. On the other hand, a woman who had no fear because she expected pain relief medication was disappointed in having a painful labor. The findings indicated that communication and interaction between women and health care providers were subtle and essential to the process of birth care. Assessment of women's fears and expectations regarding providing assurance of safety and hope should be considered.

Suffering. Women suffered mainly from the characteristics of labor pain and the reaction to pain. During childbirth, the most stressful aspect for the women was suffering from labor pains as concluded in a Cochrane review (Lowe, 2002). Labor pain is rated as one of the most intense pains in a woman's life (Niven, & Murphy-Black, 2000) so that some women avoid this pain by choosing cesarean birth (Wichaiditsa, 1997). However, it was found that women also felt positive to labor pain. Women's perception of vaginal birth was similar to the results in several studies as a paradoxical event of both pain and happiness, or both threatening risk and a natural event (Callister et al., 2001; Hallgren et al., 1995; Lundgren & Dahlberg, 1998; Waldenstrom et al., 1996). Relational meaning played an important role in suffering

as well. Because of loving their babies, many participants perceived suffering as a chance of giving life to baby. Their coping was very different from women who perceived suffering simply as a dreadful event. The differences in coping were guided by the relational meaning of pain. It was also found that even in extreme fear and suffering, a woman (case 14) could control herself if she thought about the baby. In contrast, a woman (case 10) who forgot the baby could not control herself and asked for cesarean section.

To reduce fear and suffering, continuous support is crucial (Hodnett et al. 2003). The number of health care providers is rather limited for adequate care. From observation, one nurse-midwife took care of two to three parturient women. If there was a cesarean section, a nurse-midwife had to go to the operating room for take the baby to the labor room. Thus, only two staff members worked in the labor room at that time. There were five to eight student nurses with an instructor on occasion in the morning shift. It was noteworthy that women who gave birth during the night shift complained more about feeling alone than those who gave birth during the morning shift. Although family support should be encouraged, continuous birth companionship or family presence during birth in hospital is generally not allowed as a standard practice in Thailand. Family presence depends on the policy of the hospital. Giving vaginal birth in the hospital context seems to be a stressful event for women because support is inadequate and the intolerable stress of birth sometime necessitates cesarean birth.

Findings in this study reflected the importance of woman's perceptions to the coping strategies women use in the process of childbirth. This point was similar to Howell-White's (1997) findings that women's decision-making about their birth

methods accorded to their perceptions and social class. Riewpaiboon et al. (2005) also found that a woman who had strong concern about risk and uncertainty and had ability to pay informal expenses was more likely to choose a private or personal obstetrician.

Women in this study perceived multiple views of childbirth, including fearful event and suffering. Most women believed that they could give birth naturally because women have given birth for ages. The importance of childbirth is that it provided the chance to meet the baby they have been carrying for nine months. They hope that the baby will be physically normal and healthy. Because of risk and uncertainty, women preferred giving birth in hospital in the care of reliable health personnel and using birth technology. Finally, childbirth was a rite through which women become mothers, so husbands and family members are expected to be witnesses.

Humans live in a world of symbolic meanings that evolve in the social interactive process. They respond to objects and events and interact with others on the basis of subjective meanings that others have for them. Such meanings and selves are modified through social interaction (Herman & Reynolds, 1995). Findings from this study demonstrate that the subjective relational meanings of events seem to be more important than the reality. It was notable that the subjective meaning of the same incident was diverse and altered occasionally in each participant (case 15 and 16). For the same reason, health care providers treated each woman differently according to their subjective meaning, even in the same place at the same time (case 8). This issue reflected that the perception of an individual, not the reality, made a

difference. This point implies practical implications for enhancing pregnant women's appropriate perceptions about childbirth.

Coping with Childbirth by Loving the Baby and Being Loved

Findings from this study indicate that women coped with fear and suffering by building hope, self-preparing for childbirth, self-encouraging, self-managing with labor pain and seeking encouragement and help from others. Childbirth was an significant anticipatory life event, exciting for women, especially for the first-time mother. Because of the anticipated event, it has been common in traditional cultures that knowledge about childbirth is transferred from mother's experience to daughter within the family (Biesel, 1997; Jordan, 1993), as was true of most women in this study. Childbirth around the world is similar in the physiological aspect, but rather different in its cultural aspects, one example of which is found in southern Africa were women give unassisted birth outdoors in the bush alone (Biesel, 1997). In Thailand in the past women gave birth at home assisted by traditional birth attendants or female relations, so women learned about childbirth from observing the elder's birth in the family (Anumanrajadhon, 1998). Findings from current study reveal that participants who learned seriously from their mothers, public resources or hospital booklets were full of hope of being able to cope with childbirth. Being loved by these familiar persons maintains women's confidence in their encounter with childbirth.

Women's hopes included that (a) they would give birth to a normal and healthy baby; and (b) they would give vaginal birth by themselves. Although most participants anticipated childbirth as a painful event, they sought for assurance to manage such pain by seeking for obstetrician's birth care or knowledge about

childbirth. Participants who decided to have a natural birth were rather confident of coping with the stress of childbirth.

In labor, participants firstly relied on themselves by self-encouraging and self-managing with labor pain, because of perceived social interaction difficulty between health care providers and themselves. This finding is similar to the results from many countries, such as Mexico (Campero et al., 1998), Lebanon (Kabakian-Khasholian et al., 2000), Egypt (El-Nemar et al., 2006) and also Thailand (Liamputtong, 2004; Whittaker, 1999). Later, most participants could not manage the increasing pain so they shifted to seeking encouragement and help from external resources.

The context of hospital birth in general public hospitals may cause emotional suffering because of loneliness caused by family absence. In the beginning of labor, women feel out of place because they were separated from family and were suffering pain among unknown persons. Most of them said they felt as if they had been dumped in the labor room because they did not receive any information about childbirth and care. Such data revealed that they were scared to talk to health care providers because of the social distance and the staff members' manner. Thus, they had emotional suffering in addition to unexpectedly labor pain and social loss. This finding was similar to the findings in several studies about women's experience of hospital birth (Campero et al., 1998; El-Nemar et al., 2006; Kabakian-Khasholian et al., 2000). Many participants desired to meet their family members, but they could not express their needs or were inhibited. They used many strategies to maintain self-encouragement and self-management of labor pain, including adhering to the baby and family, positive thinking, enduring, and comparing with other parturient women. Strategies for self-managing with labor pain mostly came from trial and error, such as

moving and changing positions, breathing techniques, self-massage, and concentration. Some strategies, including moving and positioning, and massage were found to reduce pain and improve some obstetric outcomes (Simkin & O'Hara, 2002).

During childbirth all women in this study interacted with health care providers according to their subjective meaning of social interaction. The few women who maintained positive thinking about health care providers could interact with hospital staff members in a positive way. But most women were silent because they were scared of the expected negative reaction from the hospital staff. Some women found that receiving encouragement from health care providers was likely to generate a satisfying childbirth experience, and also referred to the sense of being loved. The sense of being loved was interpreted from the participants' words, but it was found only in the literature of Egyptian women's birth. However, the Cochrane systematic review confirms that strong benefits of continuous labor support accrued merely as a result of the presence of a non-professional woman (Hodnett et al, 2003). Also a study in the Thai context found that women paid informal payment for private obstetrical practice in hospital for interpersonal trust or a reciprocal relationship (Riewpaiboon et al., 2005). Thus, interaction between women and health care providers or someone during birth may be related to the sense of being loved. Although there were three sources of encouragement from data, health care provider was the best possibility. Encouragement from other parturient women was sought for because the two other sources were inhibiting. It was suggested from data in this study that there were some critical issues to be reviewed for enhancing women's experience in the process of coping with childbirth. One of these issues was interaction between women and health care providers during hospital birth.

All women had no relatives present in both labor and birth period. Most women wanted husband and family nearby during labor pains and birth, but they were reluctant to say so because of the staff's authority. They also sought for encouragement and help from relatives by walking outside the labor room to meet their relatives. Therefore, some degrees of family presence should be the policy of all labor-delivery units because its benefits are widely accepted (Hodnett et al., 2003).

The outcome of the process of coping with childbirth was self-fulfillment, including feeling released, glad and proud. The self-fulfillment as the outcome of natural birth was found in many other studies as well (Simkin, 1991; Low, Martin, Sampselle, Guthrie, & Oakley, 2003). Loving the baby and being loved were found to nurture the process of coping with childbirth. Loving the baby was described as a meaningful light of childbirth in the study about women's perceptions of childbirth and childbirth education (Hallgren et al., 1995) and the baby's well-being was focused throughout the pregnancy (Kantaruksa, 2001). The sense of being loved was only found in Egyptian women's talk about the homebirth environment (El-Nemar et al., 2006). The data in this study elaborated women's feeling of being released, glad and proud under the condition of giving vaginal birth to a normal healthy baby by the sense of self-birth.

Self-fulfillment

All women in this study gave birth vaginally to normal and healthy babies. Because they loved their baby, having a normal healthy baby was their ultimate goal and achievement. Since they perceived childbirth as a fearful event and suffering, they employed all available strategies to overcome such difficulty and achieve the

sense of self-fulfillment. Following the characteristics of childbirth, severe pain suddenly disappeared as soon as the baby was born. Feeling released from pain and feeling glad for their baby's life, served as a reward for women's strenuous work during the childbirth period. In addition, many women expressed positive feelings about childbirth as a learning experience and also as a useful experience for coping with other difficulties in the future. The sense of self-fulfillment reflected that childbirth was a developmental situation for a woman's life if they were nurtured the sense of loving the baby and being loved.

Summary

To answer the research questions as to how Thai women perceive childbirth and how they cope with it, grounded theory methodology was employed. Critical findings displayed Thai women in this study viewing childbirth as a fearful event and also suffering. They assigned a subjective meaning to certain perceptions as a challenge, a threat or both. Their coping process was guided by their subjectively constructed meaning, which included building hope, self-preparing, self-encouraging, self-managing with labor pain, and seeking encouragement and help from others. After childbirth, the sense of self-fulfillment was achieved by feeling glad, released and feeling proud. The sense of loving their baby and being loved by others maintained the process of coping with childbirth through encouragement. The central category of the process of coping with childbirth by loving the baby and being loved was portrayed by the data.