Effect of the Presence of Family Members, During the First Stage of Labor, on Childbirth Outcomes in a Provincial Hospital in Songkhla Province, Thailand

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Abstract: In Thailand, most public hospitals do not allow family members of pregnant women to be present during intrapartum. Thus, women, during labor and delivery, have to face childbirth in an unfamiliar environment surrounded only by strangers. The purpose of this study, in Songkla Province, was to compare between women, who had a relative present during the first stage of intrapartum and those who did not, anxiety levels, labor pain, satisfaction with the childbirth experience, duration of the first stage of labor, type of delivery, use of Pethidine and the babies' Apgar scores at 1 and 5 minutes. A quasi-experimental design was implemented using 114 pregnant women (experimental group n = 56; control group n = 58). Four questionnaires and a visual analog scale were used for data collection. Content validity of each questionnaire was judged by five experts in intrapartum care. To assure reliability of the questionnaires and feasibility of the research procedure, a pilot study was conducted using the questionnaires with 20 postpartum women. Data analyses were accomplished using both descriptive and inferential statistics. The findings revealed a significant difference in anxiety scores between the experimental and control groups. No other significant differences were found. The results suggest having a relative present, during intrapartum, reduces a women's anxiety. However, the findings did not support the positive effect of having a relative present during intrapartum, regarding other childbirth outcomes.

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Background and Significance of the Study

In Western countries, healthcare organizations are known to recognize the significance of family-centered care by allowing relatives of pregnant women to attend their childbirth classes and be present during their intrapartum experience.[1] However, most Thai public hospitals do not allow relatives of pregnant

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women to be present in the labor and delivery rooms. Although social support, during labor, is known to have positive effects on physical and psychological outcomes[2] little effort has been made, in Thailand, to facilitate emotional support during the childbirth experience.[3] The intrapartum period, when occurring in an unfamiliar environment surrounded only by strangers, can be a difficult time. As a result, a variety of fears associated with being pregnant and entering childbirth[4] may occur.

Childbirth can be a joyful event, but also a painful and distressful one. Although the birthing experience may be one of the most memorable events in the life of a woman, many do not look forward to the pain involved. Pain during labor and delivery is unique for each woman and has been found to be influenced by a variety of factors, i.e. culture, anxiety, fear, a previous birth experience, childbirth preparation and emotional support.[5] Because of fear of pain associated with labor and delivery, some request giving birth by means of cesarean section.[6] In 2007, 44.7% of the women who had a live birth, in the hospital used for data gathering in this study, had a cesarean section.[7]

It has been reported that the presence of a family member or friend, even if the person simply sits and does nothing, has contributed to a positive intrapartum experience.[8] The woman's selection of someone to be with her during intrapartum tends to be based upon personal familiarity, ability of the person to provide her emotional support and interest in being part of the birthing experience.[8]

In the past, Thai women often were attended during intrapartum by a female relative, in addition to a traditional birth attendant.[9] Today, they tend to give birth in a hospital setting. Only a limited number, primarily those from rural areas, deliver at home with a traditional birth attendant present.[10]

The labor process involves many physical, psychological and social changes, and experiences which may result in the woman experiencing stress and anxiety. Thus, social support and simple physical comforting activities provided, by one's relatives, seems to be needed. Some postpartum women have expressed a desire to have had their relatives with them, because they felt left alone at times during the first stage of labor.[11] In addition, those in labor have said they preferred to receive social support from relatives, since they felt more comfortable asking help from them, rather than from strangers.[3,11]

Social support during labor can be provided by professional health care providers (nurses, obstetricians, and midwives), women trained to be a birth companion (*doulas*), or one's partner/husband, relatives, or friends. Providing social support is an important function for healthcare providers and one of the strategies employed to reduce stress during labor and childbirth.[12] The main objectives of providing support are to assist each woman effectively deal with pain, anxiety, fear and coping, and have a positive childbirth outcome.[13] Social support provided by the nurse to females in labor has been identified as an important component of intrapartum care that can foster their sense of security and satisfaction with the labor experience; as well as positively contribute to the birth outcome.[14,15] Unfortunately, sometimes women are left alone during labor, due to the nurses' workload[2] This may result in the women's dissatisfaction with their healthcare and childbirth experience.

Studies have shown that having social support during intrapartum has led to: experiencing personal control during childbirth;[15] improved behavior in coping with pain;[16] a sense of security;[17] satisfaction with the childbirth experience;[15,18,19] and, an increase in the baby's Apgar scores.[20,21] In addition, prior research has shown that social support can reduce: anxiety during intrapartum;[22] length of labor;[23-28] labor pain;[8] likelihood of needing medication for labor pain relief;[21,23-26] use of oxytocin;[23] rate of forceps extraction;[23] rate of cesarean sections;[15,23,29] and, neonatal complications.[23]

A non-Thai study revealed a greater proportion of 6-week postpartum women, who were assisted by a *doula,* used breastfeeding; reported greater self-esteem; had less depression; and, had increased regard for and ability to care for their babies, compared to mothers who did not have support of a *doula*.[30] The benefits of social support, from relatives, friends or *doulas,* on childbirth outcomes, have been reported extensively in the literature.[12,15,31]

Prior studies found that women wanted their husbands to be present during their labor and delivery, because it made them feel supported,[32] secure[33] and safe.[34,35] One study has shown that not only did Thai women want to have their husbands present to provide support and encouragement, but that the husbands were able to provide the support needed during intrapartum.[34]

Given the birth experience is both a painful and joyous event, pregnant Thais have been found to expect their husbands or significant others (i.e. mother, sister, or close female friend) to be with them during intrapartum.[3] Rojanasaksothorn[36] found that Thai women, during intrapartum, were afraid of labor pain, giving birth to a deformed baby and dying during delivery. Thus, it is not surprising that Bondas-Salonen[35] found women in labor want their partners available, so they can express not only their concerns and worries, but also their joys.

In providing social support during labor, husbands of expectant women can adopt three roles: coach, team-mate, and observer.[37] Being a coach involves actively assisting and leading the woman in breathing and relaxation techniques, as well as taking responsibility for helping her manage her labor. The activities of a team-mate involves following the suggestions of the woman and/or the nurse, regarding what to do. On the other hand, as an observer he serves as a companion and can hold her hand, observe her labor and witness the birth. Ip[31] stated that most health care organizations have recognized the importance of family-centered care by allowing and encouraging the partner/husband to attend childbirth education classes and be present during his partner/wife's labor and delivery. However, husband support has been found not to be associated with: decreased duration of labor;[38] reduction in labor pain;[31] or, decreased use of analgesia.[31,32,38]

In summary, social support has been shown to decrease women's stress, anxiety and fear during the intrapartum period.[11] Social support, during intrapartum, has been found to positively influence the health and well-being of both the mother and her newborn. However, limited empirical studies, related to the effect of social support provided by family members, could be found in Thai healthcare journals.

Therefore, the purpose of this study, in Songkla Province, Thailand, was to compare, between women, who did and those who did not have a family member (husband, mother, sister, other relatives) present during their first stage of labor: levels of anxiety; levels of labor pain; satisfaction with the childbirth experience; babies' Apgar scores at 1 and 5 minutes; length of the first stage of labor; type of delivery; and, use of Pethidine.

Research Method

Study Design

A quasi-experimental design was used. Data were gathered using questionnaires, a pain analog and a retrospective review of the mothers' and newborns' hospital records.

Sample and Setting

The study setting was one hospital in Songkhla Province, Thailand, where family members usually

were not allowed to be present during intrapartum. However, for this study, special permission was granted to have family members present. Purposive sampling yielded 120 pregnant Thai women (experimental group n = 60; control group n = 60) who gave birth between April and July 2006. Inclusion criteria included Thai women who were: carrying one fetus, with a gestational age of 34-37 weeks; primiparous; married; experiencing no complications; and considered to be a public (supported by governmental healthcare funds) patient. For those in the control group, the presence of family members involved them having only visitation rights, and not being present during intrapartum. For subjects in the experimental group, one family member (husband, mother, sister or other female relative) was required to attend two sessions of childbirth preparation classes during the antenatal period, with their pregnant relative, and to be present during her first stage of labor. Childbirth classes included instructions on how those in attendance should behave and what they would be allowed to do during intrapartum. Of the 120 recruited subjects, due to incomplete data, 4 experimental group members and 2 control group participants were excluded. The final sample was 114 (56 = experimental group and 58 = control group) participants, for a 95% response rate.

Instruments

Data were collected via four structured questionnaires, including a: Demographic Data Questionnaire; Obstetrical Data Questionnaire; Satisfaction with Childbirth Experience Questionnaire; and, Anxiety Scale. In addition, pain was assessed using a visual analog scale. The, researcher constructed, Demographic Data Questionnaire requested information regarding each woman's age, income, marital status, religion, occupation and level of education. The, researcher constructed, Obstetrical Data Questionnaire sought information regarding each woman's and her baby's health, including: number of antenatal clinic visits; gestational age of fetus at birth; type of healthcare provider present during delivery; complications during intrapartum; baby's birth weight; type of delivery; use of Pethedine; duration of first stage of labor; and, baby's Apgar score at 1 and 5 minutes after delivery.

The Satisfaction with Childbirth Experience Questionnaire (SCEQ) consisted to 20 items obtaining information about the laboring women's birth experience. The original SCEQ questionnaire consisted of 15 items.[39] After five experts (2 nurses, 2 nurse educators and 1 obstetrician) in intrapartum care examined the questionnaire's content, five new items were added and some minor rewording was done on other items to make them more understandable. Nineteen of the items addressed satisfaction with the type of care delivered (physical and emotional support, medical care, coping with labor pain and health education), while one item asked about overall satisfaction with the childbirth experience. Each item was worded as a statement requesting a response that ranged from 1 = lowest level of satisfaction to 5 = highest level of satisfaction. The items were summed, resulting in a possible range of scores from 20 to 100. The higher the score meant the higher the level of satisfaction. The alpha coefficient of the questionnaire, in a previous study, was 0.82;[36] in the present study, it was 0.92.

The Anxiety Scale included 19 items that addressed feelings of anxiety during intrapartum. The Anxiety Scale, used in this study, was a modification of the Anxiety Scale developed by Boonpongmanee, et al.[39] The original Anxiety Scale consisted of 15 items; however, after 5 intrapartum care experts assessed the validity of the scale's content, 4 items were added. In addition, wording of some of the original items was changed to enhance understandability. Each item in the scale was worded as a statement that requested a

rating of 1 = never to 5 = most of the time. Four of the 19 items were stated in a positive manner and, thus, required reverse scoring. The range of possible scores was from 19 to 95. The higher the score indicated the higher the level of anxiety. The alpha coefficient for the instrument, in a prior study was 0.75.[36] However, in the present study, it was 0.83.

The Pain Scale was a visual analog (numeric rating scale) which consisted of ten levels of pain (0 to 10) noted on a horizontal line. The horizontal line was divided into equal sections, numbered 0 = no pain, to 10 = strong pain. Subjects rated their labor pain, on the visual analog pain scale, during the active phase of labor (cervix dilatation 4 – 7 cms.) by placing an "X" near the number that best reflected the level of pain being experienced.

All of the questionnaires were administered to 20 intrapartum women, in a pilot study, to assure the: revised questionnaires were reliable; questions were understandable and manageable; and, the study procedure for questionnaire administration was workable. Data from the pilot study demonstrated an alpha coefficient of 0.86 for the SCEQ and 0.78 for the Anxiety Scale. No changes in the questionnaires or the procedure were found to be necessary

Procedure

1. Data were collected after approval was obtained from the Institutional Review Board of the authors' academic institution and the hospital used for data gathering.

2. Regarding the experimental group, the researchers or their assistant (trained about the details of the research study's procedure) approached pregnant women, at the antenatal clinic, who met the criteria for inclusion and her relative. The purpose of the study and the data collection procedure were explained. Then the women and their relatives, who consented to take part in the study, were asked to sign a consent form to participate in the study.

Arrangements were made with each subject and her relative regarding the time and place of the two required childbirth classes. The first class involved the showing of a video which focused on the: hospital visiting policy; process of labor; pain relief techniques used; birth attendant's expected behavior (how to serve as a birth attendant) during the first stage of labor; treatment and nursing care for women in labor; and, potential complications, i.e. prolonged labor, prolapsed cord, pulmonary embolism, dystocia and fetal distress. In addition to the video, each woman and her relative were given a leaflet that contained the same information provided on the video. During the second class, the pregnant women's and their relatives' questions and concerns were addressed.

3. Regarding the control group, the researchers or their assistant approached, in the antenatal clinic, pregnant women who met the inclusion criteria. The study and data collection procedure was explained to them. Those consenting to take part in the study then were asked to sign a consent form to participate in the study.

4. Participants, both in the experimental and control groups, were informed they could withdraw from the study, at any time, without negative repercussions. In addition, they were asked to call the primary researcher or research assistant (phone numbers were provided) when they came to the hospital in labor. The research assistant also called the nurses in the labor and delivery room daily to check whether any of the participants were admitted.

5. Subjects in both groups were administered, 24 hours postpartum, the demographic data questionnaire, satisfaction with childbirth experience questionnaire, anxiety scale and pain analog scale. Obstetrical and other birth outcome data were obtained from each mother's and baby's medical record.

Data Analysis

Both descriptive and inferential statistics, consisting of frequencies, percentages, means, standard deviations, Chi-square and independent t-tests were used to analyze the data. The significance level was set at $p = \leq .05$.

Results

Demographic and Obstetrical Characteristics

Demographic characteristics of both the experimental and the control group can be found in **Table 1**. Subjects in both groups tended to be: married, Buddhist, a laborer or housewife with at least 9 years of formal education, present in the antenatal clinic close to 10 times, at the gestational stage of almost 39 weeks, cared for in the delivery room by a physician or medical student, and free from intrapartum complications. The only significant differences noted, between the groups, were the level of education and the babies' birth weights. The level of education was significantly higher among those in the control group, compared to the experimental group, while the babies' birth weights were significantly higher among those born to members of the experimental group, compared to the control group.

Intrapartum Outcomes

Findings revealed a significant difference in anxiety levels between the two groups, with the control group demonstrating higher anxiety scores (**See Table 2**). However, none of the other variables (labor pain, satisfaction with childbirth, Apgar scores, length of the first stage of labor, type of delivery, and use of Pethidine) were found to differ between the two groups (**See Tables 2 & 3**).

Discussion

Finding the anxiety levels of participants in the experimental group to be significantly lower than those in the control group, most likely, was due to the presence of a relative, during the first stage of labor, who had been informed about what he/she could and could not do and what would be happening during labor. Similar to these findings, prior research has revealed that social support from others (friends, relatives or nurses) can reduce anxiety during intrapartum.[22,39] In contrast, Ip[31] found no significant association between the levels of emotional support provided by husbands and their wife's level of anxiety during intrapartum. Of interest is that the majority, in both groups, reported moderate levels of anxiety. Human beings often tend to demonstrate moderate levels of anxiety, even under normal circumstances, because anxiety is a biological function necessary for survival.[40] Normally, pregnant women report a level of anxiety related to fear of complications related to themselves and their baby.[4,36] Women in labor might feel a keener awareness about their bodies and the possibility of unexpected health problems. Thus, they report experiencing a moderate level of anxiety.

The fact that no significant differences were found, between the groups, regarding satisfaction with the childbirth experience and labor pain may have been due to the women, in both groups, having similar durations of the first stage of labor. If the duration of the first stage of labor had not been lengthy, it is likely they would have perceived lower levels of pain and more satisfaction with the childbirth experience.

Both groups reported pain levels between 6 and 7 on the pain scale, suggesting their pain was in the high to moderate range. Assessing one's labor pain at a high to moderate level, rather than at a high level (8-10) on the analog scale, also may have contributed to the women's satisfaction with the childbirth experience. Although those in the experimental group had the

Table 1 Comparison of subjects' demographic and obstetrical characteristics (n = 114)

Variables	Experimental Group (n = 56)		Control Group (n = 58)		χ^2/t
	No.	%	No.	%	
Age (range 18- 32 years)	$\bar{X}$ =	23.91	$\bar{X}$ =	23.50	.52 ns
	SD =	4.52	SD =	4.01	
Income	$\bar{X}$ =	7,456.07	$\bar{X}$ =	8,671.05	-1.27ns
	SD =	3,850.39	SD =	6,057.23	
Marital Status					
- Single/separate	4	7.1	6	10.3	.365ns
- Married	52	92.9	52	89.7	
Religion					
- Buddhist	35	62.5	38	62.5	.113ns
- Muslim	21	37.5	20	34.5	
Occupation					
- Labor	22	41.5	24	43.6	.130ns
- Own business	9	17.0	11	20.0	
- House wife	22	41.5	20	36.4	
Education Level					
- Primary school	9	16.1	16	27.6	8.236*
- High school 3	23	41.1	15	25.9	
- High school 6	16	28.6	10	17.2	
- Certificate or graduate school	8	14.3	17	29.3	
Number of Visits Antenatal Clinic	$\bar{X}$ =	10.30	$\bar{X}$ =	9.51	1.32ns
	SD =	3.19	SD =	1.32	
Gestational Age at Birth	$\bar{X}$ =	38.93	$\bar{X}$ =	38.56	.86ns
	SD =	1.83	SD =	2.35	
Health Care Provider during Delivery					
- Nursing student/Nurse	17	30.36	19	32.76	.076ns
- Medical student/obstetric	39	69.64	39	67.24	
Complications during Intrapartum					
- Yes	8	16.3	8	15.1	.03ns
- No	41	83.1	451	84.9	
Babies' Birth Weights	$\bar{X}$ =	3,153.37	$\bar{X}$ =	2,947.80	2.58*
	SD =	335.83	SD =	447.79	

* p <.05; ns = not significant

Table 2 Comparison of intrapartum outcomes: Anxiety, labor pain, satisfaction with childbirth, Apgar Scores and length of first stage of labor (n = 114)

Variables	Experimental Group (n = 56)		Control Group (n = 58)		t
	$\bar{X}$	SD	$\bar{X}$	SD	
- Anxiety	50.35	8.12	54.74	10.30	-2.13*
- Level of Labor Pain	6.60	2.37	6.48	1.95	.31ns
- Satisfaction with Childbirth Experience	67.23	10.26	66.00	0.45	.64ns
- Apgar Score of 1 Minute	8.80	.457	8.75	.547	.49ns
- Apgar Score of 5 Minutes	9.57	.656	9.58	.596	-.09ns
- Length of First-Stage of Labor	8.70	3.48	8.58	4.54	.14ns

*p < .05; ns = not significant

Table 3 Comparison of intrapartum outcomes: Type of delivery and use of Pethidine (n = 114)

Variable	Experimental Group (n = 56)		Control Group (n = 58)		χ^2
	n	%	n	%	
Type of Delivery					
- Normal delivery	40	81.6	52	92.9	3.04ns
- Cesarean section	9	18.4	4	7.1	
Use of Pethidine					
-Yes	2	3.6	6	10.3	2.00ns
- No	54	96.4	54	89.7	

ns = not significance

added benefit of social support, from the presence of a relative during the first stage of labor, the women in the control group did receive support from relatives during visiting hours, as well as from healthcare providers in attendance during the labor process.

The findings were inconsistent with those of a prior study, wherein women, who had social support from a relative during intrapartum, were found to have a more positive childbirth experience than those who did not have support.[19] In addition, prior studies have

found the presence of labor partners, during the first and second stages of labor, significantly improved the women's subjective experience of childbirth.[15,18]

Regarding labor pain, Ip[31] found that a husband's support did not help to reduce labor pain; while Hodnett[13] found the presence of support from others can reduce labor pain. Previous research also has revealed that women, who receive childbirth training and have a "supporter" present during intrapartum, report lower mean scores of labor pain than do those who do not have training or a "supporter" present.[26,32] Unfortunately, this was not demonstrated in this study. Quite possibly this finding was related to the educational level of the women in this study. Over 50% of subjects, in both groups, were educated at or below the 9th grade level. Their limited formal education could have hindered their ability to accurately assess their level of pain.

The fact that no significant differences were found, between the two groups, regarding the babies' Apgar scores at 1 and 5 minutes, is contrary to Collins and associates' findings, wherein social support improved the babies' Apgar scores.[20] The fact that no difference was found between the groups may have been related to the high quality of intrapartum care the women received. In the hospital, where data was gathered, close monitoring by nurses of both the women and their fetuses, along with appropriate interventions, has lead to a decrease in the incidence of complications. For example, the incidence of birth asphyxia, in 2007, was only 3.59%.[7]

The findings, of this study, revealed no significant difference, between the experimental and control groups, regarding the duration of the first stage of labor. This finding is similar to prior findings.[19,26,29,39] However, previous research also has shown that a husband's or companion's support, during labor, can reduce the duration of labor.[18,21,24,25] Having childbirth preparation classes also has been found to shorten the duration of labor.[14,27,28] Thus, the effect of social support and childbirth classes on one's duration of labor remains inconsistent.

No difference was found between the groups regarding the type of delivery (normal-vaginal vs. cesarean section). This is similar to the findings of Campbell and associates,[18] but dissimilar from the findings of other studies, wherein social support has been found to reduce the rate of cesarean sections.[15,23,24,29] Thus, the effect support during intrapartum has upon the type of delivery a woman experiences remains controversial.

Lastly, no significant difference was found, between the two groups, regarding the use of Pethidine. However, those in the control group did use it more (10.3%) than did the women in the experimental group (3.6%), even though the participants in the experimental group ranked their pain higher than did those in the control group. Some prior research has suggested that husband support is not associated positively with the use of analgesia.[21,38] In Thailand, Pethidine tends to be used only when women are in severe pain, since it can have adverse effects upon the baby's health status.

Conclusion

The only outcome that demonstrated a significant difference, between the groups, was level of anxiety, which was lower for the participants who had a relative in attendance during the first stage of labor. Reasons for a lack of significant differences, between the two groups, regarding the other outcome variables were discussed.

The fact that the presence of a relative, during the first stage of labor, had an impact on lowering the subjects' level of anxiety is a factor that should be considered regarding the existing policy that does not allow relatives to be present during intrapartum. In addition, future research needs to be conducted on the

impact the presence of husband's/partners during the childbirth experience has on Thai women regarding birth outcomes.

This study does have limitations. The research was carried out in only one hospital in Songkla Province, Thailand. In addition, since some of the data relied on the women responding to questionnaires, the researchers had to assume the women were truthful and understood the questions being asked.

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References

1. Simkim P. The labor support person: Latest additional to the maternity care team. Int J Childbirth Educ. 1992; 7(1): 19-27.
2. Yuenyong S, Jirapaet V, O' Brien BA. Support from a close female relative in labour: The ideal maternity nursing intervention in Thailand. J Med Assoc Thai. 2008; 91(2) : 253-60.
3. Chunuan S, Somsap Y, Pinjaroen S, Tiansawad S, Nangham S, Jeamamornrat A. An evaluation of childbirth policy in Thailand: A case study in the southern part of Thailand (part 1). Thai J Nurs Res. 2007; 11(4): 227-39.
4. Melender H. Experience of fears associated with pregnancy and childbirth: A study of 329 pregnant women. Birth. 2002; 29(2): 101-11.
5. Basavanthappa BT. Textbook of midwifery & reproductive health nursing. New Delhi: Jaypee Brothers; 2006.
6. Ryding EL. Investigation of 33 women who demanded a cesarean section for personal reasons. Acta Obstet Scand. 1993; 72: 280-5.
7. Labour and Delivery Room, Songkhla Hospital. Obstetrical statistics during intrapartum in the year 2007. Songkhla: Songkhla Hospital; 2008.
8. Lavender T, Walkinshaw SA, Walton I. A prospective study of women's views of factors contributing to a positive birth experience. Midwifery. 1999; 15: 40-6.
9. Anumanrajadhon P. The birth cultures of Thailand. Bangkok: Siam; 1998.
10. Thailand National Statistical Office. Thailand Multiple Indicator Cluster Survey December 2005 – February 2006, Final Report. Bangkok: National Statistical Office; 2006.
11. Chunuan S, Kala S. The effect of stress on childbirth outcomes. Thai J Nurs Res. 2004;6(1): 1-13
12. Too S. Stress, social support and reproductive health. Mod Midwife. 1997; 7:15-9.
13. Hodnett E. Nursing support of the laboring women. J Obstet Gynecol Neonatal Nurs. 1996; 25(3): 257-64.
14. Gagnon AJ, Waghorn K. One-to one labour nurse support of nulliparous women stimulated with oxytocin. J Obstet Gynecol Neonatal Nurs. 1999; 28: 371-6
15. Madi BC, Sandall J, Bennett R, Macleod C. Effects of female relative support in labor: A randomized controlled trial. Birth. 1999; 26: 4-10.
16. Dusiyamee C. The effect of progressive relaxation awareness on pain coping behavior and delivery outcome in primigravidas with having support or during labor [thesis]. Khon Kaen: Khon Kaen Univ.; 2000.
17. Hodnett E. Nursing support of the laboring women. J Obstet Gynecol Neonatal Nurs. 1996; 25(3): 257-64.
18. Gacum P. Effects of husband's helping their wives during first stage of labour in primigravida on self-control, need of pain medication, duration of labour, and birth experience perception [thesis]. Bangkok: Chulalongkorn Univ.; 1991.
19. Sankasuwan S. Effect of using childbirth preparation program on labor pain coping behavior, duration of first stage of labor, and perception of childbirth experience in primiparas [thesis]. Bangkok: Mahidol Univ.; 2000.
20. Collins NL, Dunkel-Schetter C, Lobel M, Scrimshaw S. Social support in pregnancy: Psychological correlates of birth outcomes and postpartum depression. J Pers Soc Psychol. 1993; 65(6): 1243-58.
21. Campbell DA, Lake MF, Falk M. A randomized control trial of continuous support in labor by a lay doula. J Obstet Gynecol Neonatal Nurs. 2006; 35(4): 456-64.

22. Tarasak S. The relationship between coping-support nursing care and anxiety of parturients [thesis]. Bangkok: Mahidol Univ.; 1997.
23. Kennell J, Klaus M, McGrath S, Robertson S, Hinkley C. Continuous emotional support during labor in a US hospital: A randomized controlled trial. JAMA. 1991; 265 (17): 2197-201.
24. Klaus MH, Kenel JH., Robertson SS, Sosa R. Effect of social support during parturition and maternal and infant morbidity. BMJ. 1986; 293(6547): 585-7.
25. Pascoe JM. Social support during labor and duration of labor: A community based study. Public Health Nurs. 1993; 10(2): 97-99.
26. Tuntanokij J. The effects of childbirth training program for pregnant women and supporters on pain level, pain coping behaviors, laboring period, and childbirth experience [thesis]. Bangkok: Mahidol Univ.; 2006.
27. Yosathien B, Khunsombuthi L, Intrapichase S, Prakitkprnchai A. Effect of training program on coping with pain, duration of labour, baby's Apgar score among pregnant women in labour. J Nurs Sci. 1999; 17(2): 54-63.
28. Promrak P. The effect of integrated pain management program on labour pain, length of labour, and childbirth experience in primiparous mothers [thesis]. Bangkok: Mahidol Univ.; 2004
29. Klaus MH, Kennel JH, McGrant S, Robertson SS, Hinkley C. Continuous emotional support during labor in a US hospital: A random control trial. JAMA. *1*991; 265(17): 2197-201.
30. Hofmeyr GJ, Nikdem VC, Wolman WL, Chalmess BE, Kramer T. Companionship to modify the clinical birth environment: Effects on progress and perceptions of labour, and breastfeeding. BJOG. 1991; 98(8): 756-64.
31. Ip WY. Relationships between partner's support during labour and maternal outcomes. J Clin Nurs. 2000; 9: 265-72.
32. Niven C. How helpful is the presence of the husband at childbirth? J Reprod Infant Psychol 1982; 3(1): 45-53.
33. Jones B. Who say it doesn't hurt. Nurs Mirror. 1985; 160:29-31.
34. Rice PL, Naksook C. The experience of pregnancy, labour and birth of Thai women in Australia. Midwifery. 1998; 14(2): 74-84.
35. Bondas-Salonen T. How women experience the presence of their partners at the births of their babies. Qual Health Res. 1998; 8(6): 784-801.
36. Rojanasaksothorn S. A study of stress in pregnancy [thesis]. Bangkok: Mahidol Univ.; 1986.
37. Chapman L. Searching: Expectant fathers' experiences during labor and birth. J Perinat Neonatal Nurs. 1991; 4 (4):21-9.
38. Yim IW. The effect of the husband's presence during labour in Hong Kong. J Clin Nurs 1997; 6: 169-70.
39. Boonpongmanee C, Chunuan S, Somsap Y. Effects of empowerment and continuous support on psychological factors, pain coping behavior, and birth outcomes. Songkla Med J. 2005; 23: 37-47.
40. Carr CA, Schott A. First stage labor. In: Walsh LV. Midwifery: community-based care during the childbearing year. Philadelphia: Saunders; 2001. p. 271.

ผลของการมีญาติเฝ้าในระยะที่ 1 ของการคลอดต่อผลลัพธ์ของการคลอดในโรงพยาบาลประจำจังหวัดแห่งหนึ่งในภาคใต้

โสเพ็ญ ชูนวล, เยาวเรศ สมทรัพย์, สุธรรม ปิ่นเจริญ, ศวิตา ธิติมาพงศ์, สุดใจ นางาม, ฝนทอง องค์พลานุพัฒน์

บทคัดย่อ: โรงพยาบาลของรัฐบาลในประเทศไทยส่วนใหญ่ไม่อนุญาตให้ญาติของหญิงตั้งครรภ์เฝ้าคลอด ทำให้หญิงระยะคลอดต้องเผชิญกับสิ่งแวดล้อมที่ไม่คุ้นเคยท่ามกลางคนแปลกหน้าโดยลำพัง วัตถุประสงค์ของการศึกษาครั้งนี้เพื่อเปรียบเทียบระดับความวิตกกังวล ความเจ็บปวดในระยะคลอด ความพึงพอใจต่อประสบการณ์การคลอด ระยะที่ 1 ของการคลอด ชนิดของการคลอด การใช้ยาระงับปวด Pethidine และค่าคะแนน Agpar ของทารกนาทีที่ 1 และ 5 ระหว่างกลุ่มทดลองที่มีญาติเฝ้าคลอดในระยะที่1 ของการคลอดกับกลุ่มควบคุมที่ไม่มีญาติเฝ้าคลอดในจังหวัดสงขลา การศึกษากึ่งทดลองนี้มีกลุ่มตัวอย่างเป็นหญิงตั้งครรภ์ 114 คน (กลุ่มทดลอง 56 คน และกลุ่มควบคุม 58 คน) เครื่องมือวิจัยประกอบด้วย แบบสอบถาม 4 ชุด และแบบวัดระดับความปวด เครื่องมือวิจัยได้ผ่านการตรวจสอบความตรงโดยผู้เชี่ยวชาญ 5 ท่าน หลังจากนั้นนำไปทดลองเก็บข้อมูลกับหญิงหลังคลอดจำนวน 20 คนเพื่อหาความเที่ยงและความเหมาะสมของเครื่องมือ วิเคราะห์ข้อมูลโดยใช้สถิติบรรยายและสถิติอ้างอิง ผลการศึกษาพบว่าคะแนนความวิตกกังวลของกลุ่มทดลองและกลุ่มควบคุมมีความแตกต่างกันอย่างมีนัยสำคัญทางสถิติ ส่วนตัวแปรอื่น ๆ มีค่าแตกต่างกันอย่างไม่มีนัยสำคัญทางสถิติ อย่างไรก็ตามผลของการศึกษาครั้งนี้ไม่สามารถสนับสนุนผลของการมีญาติเฝ้าต่อผลลัพธ์ของการคลอดอื่น ๆ

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