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Investigation of the relationship between fear of childbirth and social supports of pregnant women in the third trimester in Turkey

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Summary

Purpose: To investigate the relationship between fear of childbirth and social supports of pregnant women in the third trimester. *Materials and Methods:* The sample of this cross-sectional study comprised 302 pregnant women who were admitted to the gynecology and obstetrics clinic of a state hospital in Turkey. Data were collected with the Personal Information Form, Wijma Delivery Expect ancy/Experience Questionnaire (W-DEQ-A), and Multidimensional Scale of Perceived Social Support (MSPSS). *Results:* While no relationship was determined between the mean total scores obtained from the W-DEQ-A and MSPSS scales ($p > 0.05$), statistically significant positive correlations were determined between family and friends ($r = 0.206$, $p = 0.000$), family, and significant others ($r = 0.193$, $p = 0.001$), and friends and significant others ($r = 0.156$, $p = 0.006$) subscales of the MSPSS ($p < 0.05$). *Conclusion:* As the social support received from the family increased so did the support from friends and significant others, and as the support received from significant others increased so did the support from friends.

Key words: Fear of childbirth; Mental health; Pregnancy; Social support.

Introduction

Pregnancy and labor are two of the most important normal physiological events in a woman's life [1]. They are the milestones and natural crises of life affecting women physiologically, mentally, and socially [2, 3]. While a woman's mental state and lifestyle affect the course of the pregnancy, pregnancy itself creates significant reflections on her mental-emotional life [3]. Changes experienced during pregnancy vary from one trimester to another. The most prominent feelings during the first trimester are ambivalent feelings towards being pregnant. In the second trimester, while these feelings decline, biological ties with the fetus are felt more deeply and closely. During the third trimester, as the birth approaches, negative feelings accompanied by anxiety increase, the woman becomes more sensitive about issues regarding herself and the baby, she becomes more dependent on others, and fear of childbirth increases [4]. One of the factors that affect anxiety, one of the problems experienced most in the third trimester, is the fear of childbirth [5]. Fear of childbirth is reported to be associated with cesarean delivery or prolonged labor traumatic life events, relationship with the partner, depression, anxiety, and low self-esteem [1, 4, 6, 7]. In a study, the fear of childbirth was found to be associated with the health of the baby, the process and type of the delivery, the spouse's approach, and attitudes displayed by hospital staff [8]. Among the causes of the fear of childbirth are the possibility of not arriving at the hospital in time for delivery, possibility that some things may go wrong, possibility of doing something wrong, or possibility that the baby or the mother suffers injuries or dies during delivery, baby's gender, the environment where the delivery occurs, episiotomy, a change in the mode of delivery, interference with vaginal delivery, pain and suffering, staying alone in an unfamiliar environment, and lack of social support [6, 8-11]. In addition, primiparous women may experience fear of childbirth due to such reasons as loss of control, uncertainty, and considering that they cannot deliver a baby, whereas multiparous women may suffer fear of childbirth due to the history of stillbirth and complications experienced in previous deliveries [10, 12].

In the literature it is reported that about 5-20% of the pregnant women suffer fear of childbirth and that serious weakness is the kind of fear in 6% of them [5, 12-14]. It is reported that while in 57.3% of the cases, women suffer fears due to misapplications by health personnel during delivery, in 75% of the cases, fear stems from medical staff and hospital environment [10]. In a study by Fenwick *et al.*, 48% of the women had moderate and 26% had intense levels of fear of childbirth [15]. While antenatal

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fears may lead to distress and pain, a negative birth experience, administration of high levels analgesia, insomnia, and emergency cesarean during delivery, may cause an increased risk of severe mood disorders, such as depression in the postpartum period [1, 5, 6]. Akdolun *et al.* determined that 66.3% of the women having fear of childbirth and 84.6% of the women having extreme fear of childbirth during the second trimester, suffered postpartum mental distress [9]. Therefore, due to fear of childbirth, many women avoid normal delivery and prefer elective cesarean section [7, 10, 16]. One of the most important factors causing anxiety during pregnancy and affecting coping with the fear of childbirth suffered, especially during the third trimester, is the lack of social support the pregnant woman receives from other people [17, 18].

All interpersonal relationships having an important place in the lives of people and providing them with emotional, physical, and cognitive support are defined as the "social support system" which help protect health [19]. The social support system is a strong resource which contributes to the solution, prevention, and treatment of sociological and psychological problems of an individual, and to his/her coping with challenges. Social support involves emotional support which refers to empathy, concern, love, and trust, and tangible support refers to help with household chores and child care, and informational support refers to information and assistance that can be used to cope with problems [16, 18]. Social support is an important determinant of self-sufficiency, adaptation to the maternal role, and satisfaction with baby care. It is reported that if a woman receives sufficient social support, she can have a non-problematic pregnancy, adopt the maternal role quickly, and have fewer postpartum problems. Positive social support reduces the effects and complications of stress, depression, and anxiety that may arise during pregnancy and after delivery [16, 17, 20].

Early determination of fear that pregnant women are likely to suffer can help health professionals to plan healthcare they provide. Women suffering from anxiety and fear during pregnancy are provided support that all health personnel are knowledgeable about the physiology and psychology of pregnancy, and issues likely to arise during pregnancy play an important role in the identification, prevention, and early intervention of pregnancy-related problems, reduce the negative effects of these problems on both maternal and neonatal health, and improve preventive mental health services. In addition, if mental health problems such as the blues, depression, and psychosis that women suffer in the postpartum period are to be reduced, and suicides are to be prevented by determining women with suicidal intent, it is important to determine fear of childbirth and social support. Therefore, the study was conducted to investigate the relationship between fear of childbirth and social support of women in the third trimester of pregnancy.

Materials and Methods

The sample of this descriptive and cross-sectional study comprised 302 pregnant women who were admitted to the gynecology and obstetrics clinic of a state hospital in Sivas, a province, in Turkey between July 1, 2013 and September 1, 2013. The women were in the third trimester of pregnancy, and they and the fetuses did not have any diagnosed health problems. Data were collected with the Personal Information Form, a version of the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ-A) and Multidimensional Scale of Perceived Social Support (MSPSS) scale. Personal Information Form was developed by the researchers through a literature review and has 30 items related to pregnant women's W-DEQ-A is a 33-item Likert-type scale was developed by Wijma *et al.* to measure stress and fear during labor [21]. Each item is scored from 0 to 5. The minimum and maximum possible scores to be obtained from the scale are 0 and 165, respectively. The cut-off point of the scale is 84. The higher the score obtained from the scale, the higher the level of the stress and anxiety is. The scale was adapted to Turkish by Körükçü *et al.* [22]. Cronbach's alpha coefficient of the original scale was found to be 0.89 for the total group [22]. In this present study, the Cronbach's alpha coefficient was calculated as 0.88. MSPSS scale was developed by Zimet *et al.* [23]. The scale's reliability and validity in Turkey was conducted by Eker and Arkar in 1995 [24]. The scale consists of 12 items and is a seven-point Likert-type scale ranging from "very strongly disagree" (1) to "very strongly agree (7). The scale has three subscales referring to support sources: family, friends, and significant others. Each of the subscales consists of four items. The minimum and maximum possible scores obtainable from each subscale are 4 and 28, respectively. The minimum and maximum possible total scores obtainable from the scale are calculated by summing the scores from the subscales and are 12 and 84, respectively. High scores obtained from the scale indicate that the level of perceived social support is high. In Eker and Arkar's study, the scale's reliability coefficient ranged from 0.80 to 0.95 indicating that the scale has a high level of consistency [24]. In this present study, Cronbach's alpha coefficient of the scale was calculated as 0.81.

After the women who met the inclusion criteria and accepted to participate in the study were informed about the purpose of the study, their informed consents were obtained. Data collection tools were filled in by the researchers through face-to-face interviews. It took approximately 15-20 minutes to fill in the forms. The data were analyzed using the SPSS 14.00 software package, frequency distribution, Pearson correlation analysis, *t*-test. and ANOVA. *P*-value of < 0.05 was considered as significant.

Before the study was conducted, approvals were obtained from Cumhuriyet University Health Services Research Hospital Ethics Committee and from the hospital where the study was to be conducted. The purpose of the study was explained to the individuals who agreed to participate in the study by researchers and their informed consents were obtained. The study was conducted in accordance with the Declaration of Helsinki.

Results

The mean age of the participants was 26.26 ± 4.84 years. Their mean age at first marriage was 21.12 ± 3.51. The mean numbers were 2.05 ± 1.21 for pregnancies, 0.83 ± 0.96 for live births, 0.79 ± 0.89 for living children, and 0.22 ± 0.54 for abortions.

In this present study, 51.7% of the participants were in the age group of 26-35 years, 29.1% were primary school

Table 1. — *Descriptive characteristics of pregnant women.*

Descriptive characteristics	n	%
Age (years)		
19–25	135	44.7
26–35	156	51.7
36 and above	11	3.6
Education level		
Primary school	88	29.1
Secondary school	76	25.2
High school	88	29.1
University	50	16.6
Employment status		
Working	36	11.9
Not working	266	88.1
Perception of the economic situation		
Good	114	37.8
Middle	184	60.9
Bad	4	1.3
Responsible for taking care of family		
Yes	91	30.1
No	211	69.9
Smoking status		
Smoker	38	12.6
Non-smoker	264	87.4
Smoking status of husband		
Smoker	180	59.6
Non-smoker	122	40.4
Total	302	100.0

Table 2. — *Fear of birth and social support scores of pregnant women.*

MSPSS	Min-max	X ± SD
Family	4−28* (4−28)**	26.00 ± 4.36
Friend	4−28*(4−28)**	20.34 ± 8.79
A special person	4−28*(4−28)**	23.35 ± 7.47
Total	18-84*(12*84)**	69.69 ± 14.18
W-DEQ-A	4−130*(0−165)**	56.91 ± 23.81

* Taken from the scale of pregnant women, minimum and maximum points.
** Scale's minimum and maximum points.

Table 3. — *The relationship between perceived social support and birth fears in pregnant.*

Variables	Family	Friend	A special person	*Total MSPSS*
W-DEQ-A	r = -0.017	r = 0.005	r = -0.033	r = -0.019
	p = 0.772	p = 0.926	p = 0.567	p = 0.739
Family		r = 0.206	r = 0.193	r = 0.537
		p = 0.000*	p = 0.001*	p = 0.000*
Friend			r = 0.156	r = 0.766
			p = 0.006*	p = 0.000*
A special person				r = 0.683
				p = 0.000*

* $p < 0.05$.

graduates, 29.1% were high school graduates, 88.1% were unemployed, 87.4% were non-smokers, 59.6% were married to smokers, and 69.9% did not have to provide care to any other family member or relative. While 37.8% of them perceived their economic status as good, 60.9% perceived it as moderate (Table 1).

In this present study, 41.4% of the participants were primiparous, 96% conceived spontaneously, 94.7% had desired pregnancies, 75.2% had planned pregnancies, 79.8% planned to have a normal vaginal delivery, 91.7% had regular checkups, 88.4% received no previous pregnancy-related education, 53.3% had no problems in their previous pregnancies, 54.6% had no problems during their previous labor or postpartum periods, 93% had someone to help and support them during pregnancy, and 94% had someone to help and support them after delivery.

While the mean total score was 56.91 ± 23.81 (min-max: 4-30) for the W-DEQ-A scale, it was 69.69 ± 14.18 (min-max: 18-84) for the MSPSS scale. The mean scores obtained from the subscales of MSPSS were as follows: 26.00 ± 4.36 (min-max: 4-28) for the family subscale, 20.34 ± 8.79 (min-max: 4-28) for the friends subscale, and 23.35 ± 7.47 (min-max: 4-28) for the significant others subscale (Table 2).

In the present study, no statistically significant relationships were determined between the mean total scores obtained from the W-DEQ-A scale and total and subscale scores obtained from the MSPSS scales ($p > 0.05$); however, correlations between the mean scores obtained from the family and friends, family and significant others, and friends and significant others subscales of the MSPSS ($p < 0.05$) were statistically significantly positive ($p < 0.05$). Correlations between the mean total MSPSS score and mean scores for the family, friends, and significant others subscales were also statistically significantly positive ($p < 0.05$) (Table 3).

Discussion

The period of pregnancy and childbirth during which several physiological and psychological changes are experienced is important since it requires adaption to new and different roles. In this present study conducted to investigate the relationship between fear of childbirth and social support of pregnant women in the third trimester, the total mean score of the W-DEQ-A scale was calculated as 56.91 ± 23.81. out of 165 points when the cut-point of the W-DEQ-A scale was taken as 84 (11.2% fear of childbirth). The present study showed that the participants' level of fear of childbirth was low. The results obtained from other studies using the same scale related to the fear of childbirth ranging between 9.1% and 15.8% and thus were close to the results of the present study [7, 14, 25, 26]. Fear of childbirth is often associated with the thought that the woman will not be completely independent and will suffer pain, loss of control, negative perception of childbirth, depression, lack of confidence in the healthcare team, previous birth experiences, the woman's

personality traits, low self-esteem, problems with the husband, daily intense stressors and lack of social support, and they may lead to negative birth expectations, cesarean sections, increases in pain during delivery, postpartum depression, stress and anxiety [6, 7, 10, 11, 25, 27, 28]. Babacan Gümüş *et al.* reported that mothers who suffered fear of childbirth during pregnancy and/or had problems during the postpartum period had higher levels of depression [29]. Akdolun Balkaya *et al.* determined that more than half of the women who suffered fear of childbirth during the second trimester continued to have mental distress in the postpartum period [9]. Therefore, the low level of fear of childbirth determined in the present study is important for the prevention and reduction of adverse conditions that may arise during pregnancy and in the postpartum period. Contrary to the present results, the results of Melender's study conducted in 329 pregnant women indicated that 78% of them had fears related to pregnancy or childbirth, or both, and that their negative moods played a part [11]. In Akdolun *et al.*'s study of 184 pregnant women, 98.4% of the participants suffered fear of childbirth [9].

Social support is an important factor that reduces anxiety, stress, and fear of childbirth during pregnancy and delivery. Social support also plays an important role in motivating a person to cope with the problems [2, 17]. In the present study, while the mean total MSPSS score was 69.69 ± 14.18 out of 84 points, the mean scores for the family, friends, and significant others subscales of the MSPSS were 26.00 ± 4.36, 20.34 ± 8.79, and 23.35 ± 7.47 out of 28 points, respectively. According to the results of this present study, pregnant women seem to have high levels of social support, which may account for their low level of fear of childbirth. In addition, the result that social support from friends and significant others increased as the social support the pregnant women received from the family increased, that social support from friends and the family increased as the social support from significant others increased, and that social support from significant others and the family increased as the social support from friends increased, may account for their low level of fear of childbirth. Supportive relationships play an important role in promoting health, preventing health-related problems and stress, protecting an individual from the effects of stress, changing the perception of events where there exists stress, helping the person in cases where he/she suffers difficulties, and increasing their coping capacity [16, 19]. If a pregnant woman receives high levels of social support from the spouse, family, friends, and other people, and if she perceives that this support is sufficient, she may experience less physical and psychological problems [30]. In the literature, it is stated that social support has a positive effect on pregnancy, helps women to perceive labor as a more positive experience and facilitates their transition to the maternal role [18, 31]. Gözüyeşil *et al.* found that while 72.9% of the pregnant women received most of the support they needed from their husbands, 25.6% received it from their relatives [30].

Conclusions

The participants had low levels of fear of childbirth and high levels of perceived social support. There was no relation between their fear of childbirth and perceived social support. As the social support received from the family increased, so did the support from friends and significant others, as the support received from significant others increased, so did the support from the family and friends, and as the support received from friends increased, so did the support from the family and significant others.

A limitation of the present study is that the results obtained from it are applicable only to the study sample and cannot be generalized. Based on the results, it is recommended that pregnant women should be provided with information and counselling on, including: physiological and psychological changes that occur during pregnancy and childbirth, having desired and planned pregnancy before they become pregnant, pregnant women should be helped to develop their skills to cope with challenges such as anxiety and stress, reduce their fear of childbirth by determining risk factors regarding fears of childbirth during the pre-pregnancy period, receive support from the family, friends, and significant others during pregnancy by providing education and counselling, have a positive childbirth experience, and to suffer from fear of childbirth as little as possible.

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