Original Article

A comprehensive description of delivery pain using a qualitative approach

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ABSTRACT

Introduction: Description of delivery pain and paying attention to all aspects of pain due to its unique nature face many challenges. This study was conducted with the aim of comprehensive description of delivery pain. Methodology: This is a conventional content qualitative study. The required data were collected through an in-depth personal interview with 17 qualified mothers with normal birth experience. Then, delivery pain perception was defined. Inclusion criteria of this study was to have a normal delivery without complication and a gestational age of 37 weeks or older and a good informant. Exclusion criteria included the inability to speak Persian language, having mental disorders, instrumental normal delivery, and caesarian section termination for any reason, high risk pregnancy, infertility, addiction and drug use. Results: The participants in this study had a mean age of 33 years and most of them had a bachelor level of education and had moderate level of income. The results of the qualitative phase led to the identification of 14 subclasses and 5 main classes, including "Preparation to experience delivery pain, the nature of delivery pain, stressors during delivery pain, perceived support during delivery pain and a time for transcendence". Conclusion: The results of the study showed that all patients had appropriate behavioral and therapeutic measures in order to achieve pleasant and safe delivery.

Keywords: Comprehensive approach, normal delivery, qualitative study

Introduction

In the process of delivery, experience of pain is part of the inherent and biological process. While it is a reality in the delivery process, it can be associated with deep psychological and even spiritual experiences due to its existential nature [1, 2]. Evidence suggests that this pain can make a person aware of the body's intelligence and inner capabilities and reach to another stage of human evolution or spiritual development, if physical, mental and psychological interaction occurs. Some researchers argue that pain for both the mother and embryo means transition to a new development and a threshold stage for the completion of the maternal role. It finally leads to the optimal mental, physical, and psychological health of the individual during delivery. Thus, its nature is different from the pain caused by the disease, trauma or surgery and should not be perceived as physical harm or suffering [3]. Statistics in Iran indicated that 60% of primiparous women and 40% of multiparous women reported severe pain during delivery [4]. The important issue is that women will gain important experiences during tolerating this severe pain, which will remain in their minds throughout their lives. Therefore, in order to achieve positive experience with delivery pain, a merely clinical and medical management approach to reduce delivery pain is not enough and it is necessary to recognize the meaning of pain and women's full perception of this unique experience and to provide appropriate behavioral responses by midwives, physicians, and nurses. It can be very important to create satisfaction with the experience of delivery pain. Unfortunately, despite Iranian religious and cultural backgrounds in emphasizing the value of normal delivery during the last few decades, improper interventions of physicians have caused problems for women in complince with global standard criteria of the normal delivery.Most of the domesic studies have merely described the experience of pain severity of delivery or mainly examined types of pain reducing techniques with a quantitative and interventional approach and compared them

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with each other. Thus, the researcher decided to identify the deep feelings of women using the delvery experience of women and by discovering these experiences, he wants to find the ways to make the pain pleasant and transfer properly to the maternal stage. Thus, this study was conducted to describe delivery pain comrehensivly.

Methodology

In this study, a qualitative conventional content analysis method was used to obtain the deep experiences of the women [5]. The research population was selected purposefully. The research population included 17 mothers with normal delivery experience with maximum diversity in terms of age, job, socioeconomic status, and educational level. The inclusion criterion of this study included normal delivery without complication and a gestational age of 37 weeks or older and a good informant. Exclusion criteria included the inability to speak Persian language, having mental disorders, instrumental normal delivery, and cesarean section termination for any reason, high risk pregnancy, infertility, addiction and drug use. After obtaining license from the University's Ethics Committee (code: 1394-1577) and obtaining informed consent from the participants, data were collected through in-depth and semi-structured interviews**.** Interview began with the main question ("state your experience with delivery pain") and interviews were conducted individually in a relaxed environment for 30 to 90 minutes. The research environment in this study was the postpartum care unit of Shiraz Medical Sciences Maternity Hospitals. Finally, a general analysis was performed by using MAXQD A 10 software and the content analysis technique by using Graham Him and Lundman method [6]. Thus, after reading the entire text, the explicit and hidden themes were identified as semantic units and converted into primary codes. By organizing them based on their relations, the similar classes indicated the subclass of data and different classes indicated the main classes. In order to ensure the accuracy of the qualitative data, according to the principles provided by Guba and Lincoln, the acceptability criteria and the review of the accuracy of expressions expressed by the participants, capability of conformation of results by review of the observers and transferability of results were used [7, 8].

Results

The participants in this study had age between 27 and 56 years and a mean age of 32.2 years. None of them were primiparous women and 8 of them were multiparous women. Most of them (58.8%) had bachelor level of education. Only 4 of them had delivery physiologically and without any intervention, and the majority of them were in the middle class in terms of income. During the analysis stages, after formulating the appropriate text from the participants' experiences, the semantic units were first identified. Then, they were encoded and codes were classified by continuous comparative analysis approach to form the sub-classes. Given the relations of the classes, the main classes were formed. Accordingly, 18 interviews were performed with 17 people, and one interview was performed to complete the findings and resolve the ambiguity. Finally, 735 codes were formed, and with the classification of similar codes, 14 sub-categories were formed, and with the integration of similar sub-classes, five main classes were formed **[Table 1]**.

Table 1. main classes and sub-classes extracted from primary codes in the qualitative stage of the study of explaining the concept of delivery pain

Main classes	Sub-classes
Preparation to experience the delivery pain	Non-acceptance of normal delivery pain
	Acceptance of normal delivery pain
	Pattern of severity and progressive reduction of delivery pain
	Coping strategies
Delivery pain nature	Different experience
	Positive tolerance
Stressors of delivery pain	Internal Stressors
	External Stressors
Perceived support during the delivery pain experience	Support of others
	Caring resources support
A time for transcendence	Conflicting emotions towards pain
	A new insight to pain
	Self-actualization
	Spiritual flourishing

Discussion and Conclusion

While delivery pain and its biological nature are a reality, this pain in humans is affected by the social, cultural and even spiritual conditions of life and it make individuals experience and perceive it differently. The objective of this study was comprehensive description of delivery pain with a conventional content analysis approach. The main classes extracted by this analysis include five themes: "Preparation to experience the pain of normal delivery, the nature of the pain of normal delivery, stressors during normal delivery, perceived support during normal delivery pain and **a time for transcendence".** In support of our study and the importance of humanizing the delivery, the results of the qualitative study conducted by Boryr et al. (2016) also suggest the extraction of five themes of "spiritual and religious beliefs", "the continuous support and presence of midwife and delivery room staff", "support of spouse and family during pregnancy and encouragement to delivery ", " the use of drug- and non-drug analgesia", and finally, the lack of knowledge on delivery room and the lack of knowledge on structured delivery process ". In fact, mothers received more relaxation from humanistic support to modern equipment [9].

The qualitative class of " Preparation to experience pain of natural delivery" in the women was the effective factor in forming the perception of delivery pain, explained by the participants in this study and included two sub-classes of

"accepting the experience of delivery pain and not accepting delivery pain experience". Many of our study participants, which accepting the pain has prepared them for normal delivery experience, stated that having adequate information about the natural delivery process by participating in delivery preparation classes, individual study or previous knowledge on the delivery environment, and a positive memory of the previous delivery caused pain acceptance. In support of this result, some studies have shown a change of positive attitude to delivery pain and increased self-efficacy of women in the normal delivery experience by obtaining a suitable educational program and the use of proper books and Internet resources during pregnancy [10, 11]. In our study, non-accepting the delivery pain had a negative role in women's preparation for normal delivery. Veringa et al. (2012) also stated that other people views and considering the pain a catastrophic event are a very powerful factor in creating fear of pain and the demand for excessive use of pain relievers or cesarean section in women [12]. The "nature of the pain of natural delivery" was the second main class created following the comprehensive description of delivery pain. From the participants' perspective, the severity of the pain was less than that they had heard. Some others stated that they did not show much emotional behaviors due to shame and they were embarrassed to scream or shout. In line with these results, a study conducted on Brazilian women showed that they were trying to associate their pain with appropriate behaviors instead of screaming and being frustrated [13]. Some other participants in our study admitted that the severity of the pain was so that they were hated to live and even see the infant, and they constantly screamed or, and sometimes, their severity was so high that were rubbing their waist and stomach. In support of the results of the present study, the majority of Nigerian women described the pain of delivery very terrible [14]. Muhammed & Danlami (2015) also stated that some Indian women were crying and some others were screaming. However, some others were waiting quiet to receive caregivers' guidelines [15].

All of these behaviors are affected by personality, socio-cultural and ethnic backgrounds, which can make the delivery tolerable or non-tolerable. The class of "Perceived support during delivery pain experience" was formed as the third main class, which included two types of "support of others and support care resources". These supports were in the form of physical presence and verbal sympathy of the spouse and mother, waist rubbing, or massage by the spouse or mother, the presence of a caregiver and standard care equipment, which provided comfort and peace of mind for women. In support of this study, studies conducted in Nepal, New Jersey, Italy, South Africa, Nigeria, and many European countries and even in Iran showed that the support of the spouse and others (relatives and friends) and informed and responsible and kind care team reduced negative experiences and increased satisfaction in women [16-23]. In Iran, owing to multiplicity of deliveries in public hospitals and, in some cases, the insufficient number of caregivers to provide health services and the multiple responsibilities assigned for the caregivers, these women are not supported adequately.

The class of "stressor factors of delivery pain" class was formed with two sub-classes of "external stressors during pain" and "internal stressors during pain". Stress and anxiety caused by delivery with a sense of loneliness when entering and staying in the pain room along with other stressors such as dealing with strangers, lack of staff attention to individual needs, complex care devices, unpleasant smells, environmental noise and some usual measures, such as intravenous injections, restriction in food and fluid intake, frequent vaginal examinations, continuous monitoring of heart rate of embryo, restriction in maternal movements were among the stressors expressed by participants. In line with results of this study, the results of the studies conducted by Pirdel and Pirdel (2009) indicated a significant positive correlation between stress and severity of delivery pain and environmental factors such as congestion of delivery room, and lack of intake of oral liquids [24]. Kathleen et al. (2007) also reported that anxiety during delivery was significantly associated with decreasing the rate of autoimmunity at the end of pregnancy, increasing severity of delivery pain, accelerating the onset of pain and decreasing cervical dilatation [25]. In fact, stressful and disturbing factors cause delay in the process of delivery and the formation of a negative memory of pain.

The last main class of comprehensive description of the delivery pain was "a time for transcendence", which consisted of four sub-classes of "conflicting emotions towards pain, a new insight to pain, self-actualization and spiritual flourishing " and resulted in the formation of a positive perception of pain. Some of the participants in this study gained very bad experience of delivery due to unmet needs of pregnancy or unwanted pregnancy following experiencing pain, fear of an internal examination and painful examinations, led to lack of recommendation of normal delivery for others. In this regard, Ternström et al. (2015) also stated that delivery concerns are reflected in negative thoughts and feelings [26]. In expressing positive emotions, some women expressed their sense of pleasure, such as feeling comfortable and satisfaction after delivery, and even considered it a sweet experience. In confirming the present research results, Kalstrome (2015) also reported the positive experiences of women of delivery in the form of obtaining feeling of joy and happiness after delivery [27]. A new insight to pain was another theme of the present study, developed by deep recognition of the nature of pain and expressions such as rebirth, the natural sense of delivery, and expression the real self, and the recognition of the mother's status. Barnes (2010) also stated that when she enjoys the experience of delivery pain, she experiences transition from unconsciousness to consciousness spontaneously and inherently [3]. Self-actualization was one of the inner beliefs seen in most participants of the study after a new insight to pain. The belief of an individual, family, and caregivers plays an important role in expressing and forming this insight. By tolerating the pain of delivery and victory in the inner battle, they found feelings of pride and power, and the sense of success and self-esteem was developed in these people, and this result has been confirmed in many studies [28-32]. Spiritual flourishing was the last theme. Based on some women,

by experiencing the pain and its tolerance, the women were cleared of sins and sense of purity and self-sacrifice were developed in them. In support of this result, Schwartz (2014) showed that most women with different religions and cultures look at the delivery with spiritual lens, and their descriptions of delivery were stated in the form of observing the real self, perception of existential value and belief in God's ability, and viewing the infant as the God's gift [33]. The turning point of this study is the emergence of a qualitative class of a time for transcendence, which less studied in other studies. In other words, those who had experienced normal delivery with physical and mental preparation attained positive from the pain of natural delivery, had a positive vision and even knowledge of inner abilities and self-esteem, and at a higher stage, they reached a certain level of spiritual growth.

Conclusion

Finally, it can be stated the experience of delivery highlights some aspects of pain reality. It can be the most exciting and the most spiritual period in natural life of women. It can also play an important role in the spiritual, psychological and emotional development of women. Thus, delivery should be viewed from another angle and it should be accepted positively in one's development. Its denial and control would have adverse effects; while its acceptance would leave a positive and pleasant memory of a natural event in the mind of the person. This result is important in the planning of reproductive and midwifery health policy makers and experts to promote and welcome the safe and satisfactory normal delivery.

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