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Mårtensson Lena, Mogren Lisa, Lindbom Emma and Thorstensson Stina

*Full Length Research Paper*

# What helps? A description of experiences of support among primiparous women with fear of childbirth: An interview study

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Fear of childbirth is described as a major problem for many women as this has a negative effect for both the women and the babies. Health care professionals need to be able to offer these women adequate support which could be important for primiparous women. The aim of this study was to describe what primiparous women experience as support in coping with their fear of childbirth. A qualitative, inductive approach was used. Data was collected at two hospitals in Southwestern Sweden. Five primiparous women with fear of childbirth were included after a purposive, snowball sampling technique. Data were analyzed with qualitative content analysis. Findings are described through the main theme support adapted to the needs of the individual woman and of three categories: (1) the importance of receiving reassurance; (2) increased knowledge and understanding and; (3) combining all kinds of support. The conclusion of this study is that women's fear could rapidly shift focus and individualized support sensitive to these shifts was important to increase primiparous women's coping capacity. Support should include; reassurance, improved knowledge and understanding.

**Key words:** Women's experiences, primiparous, fear of childbirth, social support, professional support, women's health, life change events.

## INTRODUCTION

Fear of childbirth can affect the everyday life of pregnant women, causing increased worry, anxiety, sleeping disorders, and mood swings (Onell and Thelin, 2005), as well as increasing the risk of emergency caesarean birth (Waldenström et al., 2006; Laursen et al., 2009; Ryding et al., 1998), difficulties in attachment (Ryding et al., 1998) and prolonged labour (Laursen et al., 2009; Adams

et al., 2012). Fear of childbirth, is graded from mild to severe depending on the experience of the individual woman. Mild fear of childbirth means that women are able to cope with their fear without extra support, while severe fear of childbirth means that women needs extra support to be able to prepare for childbirth (Areskog et al., 1981).

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Severe fear of childbirth is defined as fear before, during or after childbirth which may mean avoidance of a new pregnancy or wishing for a caesarean birth (Areskog et al., 1981; Almström et al., 2004). In Australia, 26% of women report fear of childbirth (Fenwick et al., 2009), while in Scandinavian countries, around 20% of women suffer from fear of childbirth and approximately 5 to 10% of these women experience severe fear, such as the fear that limits their everyday life (Areskog et al., 1981; Heimstad et al., 2006; Hofberg and Ward., 2003; Niemenen et al., 2009; Waldenström et al., 2006). Fear of childbirth is complex and influenced by both personal and social factors (Fisher et al., 2006; Saisto and Halmesmäki, 2003) such as low education level or lack of social network (Laursen et al., 2008) or psychological ill health as anxiety or depression (Storksen et al., 2012). Fear of childbirth is more common in primiparous women (Rouhe et al., 2009) and has different origin such as, history of abuse or other psycho-social factors (Nerum et al., 2006).

However, primiparous women also describe the unknown in giving birth for the first time as frightening (Melender, 2002; Nilsson and Lundgren, 2009; Rilby et al., 2012). In addition, when health professionals search for things that may go wrong, women start to doubt the capacity of their own bodies and develop an increased fear of childbirth (Nilsson and Lundgren, 2009). To cope with their fear, women try to avoid, try to adapt, or ask for help, depending on the actual situation. However, pressure to accept the social norm that women should be happy during pregnancy could make it more difficult for them to acknowledge their fear and ask for help (Eriksson et al., 2006). Women who experience fear of childbirth need health professionals to be supportive and open to the individual experience of each woman (Eriksson et al., 2006; Eriksson and Nilsson, 2009). When women are supported to cope with their fear and they experience a positive birth they can be cured from their fear (Hildingsson et al., 2011; Nerum et al., 2006). Support can be empowering and has been described as emotional, appraisal, informative or practical. For the recipient support is influenced by personality, age, earlier experience and context (Thorstensson and Ekström, 2012).

As described earlier, fear of childbirth is described as a major problem for many women as this has a negative effect for both the women and the babies. For these women to cope with their fear, they need adequate professional support, which is important for primiparous women. Therefore, the objective of this study was to describe primiparous women's experience of support in coping with their fear of childbirth.

## MATERIALS AND METHODS

A qualitative approach was used to address the research question (Polit and Beck, 2011). To understand women's experience of fear of childbirth, the interview method was considered to be the most

suitable approach. This study was performed at two hospitals in the south west of Sweden.

## Participants and procedure

Inclusion criteria to participate were healthy primiparous women at the end of a normal pregnancy or women who had recently given birth, women experiencing fear of childbirth and who had received counseling with specially trained midwives, such as Aurora midwives in Sweden (Nilsson, 2012). To achieve a variation in the sample, a purposive sampling method was used (Polit and Beck, 2011). The intention was to get a variation of age, education, accommodation, religion, and women who were living with the child's father and those who were not. Contact was made with two maternity health centers and one midwife at each center was responsible to forward information on women fulfilling the inclusion criteria. Three women initially agreed to participate and, to recruit more informants, snowball sampling technique was used (Polit and Beck, 2011). One of the authors asked one woman, who asked another woman, and both agreed to participate in the study. The participating women were between 26 and 32 years old, three had university education and two had secondary school education, four lived with the father of their baby and one had separated and their living conditions varied from apartment in a city to house in the country. Two were pregnant at gestation week 35 and 38, respectively. Three women had recently (around one month before the interview) given birth to their children. Two of women did not speak Swedish as their first language but spoke good Swedish. One of the women alternated between Swedish and English during the interview. Altogether, five women participated in the study. Including both pregnant women and women who had recently given birth was deemed to increase variation of the sample since a positive childbirth experience can influence women's coping capacity for fear of childbirth (Hildingsson et al., 2011). After informed consent, the interviews were carried out at a place the women choose. The interviews began with two open questions, "how do you handle your fear of childbirth" and "what helped you most in coping with your fear of childbirth". Follow-up questions were all probes to elicit further clarity or explanation. The interviews lasted between 25 to 40 minutes; the interview was recorded and then transcribed verbatim.

## Data analysis

The data were analyzed using qualitative content analysis according to Graneheim and Lundman, (2004). The interviews were read and re-read by the authors in order to grasp the meaning of the data and the underlying messages of the material were then discussed together with all authors. Meaningful units, as constellations of words or quotes that were relevant to the purpose of the study, were identified. These units were highlighted in different color codes in an attempt to easily see differences and similarities in the text. Group codes were arranged and rearranged into categories, as listed in the table below. The compilation process that followed yielded three categories. The latent content was visible during this phase and resulted in the creation of the main theme. An example on the data analysis process is shown in Table 1.

## Ethical considerations

Permission to carry out this study was given by the head of each department and in accordance with the Ethical Review Board of Sweden. This kind of study, does not need to apply for ethical approval in accordance to Swedish law (EPN). The study was carried out according to the guiding principles of the "Declaration of

**Table 1.** Example of the data analysis process.

Meaningful units	Condensed sentence	Code	Categories
It is really good if one is told the truth	To gain an image of reality	To gain information	Increased knowledge and understanding
She really listened, I suppose you feel as if you are seen and listened to	Someone listens and creates a sense of being seen and listened to	Someone cares about me	The importance of receiving reassurance
All in a kind of symbiosis, it was a chain of it all together	All in a kind of symbiosis, a chain of events	A chain of events	Combining all kinds of support

Helsinki" (EPN). Written and informed consent was obtained from all women who participated in accordance with the four ethical principles of autonomy, beneficence, non-malicious and legality. Women were also informed that participation was voluntary and that they could withdraw at any time.

## RESULTS

The findings are described through the main theme, *support adapted to the needs of the individual woman*, and the three categories: (1) *the importance of receiving reassurance*; (2) *increased knowledge and understanding*; (3) *combining all kinds of support*. Direct quotes are presented with fictive names.

### Support adapted to the needs of the individual woman

The main theme, described that individually adapted support was necessary for women to be able to cope with their fear. Individually adapted support, meant that women's individual needs for support were seen and met and this was experienced as positive, regardless of whether this support was about reassurance, increased knowledge and understanding, or a combination of all kinds of support.

### The importance of receiving reassurance

Receiving reassurance was about someone caring about, taking time, and showing an interest in helping women. It was essential to be listened to and important that health professionals did not neglect women's fear or need for support. Support could be small things like having access to an extra appointment with the midwife or the midwife at the labor ward reading women's delivery letter (that is, birth plan) without her having to ask for it.

*She was so fantastic, my midwife, she really listened. I suppose you feel as if you are seen and listened to (was emphasized). It is such a strange feeling that someone is sitting there and someone is really trying to help you, it is*

*not often like this in life that someone is really committed to you – now it is just you and me and I will help you until you can manage on your own (Sophie).*

Gaining access to an Aurora midwife, gave a feeling of reassurance, not only because women perceived they needed support but also because there was support available. Obtaining an appointment quickly felt good and gave women the sense of receiving help and support without having to fight for it and thereby, minimizing the need to describe their fears to many different people. It was important that health care professionals engaged with women's problems, allowed the women to open up to them in their own time. Women emphasized that coping with their fear was easier when they felt no pressure and were reassured that they could decide the pace of meeting their fear without health professionals imposing pressure.

Women felt it was easier to speak to the midwife and talk about what was frightening them when they were alone with the midwife. Being asked about what was frightening, enabled women to receive information in accordance with their coping capacity. Information in a group could mean having to listen to some information women were not ready to cope with. It was important that women were "in charge" of the dialogue since their fear could change focus and then the dialogue would need to change direction. Women were reassured when the midwife was sensitive to their need to change direction in the dialogue. Meeting women's fears one step at a time increased their coping capacity and this made them to be proud of themselves.

*That I in my own pace could encounter my fear... without someone else pushing or evaluating if, how or at what speed one does it ...So it was just a step at a time all the way. I felt very grown up, proud when I did it... it was sensitive toward how I myself felt (Sophie).*

Sensitive health care professionals, made women feel reassured and a mutual sense of trust was achieved. This mutual sense of trust and rapport between women and the midwife increased their trust in the midwife and they felt safe and secure. Having trust in the midwife was



essential for women to open up and describe their fears. Likewise, it was important to receive reassurance from family and friends, that they showed understanding for women's fear. It was a relief that their fears were not questioned but understood.

When women perceived that people showed a strong belief in them and reassured them of their capacity, it increased their self-esteem and belief in themselves. Increased self-esteem meant feeling more in control with their feelings, thus gaining a sense of empowerment. Empowerment gave them strength to meet the inevitable, which was the delivery. It promoted a sense of having the capacity to give birth to their babies and being safe with their body's capacity to give birth. A positive childbirth experience could be receiving reassurance and strengthening a belief in women's capacity. A reassurance that women could achieve something they thought they could not achieve. Having a positive childbirth experience, decreased women's fear and they felt calm with the thought of a possible second childbirth, gaining increased trust in their body's capacity and increased self-esteem.

### Increased knowledge and understanding

It was essential for women to cope with their fears and to gain increased and detailed knowledge about the childbirth process and all information was seen as important. Information could come from the midwife, the mother, sisters, or friends, as long as the information was deemed as correct and valid by women. Increased knowledge, gave insights into what to expect and in turn imposed a sense of calm. Knowledge about the statistics, that the probability for complications will be low, was important and contributed to a sense of calm and a certain sense of control in the situation. Having trust in the fact that healthcare professionals know what to do and that they would support them, contributed to a sense of relief. Women understood that it was not necessary for them to have complete control during childbirth.

Women wanted advice about practices that could help them shift focus from fear to something practical. It could be prophylactic breathing, different forms of massage, or knowledge on how to control and change thoughts and create a positive goal, such as imagining themselves with their babies in their arms.

*"So she (the Aurora midwife) talked about shifting thoughts and to imagine a good delivery and that it all went well.... she was very good (is emphasized) (Sandra)*

Women also described a need to shift their fantasies to reality since their fantasies tended to be worse than how it actually turned out to be. As far as women were concerned, the labor ward was frightening, a scary unknown place to be in, and they wanted to feel safe and secure in the place where they would give birth to their

child. For women to visit and get acquainted with the hospital environment, gave them a better idea of what to expect when it was time to give birth.

*... and still we visited the delivery ward ... and that made me feel much more at ease, I had imagined something horrible but it felt just like an ordinary room sort of ... (Sandra).*

When childbirth was frightening, it was important that the midwife offered detailed knowledge about the issue to increase women's understanding. Getting information about possible complications was considered supportive and gave insight about reality. In contrast, when the midwife was perceived to avoid a question or to answer in a vague manner, women felt like that information was being kept from them. They understood that this was an attempt to protect them, but it did not support them in coping with their fears.

*...yes she was more factual...(the Aurora-midwife), she told me all about it, it was not as if she was trying to cover up but made me understand that it could be very tough (was emphasized) it made me feel prepared (was emphasized) (Sarah).*

To gain knowledge about a worst-case scenario gave women a chance to mentally prepare ahead should this situation occur. Being mentally prepared for their worst-case scenario supported them in coping with their fear. It was important for women to gain an understanding of the origin of their fear and to process their fear step by step. It could be a chance to reflect on their childhood or background. Despite the emotional difficulty of talking about the origin of their fear, phrasing this increased their understanding and processing. Women felt courageous and strong after daring to face the origin of their fear. Being able to reflect on their background was liberating and gave them a sense of permission to let their fear out in the open and thereby beginning to process it.

*"You have to find where the fear comes from, then you have to deal with it!" (Sabina).*

It was important for women to cope as they gained more understanding of importance for processing instead of repressing their fear. That health care professionals encouraged women to face and process their fear was seen as a positive impact though, women automatically resist talking about it. Initially, their fear would be repressed but, through encouragement, women crossed "a threshold" that made it easier to process their fear. In this process, the encouragement to talk about their fear was necessary. For women, it was irrelevant whether it was health care professionals or their partners who encouraged them to face their fear.

*...he was there and nagged about us being forced to talk about it (my fears) sooner or later, but I resisted as long as I could... so he was there and pushed me to try and start talking about it... so his support was really good (was emphasized) (Sarah).*

Women wanted increased knowledge and understanding as early as possible during their pregnancy. They described it as being important that the midwife asked about their feelings towards giving birth, in order to help them to start reflecting and processing their fear.

### **Combining all kinds of support**

Women felt it was the combination of all kinds of support that made it possible for them to cope with their fear. It was described as a chain of events that led them to be able to cope with their fear of childbirth. Women could talk about what kind of support helped them the most but, at the same time, they experienced that everything was needed to achieve functional support. They could not imagine being without any of the support mechanisms they received. Retrospectively, they felt that all supporting efforts were important and different focuses of their fears require different types of support to be handled and processed.

*It is a mixture of different parts...some parts from talking to the Aurora midwife, some parts from parental education meetings and from the film we saw there, some from books one has dared to read and so on... so I feel that nothing was a waste of time to hear (Sandra).*

Before women understood what worked best, it was important for them to test many different kinds of support. Women knew they might need different kinds of support at different times. If women understood their need for different kinds of support at different times, trying several kinds of support may be perceived positively. Hence, it was important to individualize the amount and type of support in order to receive the correct support at the right time.

### **DISCUSSION**

The most important finding of this study, is that primiparous women who suffer from fear of childbirth describe that their fear could shift focus. Offering support should be on an individual basis and sensitive to this change of focus. kinds of support were important to enable women experience increased coping capacity. Support should come in the form of offering reassurance as well as increased knowledge and understanding. Women described different kinds of support that were most helpful but their overall experience was that they

needed all kinds of support. This was because their fear might rapidly change focus and therefore, would require a different kind of support. Earlier research indicates that women coping with their fear could be divided into avoiding the fear, processing the fear and seeking help. These coping strategies were often used in an interchangeable fashion depending on what was perceived as most helpful in any given situation (Eriksson et al., 2006). Childbirth is not only a physiological process; women must also meet their fear through a psychological process (Nerum et al., 2006). Fear of childbirth is a complex problem (Fisher et al., 2006). Thus, it is important that support offered to women with fear of childbirth should be adjusted to the needs of the individual woman in order for her to process the complex parts of her fear. This demands that the midwife is sensitive to what the individual woman is afraid of in each situation.

Women experienced support as effective and useful when it is adapted to their individual needs and wishes when it is sensitive to their fear shifting focus. Individualization of support was necessary for them to be able to accept the offered support. Lyberg and Severinsson (2010), describe that in order to achieve a trusting relationship, it is necessary to create flexible models and to offer individualized support to women with fear of childbirth. A trusting relationship could empower women and their partners to mobilize necessary resources and also enhance their own abilities to handle childbirth. Hermansson and Mårtensson (2011), state that this trusting relationship is based on mutual respect and integrity. Hence, it is important that midwives offering support to women with fear of childbirth meet them with curiosity and ask each individual woman what she needs to be able to feel safe. Women expressed that they felt reassured when they entered into individual dialogue with a midwife who is understanding and sensitive to their needs. Then women were able to really listen and to understand the offered information, which was in contrast to the one shared in a group, which they described as difficult to handle. It has been earlier stated that when the midwives offer support to women, it is crucial that they show an interest in them and understand their situation (Eriksson et al., 2006; Hertfel et al., 2007).

In relation to women with fear of childbirth it might be important for midwives to initiate a private dialogue with these women about their thoughts before information is offered in a group session, or offer individual parental education sessions to them and their partners. It is important for women to gain increased knowledge and information from their midwife, especially when the issue in question was frightening and they needed help to replace fantasy with reality. Research indicate that fear of childbirth can predate pregnancy as students' saw childbirth as risky and fearful, and this was associated with the media being their prime source of information (Stoll et al., 2014). Unrealistic fantasies and lack of knowledge are described in earlier research as increasing

their fear, since women could not determine what was real and what was not (Onell and Thelin, 2005; Fisher et al., 2006; Melender, 2002; Eriksson et al., 2006), and the ethical code for midwives requires them to encourage women to develop a realistic view of childbirth (ICM, 2014). However, women in this study explained that the antenatal midwives sometimes avoid giving them straight answers on certain topics. This might be because the midwives were concerned about creating more fear, or maybe they lacked the time or knowledge to address the fear that a direct answer could create. This professional approach could be negative since women in this study also described a need to be encouraged to process their fear instead of repressing it. A different professional approach, including straight answers and helping women to get a realistic view of childbirth, could decrease women's need for specialist treatment (Lundgren and Berg, 2007). Research indicates the importance of professionals within the health care system giving priority to support and encourage in order to decrease the fear of childbirth in women (Melender, 2002; Nerum et al., 2006).

Findings show that women described an increased understanding of the importance of handling instead of repressing their fear. That someone encouraged women to handle and process their fear is being experienced as positive, despite women's automatic reaction to resist. Earlier research also describes that women want to deny their fear but they found out that an active process of confronting their fear is necessary (Eriksson et al., 2006; Nerum et al., 2006). It is also important that the midwife supports women to meet the inevitable and to stress that she is available for them (Eriksson et al., 2006; Hertfelt et al., 2007). In light of this, it is important that both midwives and relatives persist when women resists being confronted with their fear. Low self-esteem and fear that no-one will support them are among the reasons why women resist confronting their fears. Hence, it is important that the midwife communicates that she is there to support women in handling and processing their fear.

Further, it was shown that women needed reassurance to be able to believe in their own capacity to give birth. This corresponds with earlier findings of (Saisto and Halmesmäki, 2003) that fear of childbirth may be affected by low self-esteem. Women's self-esteem may be affected when health care professionals look for medical signs indicating that something might be wrong. Research indicates that this experience gives women a reason to doubt their own bodies, to think that their bodies are unreliable and need to be controlled (Nilsson and Lundgren, 2009). Women with fear of childbirth may deem themselves inadequate as mothers and it is not strengthening for these women if health professionals act as if they also doubt these women's capacity (Melender, 2002; Nilsson and Lundgren, 2009; Eriksson et al., 2006).

Women with fear of childbirth need confidence and courage to express and cope with their fear (Saisto et al., 2006; Nerum et al., 2006). Maybe women's lack of trust

in themselves could be related to the medicated view of childbirth that is dominating health care till this day (Bryar and Sinclair, 2011). Students' attitudes toward child-birth imply a decrease in trust in the physiological process and an increase in trust for technique and obstetrical interventions (Stoll et al., 2013). Hence, women's low self-esteem in relation to giving birth could be due to the fact that their faith in medical technology is stronger than their faith in themselves and their own bodies. Midwives offering support to women with fear of childbirth should focus on women's existential need to believe in their own capacity to give birth. The midwife needs to address women's need for increased self-esteem and communicate a trust in women's ability to cope with their fear.

The main limitation of this study was that only women who asked for help to overcome their fear of childbirth were approached for interviews and it will not be possible to generalize the results. However, qualitative research does not aim to generalize results but aim to increase knowledge about a phenomenon. Using interviews and purposive sampling and also gaining a variation among participating women increased trustworthiness in the results (Polit and Beck, 2011). Adding snow ball recruitment may have affected the purposive sample and could be seen as a limitation of the study. However, in qualitative studies, rigor is obtained by the researcher in adjusting when it will be appropriate to increase the quality of data (Morse et al 2002). Hildingsson et al. (2011), described that prevalence of childbirth fear change over time. Further, women with prenatal fear of childbirth may be cured of this fear by having a better birth experience. Therefore, it was of interest to include both pregnant women and women who had already given birth to gain a more wide perspective.

## Conclusion

Women in this study described that their fear rapidly could shift focus and then a combination of all kinds of support was important to increase their coping capacity. This implies that the support for women with fear of childbirth should be individualized. Support should also aim to reassure women of their capacity to give birth and offer increased knowledge and understanding for giving birth. Further research, is needed on how to best strengthen women's self-esteem in her capacity to give birth, regardless of her experiencing fear of childbirth or not. Further research, is also needed on how to best prepare women and their partners for childbirth.

## Conflict of Interests

The author(s) have not declared any conflict of interests.

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A close-up photograph of a newborn baby's face, showing the mouth and eyes. The image is slightly blurred and has a soft, warm tone. The baby's mouth is open, and the tongue is visible. The eyes are partially closed.

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