Public Display of Affection in Couples Attending Childbirth Education Classes: Implications for Practice in Thailand

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Abstract

The purpose of this article is to describe couples' touch behaviors and positions during their interactions in childbirth education class exercises in the United States—practices that might be construed differently among couples in Thailand. Using observations collected at childbirth education classes conducted in the United States during the fall of 2002, the author found four positions that would be considered culturally sensitive with her Thai experiences. Perhaps with some modifications in the technique, mothers and their partners in Thailand will more readily accept childbirth education classes.

Journal of Perinatal Education, 12(4), 8–15; childbirth education, touch, public display of affection, cultural sensitivity, Thailand.

Introduction

As an international doctoral student from Thailand, I observed my first Lamaze Certified Childbirth Education class in the United States during the fall of 2002. I found that these classes were very useful to expectant parents. I saw close relationships and sharing experiences between couples who seemed to benefit from supporting each other during labor and birth. In some of the classes, I noticed that couples touched each other more than and in different ways from couples in my native country. As I observed these exercises and thought about returning to Thailand and teaching childbirth classes, I was concerned about the couples' positions and touching. Positions requiring close, physical contact and touch between couples are not congruent with my cultural norms. Therefore, the purpose of this paper is to

describe touching and positions of couple interactions during childbirth education class exercises in the United States that might be construed differently in Thailand. Perhaps with some modifications in the technique, Thai mothers and their partners in my native country will more readily accept childbirth education classes. The observations made here have implications for those who are currently exporting Lamaze classes to countries around the world and for teachers in the United States who need to offer flexibility in classes so they will meet the needs of an ever increasingly diverse population.

Background

Pregnancy, childbirth, and early parenting experiences are considered not only normal transition periods but also potentially stressful events for women and their partners. The couples' roles, communication patterns, and activities of daily living need to be redefined and negotiated to fulfill changes in their relationships (Polomeno, 2000). Labor and birth experience can also be defined as critical turning points. The onset of labor can produce anxiety, especially for unprepared laboring women. They may experience increased anxiety related to the process of birth, pain, and loss of control. Therefore, across many cultures, childbirth education classes have the potential to prepare pregnant women and their partners to increase their confidence and reduce stress in the processes of experiencing pregnancy, giving birth, and becoming a parent (Bechelmayer, 1995; Bradley & Schira, 1995).

Generally speaking, physiology of childbirth is universally accepted as the same process for all women, worldwide. Each society's cultural system informs its members about the importance of childbirth practices—such as what should be done, what is a proper method, who will

cooperate during labor, and what the expectant parents' roles should be during these experiences. However, some aspects of childbirth are unique within each culture (Nichols, 1996): for example, the manner in which couples relate to each other. Additionally, cultural beliefs, traditional practices, and other variables play important roles in shaping the meaning of childbirth and a woman's perception of her birth experience.

Beliefs, rituals, and traditions provide ways of caring, coping, and facilitating a safe and pleasurable birth experience for couples and their families (Lothian, 1998). For example, a laboring woman can experience both physiological and psychological supports from her family members. She can also receive comfort measures and be surrounded by her family members. A century ago, this warm childbirth practice in the United States was inherited through generations of women, their families, and society (Lothian, 1998). Thailand's society also used to widely perceive childbirth as a normal physiological function of a woman's life. Most births occurred at home and were attended by traditional birth attendants or midwives. However, during recent decades, birth became viewed and managed as a medical event in favor of "safe birth practice," and the warm, family-supported childbirth practice of the past gradually disappeared from the Thai society.

Although health care providers in Thailand have verbalized that they perceive birth as a normal, physiological process, they rely more and more on routine, unnecessary medical interventions in order to achieve a "safe birth practice." According to my observations in Thailand, current antenatal education is typically limited to offering information about the process of pregnancy, the management of common discomforts, the danger signs of pregnancy, the signs of labor, when to come to the hospital, and breastfeeding techniques. In Thailand, prenatal education classes are not about birth. They rarely present information about the birth process, coping skills concerning labor pain, support from a partner, and birth options.

Research in Western societies has consistently found that preparation for the birth process is associated with an increase in satisfying birth experiences (Nichols & Humenick, 2000). In order to facilitate a satisfying and joyful birth experience, should worldwide antenatal education expand the contents to include various aspects of labor and birth to support a woman's need to give birth

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based on her choices? If I insert a childbirth education program into traditional antenatal education in Thailand, to what extent will the program fit with my clients' expectations and comfort with such information and practices? What unforeseen side effects might occur while blending the two cultures in this manner?

Theoretical Framework

In general, childbirth education programs in Western societies are constructed to prepare and help expectant parents as they pass through the perinatal transitional periods. As a result, a childbirth education program can be identified as an educational intervention. Its aims are to offer education related to the process of pregnancy, giving birth, and early parenthood; to support pregnant women and their partners' needs to give birth, based on their choices; and to improve the health and well-being of pregnant women, their babies, and their family. As illustrated in the Figure, educational interventions affect and are affected by both the clients' characteristics and the health care systems (Humenick, 2000). In this model, the educational intervention programs are not expected to act directly on the birth outcomes; instead, this educational intervention usually acts indirectly and dependent upon the clients' characteristics and the health care systems (Humenick, 2000).

Many aspects of a client's characteristics that may affect an educational intervention are readily evident, such as demographic, social, cultural, and economic aspects. Here, the focus is on the cultural aspect of the client. In this case, the client is a Thai mother attending a series of childbirth education classes. As discussed above, I became concerned about the differences of clients' cultural expectations between Thailand and the United States. Consequently, I believe some positions and touching between couples in childbirth education class exercises would have to be modified from practices

Figure Interactive Quality Health Education Outcomes Model*

* Based on concepts from:
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in the United States in order to correspond with Thai clients' expectations, comfort, and cultural norms. This may be true in some other Asian countries, as well. Therefore, the main focus of this paper is clients' characteristics and an educational intervention program known as Lamaze Childbirth Education classes (as shown in the Figure, two variables inside the dashed line).

Review of Literature

Childbirth Education in the United States

Lamaze Certified Childbirth Education programs use a psychoprophylactic technique, which was first devel-

oped in Russia and modified by Dr. Fernand Lamaze and his colleague in 1951 to suit the French culture. The program became the most popular psychological technique for labor-pain management in the United States. In 1960, the American Society of Psychoprophylaxis in Obstetrics (ASPO/ Lamaze) was established in New York City. In 1997, the organization's name was changed to Lamaze International, Inc. Based on Dr. Lamaze's psychoprophylaxis concept, childbirth education not only benefits expectant parents and natural childbearing but also potentially turns birth into a vital experience of fulfillment, meaning, and joy (Ondeck, 2000).

Today, despite a variety of childbirth preparation classes, most childbirth education classes share some similarities. They are composed of information about the process and procedures associated with birth; coping skills related to labor pain; and support from a labor partner, family, and instructor, as well as the development of a support system (Ondeck, 2000). The most important goal of childbirth education is to offer the education and support that a woman needs in order to give birth naturally and confidently (Lothian, 1998). It logically follows that women and their partners need to know about their birth options in order to decide what is their desirable birth experience and how to maintain control over decisions affecting their birth experience.

Childbirth Education in Thailand

I have observed that, in contrast to the United States, antenatal education classes in Thailand are offered in the antenatal clinic during office hours. Such classes in Thailand are called *health education during pregnancy*. The content only focuses on general knowledge of pregnancy, common discomfort and its management, danger signs during pregnancy, true-false labor pain, when to come to the hospital, breastfeeding, and newborn clothing. Health education during pregnancy is divided into two sections: Section I is offered to pregnant women during their first and second trimester, and Section II is offered to pregnant women during their third trimester. Each of the two sections lasts 30–45 minutes and is offered at the antenatal clinic. Thailand does have some childbirth education classes that are similar to those offered in the United States. However, they are not widely provided throughout the country. This is in part due to

limitations on resources, as well as current rules and regulations of the hospital systems. It is also partly because the classes are not traditional in the society, and they contain a level of touching techniques that would need modification to fit in with Thailand's societal acceptance.

Touch and Public Displays of Affection

Touch can be identified as a form of communication through physical contact (Kitzinger, 1997; Sung, 2001). According to Routasalo (1999), touch means to make contact with, to show friendship or affection, or to give sexual pleasure. To be touched by something also has the meaning of being emotionally affected (Routasalo, 1999). Routasalo also gives synonyms to the verb *touch*, which include *brush*, *caress*, *fondle*, and *handle*. The expression of touch has many forms, such as comfort, love, and healing. The negative expression of touch includes anger, rejection, or control (Routasalo, 1999). Therefore, touch is clearly composed of two important aspects: physical contact and emotional interaction.

According to a study by Regan, Jerry, Narvaez, and Johnson (1999), the type of touching behavior displayed among their subjects differed as a function of race or ethnicity. For example, heterosexual couples from non-contact-prone cultures were less likely than couples from "contact" cultures to display one-armed embracing while walking together in public. But hand-holding behavior between these two cultures was not significantly different. This is because hand-holding appears to be a universally accepted form of public touch among heterosexual couples. Regan and colleagues (1999) classified noncontact-prone cultures—Asia, North America, and northern Europe—and contact-prone cultures—the Middle East, Latin America, and southern Europe. (The contact referred to here is general and not specifically applied to romantic, affectionate touching.) Thus, the use of interpersonal distance, body orientation, and touch in dyadic interactions are affected by people's culture, gen-

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der, and age (Remland, Jones, & Brinkman, 1995). Furthermore, considerable variation exists in contact comfort between these two categories.

People choose to employ touch as a way to display their affection either in public or private places, depending on their values, norms, and culture. Various forms of public display of affection include holding hands, hugging, kissing, and exchanging eye contact. Each society has its own pattern of public display of affection. For example, an American couple may publicly express their affection through holding hands, hugging, or kissing each other. They can even publicly display their love for each other through expressions in their eyes. In contrast, a Thai couple may publicly express their affection only by holding hands. Thai people are taught to be very careful with demonstrating their expressions of love for one another in public. They refrain from being physical or from displaying expressions in their eyes.

A variety of touching behavior exists: for example, comforting touch and physical-support touch. Comforting touch can provide emotional support and pain relief, and it can help stimulate relaxation. Both massage and the use of cold, warm, or hot compresses are considered forms of comforting touch. To reduce pain perception during labor, light- and strong-stroking massage techniques are effective (e.g., using fingertips or the entire hands or using devices—such as a tennis ball—that roll or apply pressure). During childbirth education classes in the United States, women and their partners are taught to use massage, touch relaxation, and hot and cold compresses to relieve future labor pain (Lothian, 2000). In these same classes, women and their partners also publicly rehearse different types of massage techniques such as light massage using fingertips, stroking massage using palms, or pressure massage using palms or a tennis ball.

In the United States, physical-support touch by a labor partner can provide a laboring woman with the assurance she needs to easily move and change positions during her contractions (Lothian, 2000). Additionally, physical-support touch is frequently used with different positions for laboring such as kneeling, sitting, and squatting. In childbirth education classes, women and their partners are taught to publicly exercise different positions (e.g., leaning, walking, standing, kneeling, sitting, and squatting) in order to promote comfort and progression of their labor (Zwelling & Anderson, 1997).

Therefore, the use of touch is commonly taught and considered to be an important means to provide comfort and support to facilitate birth and to help women and their partners trust their inner wisdom and feel confident in their ability to give birth (Lothian, 2000).

In my experience, the meaning and expression of touch in Thai culture is similar to that discussed above. Thai people touch each other for both physical and emotional comfort. However, Thai men and women rarely touch one another in front of others. The only touch behaviors between men and women that are acceptable to display in public include holding hands and touching another's shoulder and arm. One exception is that Thai people display physical-support touch for a sick person, regardless of gender, with arm support. Sometimes, Thais touch each other on the forehead if they suspect the other person has a fever. In summary, the body parts that Thai culture deems acceptable to be touched in front of others are limited to hand, arm, shoulder, and forehead.

Currently in Thailand, only nurses perform touch techniques during labor. The husband and relatives of a laboring woman wait outside the labor and delivery rooms.

Currently in Thailand, only nurses perform touch techniques during labor. The husband and relatives of a laboring woman wait outside the labor and delivery rooms. Most of the touching techniques used by nurses are comfort touches that assist laboring women to cope with their pain. The most frequently employed comfort touches are massage and physical-support touch. Most nurses offer strong-stroking massage and pressure massage, using their palms or hands on the lower back of laboring women. Thai nurses perform physical-support touch to help laboring women easily change position or move their body during uterine contraction. Thai nurses also teach laboring women to cope with their pain by using breathing and focal-point techniques; however, women have seldom been taught these techniques, prenatally. Thai nurses rarely use hot, warm, and cold compresses to relieve the pain of laboring women.

Positions that require close, physical contact in childbirth classes may need to be adjusted to correspond with clients' characteristics.

In summary, although touch and affection share similar concepts and meanings, how people publicly display touch and affection are different in each culture. The body parts that are touched in public also vary in every culture. Therefore, nurses, childbirth educators, and other health care personnel should be aware of the client's cultural background when teaching positions that require close, physical contact between a couple or when imparting support strategies to another culture.

Methodology

While in the United States, I asked permission to observe a series of Lamaze Certified Childbirth Education classes. The setting was in the conference room at a hospital. Approximately 8–10 registered couples attended the classes. Demographic data were not obtained from clients. I did not participate in the program; rather, I only observed class activities and took notes to collect information on childbirth classes.

The program series was divided into four classes. Each session lasted about two hours. The four-class series was part of a larger program offered to expectant parents that had previously included some instruction on early pregnancy. My observations were focused primarily on couple positions and touching between couples while they were engaged in practicing relaxation exercises.

Results

I attended all four classes of the childbirth education series. I observed that the childbirth educator encouraged couples to employ a variety of positions for use in their upcoming labor experience. The childbirth educator spent approximately 20–30 minutes in each two-hour class for couples to practice these various positions. I observed four positions in particular (see the Table), along with additional touching between couples that, in my experience, would be considered culturally sensitive

in Thailand. I believe if Thai couples are urged to practice these four positions, they might feel too shy to do so, especially in front of a group. They might also feel reluctant to touch each other on the belly or to put their arms around each other's waist or shoulder. In Thai culture, these four positions represent culturally sensitive displays of close, physical contact and intimate relationship between a couple. In addition, they illustrate body parts (e.g., waist and belly) that are not supposed to be touched in public. If Thai couples practice these four positions in childbirth classes, they may feel as if they are improperly hugging each other in front of others.

Limitations

I have not had any direct experience with similar childbirth education classes in Thailand as they currently exist and, thus, I have not observed how they may have been modified for today's Thai culture. Presently, I only have experiences in Thailand's typical health education during pregnancy.

Discussion

The context of childbirth education classes in the United States is one of couples being more publicly active than in Thailand. For example, in the United States, couples feel free and confident to express their ideas and feelings. They appear more likely than Thai couples to ask questions concerning their problems or curiosity about pregnancy and birth. During each class that I observed, I noticed two topics that elicited the most discussion:

1. epidural anesthesia or other pain-relief medications (e.g., pethidine versus comfort measures) and
2. positions for laboring out of bed (e.g., squatting, sitting, and standing).

While they practiced each of the four positions (as illustrated in the Table), I observed how the couples felt free to touch each other, relax their bodies, and take good care of one another. During these childbirth education classes, I saw a close relationship between each couple and it was publicly apparent how much they cared for each other. I was impressed with childbirth classes in the

Public Display of Affection in Couples Attending Childbirth Education Classes

Table Examples of Positions and Touching That Are Culturally Sensitive in Thailand

Positions	United States Culture	Thai Culture
<p>Figure 1</p>	<p>The couple sits on the floor—husband in the back, wife in front—and place their hands on her belly. If they feel uncomfortable, they can lean back against a wall.</p>	<p>In public, the husband will not touch his wife on the belly or sit in this position with his wife.</p>
<p>Figure 2</p>	<p>The wife sits on a chair and the husband kneels on the floor. She puts her arms round his neck and shoulders, and he puts his arms around her waist.</p>	<p>In public, the husband will not hug his wife and kneel on the floor, as illustrated in this position. Also, in public, the wife will not put her head on or her arm around her husband's shoulder.</p>
<p>Figure 3</p>	<p>The couple stands on the floor—husband in the back, wife in front—and places their hands on her belly.</p>	<p>In public, the husband and wife will not stand in this position, and he will not touch his wife on the belly.</p>
<p>Figure 4</p>	<p>The couple stands on the floor and, facing each other, the wife places her face on his shoulder while he puts his arms round her waist.</p>	<p>In public, the husband will not put his hands around his wife's waist. Also, in public, the wife will not put her arms around her husband's shoulder.</p>

United States because the exercises seemed to produce a warm bond and attachment between each couple. I valued the fact that they felt free to relax, express their feelings, practice breathing techniques, talk, hug, and touch each other in front of others.

The context of a class in Thailand is very different. Couples would feel shy about publicly expressing their ideas and feelings. They would be less likely than United States couples to ask questions, except when they really do have a problem concerning their pregnancy. The four positions (as detailed in the Table) illustrate some body parts that, in Thailand, are not supposed to be touched in public: the waist and belly. Therefore, these four posi-

tions would not be acceptable in Thailand because of the culture's feelings about public displays of affection. As a result, I believe these four positions must be modified to fit with my potential clients' characteristics and cultural norms. Theoretically, I believe that modifications can make childbirth classes more acceptable to Thai couples, thereby enhancing their childbirth experience and their abilities to cope with challenges during labor and birth. Another challenge would then become to persuade the Thai health care system to allow fathers in birthing facilities and to ensure that labor nurses are familiar with the same techniques as the couples learned in class.

Implications for Practice and Future Study

This paper explores impressions about different characteristics of clients, especially in terms of cultural aspects and public expressions of feeling. Childbirth educators should consider and remain sensitive to such potential differences. Positions that require close, physical contact in childbirth classes may need to be adjusted to correspond with clients' characteristics. An example modification may be merely to discuss positions that couples are not comfortable to practice openly in class. The educator may inform clients about the advantages, disadvantages, and procedure of these positions and, perhaps, show pictures for her clients to study. She may ask clients to practice these positions at home, especially if she believes these positions will comfort expectant parents during their upcoming labor experiences. She may need to work hard and be sensitive in order to encourage her clients to ask questions and feel confident about deciding their options, based on their cultural needs and desires.

Further studies could address clients' thoughts about exercises and positions that require close, physical contact between couples in childbirth education classes conducted in a variety of cultures. Additional research may also identify what aspects need to be changed to suit clients' goals and feelings. The comfort needs of laboring women are universal, but the educational strategies for meeting these needs are culturally specific.

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It is better not to know so much than to know so much that isn't so.
—Author unknown

We must train ourselves not to see the world only through our own eyes.
—Michael Levine