‘Fear of childbirth’ and ways of coping for pregnant women and their partners during the birthing process: a salutogenic analysis

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Abstract

Aim. To explore ‘fear of childbirth’ and its impact on birth choices among women and their partners in Northern Ireland.

Background. Despite a growing interest in other countries, research on the impact of childbirth-related fear on the experience of birth and on birth choices for anxious couples within the UK is limited.

Method. In-depth interviews were conducted with 19 women and 19 men between November 2009 and September 2010.

Analysis. Thematic content analysis of the interviews was carried out within the sense of coherence (SOC) theoretical framework (Antonovsky, 1987).

Findings. Three concepts underlying fear of childbirth were found, namely: ‘riskiness’, ‘ways of coping’, and ‘being a good parent’, which related to the comprehensibility, manageability and meaningfulness dimensions of SOC. Almost all of the women and men in this study (89%) expressed a desire to have a normal birth, but most of the participants (86%) appraised vaginal birth as risky. All the women feared the pain of childbirth and more than half (68%) feared they would not be able to achieve a normal birth, or that the baby would be injured during the birth process (58%). The most common fears for men were that their partner’s mental health would suffer as a result of a traumatic birth (74%), that they would be unable to provide adequate support during labour (58%) and that their partner or baby would be injured as a result of the birth (47%). Most of the women and their partners (73%) identified medical interventions, such as early induction of labour, electronic fetal monitoring, epidural and planned caesarean section (CS), as resources to help ensure a safe birth. Four participants (11%) identified midwifery support as a resource to help them cope with birth.

Conclusions. Fearful parents choose medical interventions in birth as a means to cope with the uncertainties of birth and ensure a safe transition to parenthood. To promote normality in childbearing and reduce medical intervention in birth, midwives need to be more proactive in offering credible alternatives.

Key words: Fear of childbirth, sense of coherence, wellbeing, men, coping, medical intervention, evidence-based midwifery

Introduction

While pregnancy and childbirth are usually seen as a time of wellbeing and happiness, for some women and their partners this is not the case, as they suffer from anxiety and fear (Nilsson and Lundgren, 2009; Eriksson et al, 2006a). Although our knowledge of how women and men cope with fears related to childbirth is limited, a growing interest in this topic is beginning to improve our understanding (Maier, 2010).

Estimates of the incidence of fear of childbirth among women vary considerably between countries with 10% reported in Scandinavian countries (Waldenström et al, 2006) and 40% in Turkey (Körükçü et al, 2010). This may be caused by methodological issues, such as the lack of a clear operational definition of the fear of childbirth concept (Nilsson et al, 2010); different cultural perspectives or different birth practices between countries (Fenwick et al, 2009). There is, however, consensus within the literature that fear of childbirth is associated with adverse clinical outcomes for mothers, such as labour dystocia, increased incidence of medical interventions such as epidural use, CS, and operative vaginal delivery (Sydsjø et al, 2013; Adams et al, 2012; Handelzalts et al, 2012; Alehagen et al, 2005; Heinze and Sleigh, 2003).

During pregnancy, primiparous women are more likely to report fear of childbirth than multiparous women, but multiparous women more often experience intense fears (Ryding et al, 2009), which are closely related to negative birth experiences such as poor professional care received during birth, lack of support from a midwife, feelings of loneliness during birth, feeling incapable of giving birth, a perception of loss of control during the birth, vaginal instrumental delivery, and emergency CS (Storksen et al, 2013; Rilby et al, 2012; Nilsson et al, 2010; Rouhe et al, 2009).

‘Tokophobia’ is defined as morbid fear of childbirth (Bhatia and Jhanjee, 2012), and this diagnosis has recently been endorsed within the UK as an indication for planned CS (NICE, 2011). This decision seems contrary to current trends within maternity services that focus on promoting normality in birth (Gould, 2012). However, there have been concerns for some time among midwives that the conceptualisation of fear of childbirth as a pathological process, situates the problem within the individual woman, and deflects attention from maternity care provision (Walsh, 2002).

Men can also suffer from fear of childbirth, although most research to date has focused on mothers. Currently in western societies, men are expected to be fully involved in all aspects of childbirth (Longworth and Kingdon, 2011), but, for some men, fears related to childbirth can lead to feelings of distress and helplessness (Dellman, 2004). It has been estimated that between 11% (Bergström et al, 2009; Hildingsson et al, 2013) and 37% (Sjogren, 1997) of men experience significant fears.

One-third of the partners of women with ‘fear of childbirth’ expressed significant fear themselves (Holberg and Ward, 2003). It is also known that fear of childbirth can lead fearful women and men to request medical interventions, such as planned CS (Hildingsson, 2014; Sahlin et al, 2013), and it is these preferences for medical procedures that make fear of childbirth such an important topic (Ayers, 2014).

**Method**

The paper describes a qualitative study that explored the effects of fear of childbirth on the birthing preferences for women and their partners. It builds on the theory of salutogenesis (Antonovsky, 1987), which focuses on how ‘wellbeing’ is developed and maintained. ‘Wellbeing’ is operationalised by what Antonovsky (1987) termed a ‘sense of coherence’ (SOC); a psychosocial concept involved in the mediation process between stressful life events, wellbeing and health. Antonovsky (1987) proposed that individuals with a strong SOC maintain wellbeing by managing the stressors of life better than those with a weaker SOC, who are more vulnerable to ill health. This is because individuals with strong SOC have the ability to find appropriate solutions to stressors and resolve conflicts through adaptability, leading to improved wellbeing (Lazenbatt and Thompson-Cree, 2009).

Central to building a strong SOC are coping resources called ‘generalised resistance resources’ (GRRs). These can be promoted by positive life experiences and in structures such as social support and family relationships (Antonovsky, 1996). Professional groups, such as midwives or obstetricians, could also be described as GRRs. According to Antonovsky (1987), when faced with stressful situations, individuals search among the GRRs at their disposal to find the resources needed.

Accessing healthy GRRs could provide a key to optimum childbearing for new parents. Identifying healthy GRRs could guide midwifery practice and research towards ways of encouraging successful coping for new mothers and fathers (Downe and McCourt, 2004). Salutogenesis offers midwives a conceptual way of thinking about how women and their partners could be supported to move towards health and wellbeing, rather than concentrating on avoiding risk factors (Sinclair and Stockdale, 2011).

**Setting and sample**

In 2010, a purposive sample of 19 pregnant women and 19 male partners (n=38) were recruited at the Royal Jubilee Maternity Service (RJMS) in Belfast – the largest maternity hospital in Northern Ireland (NI). No attempt was made to recruit couples who had specifically expressed fear of childbirth, but rather the study aimed to explore fear of childbirth with women, who were assessed to be of low obstetric risk, and their partners.

Potential participants were introduced to the study and its aims by midwifery staff at routine visits to the hospital. Those who expressed an interest were contacted by the research midwife to arrange an interview. Written informed consent was obtained from participants before the interviews took place. Although more than half of the men and women were couples, they were interviewed separately. (For the demographic profile of the participants, visit the RCM website.)

**Procedure**

Face-to-face in-depth interviews were carried out by a female researcher who is a midwife. The researcher was careful to ensure confidentiality, as well as sympathetic support, for those interviewed. The study used a semi-structured interview format which lasted, on average, one hour and was audio-taped. Interviews took place in a safe place, as defined by the participant. Most participants (n=25) were interviewed in a private room in the hospital, the others (n=13) were interviewed in their own homes.

An evidence-based topic guide, developed from the literature, was used to ensure consistency and focus (Arthur and Nazroo, 2003). The initial question participants were asked was: ‘Will you tell me about any anxieties or fears you have about childbirth?’ When participants raised fears or anxieties about childbirth, non-directional prompts, such as ‘Why is this a worry for you?’, were used.

**Ethical considerations**

Confidentiality was respected at all times and all names were removed from the data. Arrangements were in place with the lead clinical psychologist at the RJMS so that any study participant who reported significant fears could be referred for assessment and support. All were made aware of this, but none requested an appointment. Ethical approval for the research study was obtained from the office of research ethics committee NL. For purposes of data protection and in accordance with Queen’s University research governance, the transcripts were stored on a private computer that was password protected.

**Data analysis**

An interpretive summary was written for each interview which was transcribed verbatim, and the full transcripts were imported into QSR NVivo 8. Thematic framework analyses based on ‘salutogenesis’ theoretical dimensions were used to explore participant fears and coping around the birthing process. SOC comprises three dimensions: comprehensibility, manageability, and meaningfulness. Comprehensibility means that whatever happens to a person, s/he is able to make cognitive sense of it and understand it as structured, predictable, and explicable. Manageability is a psychological component, which means that either internal resources are available to meet the demands posed by the stress, or there are ways to access resources externally. Meaningfulness is interpersonal and involves having a sense of meaning in the important areas of one’s life or recognising these demands as challenges, worthy of investment and engagement.

**Findings**

All women and their partners were very motivated to have good births, to make good transitions to parenthood and be good parents (meaningfulness). However, the participants differed significantly in their assessment of the risks posed
by childbirth (comprehensibility), and in their choice of the resources to enable them to cope (manageability) with the birthing process. Fears about childbirth for the men and women in this study were concentrated in three main areas:

- Risks associated with vaginal birth
- Impact of pain during childbirth
- Mother or child being injured during the birth process.

**Comprehensibility (cognitive)**

For men and women the comprehensibility dimension was related to the individual’s assessment of the risks and uncertainties associated with birth. The greater the perception of uncertainty or risk, the greater the fear:

“...that’s what this whole thing is all about, isn’t it. Nobody knows what’ll happen or how it will go” (W17, prim).

Over half of the women (n=11) and almost half of the men (n=9) appraised labour and vaginal delivery as posing considerable risks to the physical health of the mother and baby. In total, 68% of the women and 42% of the men feared that their baby was too big to be born vaginally:

“...you see the baby on the scan and you see the head and you think... how could it get out of down there?” (W6, para 1).

Five (26%) of the women feared that they could be coerced into doing something they didn’t want to during labour for the sake of the baby:

“I think once you come into hospital it’s all about the baby... they told my mother that... she didn’t want the forceps, but she had to get them for our [brother’s name]” (W17, prim).

A total of 74% of the men (n=14) were fearful that their partner would be unable to cope with, and would be traumatised by the pain:

“She was already fragile with it... she couldn’t... it was such a scar mentally for her... the way both of the births had went that if another bad one had of come along – we would have struggled... you know” (M19, third baby).

The men feared that being traumatised by the birth would affect their partner’s postnatal mental health and impact negatively on the new family unit:

“My first relationship broke up because of the birth... and [led to] parenting difficulties and postnatal depression” (M13, second baby).

In contrast, with the perceived riskiness of vaginal birth, all the men and women (n=28) who expressed an opinion about CS said it was a safer mode of delivery for the baby and only four participants (11%) said it was more difficult for the mother than a vaginal birth:

“To be honest – they were talking about sections the other night – they don’t scare me – because I feel it’s a more controlled environment” (W8, prim).

“Yes it would be quicker and more organised – and less for [partner] to worry about... it would be over in about half an hour” (M7, first baby).

Perception of riskiness of vaginal birth was increased when there were previous negative birth experiences. One woman described how a negative experience of birth had affected her:

“...I was always so afraid of that happening to me again [painful episiotomy wound] that that’s why I had a planned section with [second child]” (W18, para 2).

However, this woman (W18, para 2) went on to describe a very positive experience as birth partner for her sister and how this changed her mind:

“I went with my sister and she had her waterbirth and it was the most amazing experience of my life, it was absolutely an inspiration for me” (W18, para 2).

She was planning a normal birth during this pregnancy, demonstrating how positive birth experiences and positive birth stories can have the potential to reduce the perception of riskiness and increase the expectation of being able to cope with normal birth.

**Manageability (psychological)**

The manageability dimension was related to the perception of ability to access resources needed to cope with the birthing process. These were focused on accessing resources to cope with pain and resources to reduce the risk of injury to mother or baby during birth. The bigger the gap between the individual’s assessment of their needs and their perception of the availability of resources, the greater the fear.

All the women anticipated they would have their partner’s support during labour but more than half of the men (58%) feared they would be unable to provide adequate support:

“I’m going to stand like a spare tyre at the side of the bed... you know. Holding her hand like but there’s nothing much I can do for her” (M12, second baby).

Four of the men expressed more confidence in their ability to provide practical help following a CS than support during active labour:

“Yes... there is more pain after a caesarean and then I can help her all the time... shopping and cooking... with the baby and get her to rest plenty. I have not to go to work for four weeks and I can help her very much... but I can’t help her with the pains before the baby comes” (M4, first baby).

All the women feared the pain of labour and were reassured by the availability of a 24-hour epidural service. Despite this, the majority of the women (65%) expressed hope that they could labour without an epidural, although they lacked confidence in their ability to cope and feared the pain would be too severe. Six of the primigravidas in this study (40%) had already been advised to have an epidural during labour by family or friends and all the men wanted their partner to have as much pain relief as possible during the birth:

“She [her mother] said: ‘If you want my advice, you get an epidural as soon as you go into labour because you’ll never be able to cope.’ You see they all know me and know what I’m like” (W10, prim).

As with epidural anaesthesia, the men were more positive about the use of medical interventions in birth than were the women. All of the men who expressed an opinion (n=18) were reassured by the availability of birth technologies and the majority (88%) were keen for them to be used in the expectation that it could make the birth easier and safer:

“...it’s why you come to the hospital isn’t it?... so they can watch out for that sort of thing... and sort it out... like there’s so many monitors and scanners and that... if there’s a problem they can get it sorted out fast” (M5, third baby).
All the women who expressed an opinion about medical intervention (n=17) were willing to accept it, if necessary for the wellbeing of their baby, but most (65%) hoped to be able to manage without it. The women who preferred normal birth expressed more confidence in the safety of the birth process than those who preferred CS:

“...it goes back to what I believe about birth, that that's the way babies are supposed to come into this world” (W6, prim).

These beliefs seemed to also boost the women’s confidence that they had the internal resources to cope. These women were inclined to perceive birth as a challenge to be well met in order to make a good transition to motherhood. The desire to overcome that challenge motivated these women to achieve a normal delivery without intervention:

“I want to sort of enjoy the birth and the struggle to do it... if you know what I mean” (W5, prim).

Four participants (11%) identified midwife support as a resource to help them cope with birth. These were two multiparous women and partners. Recalling previous births, they described how the midwife had reduced their fears:

“...from what I could see, the midwife had everything under control and like it seemed ok... so I was pretty relaxed” (M3, third baby).

“I felt totally safe, even when I had just met [midwife’s name], I just knew I was going to be ok” (W18, third baby).

The only participants in this study who had met the person who would provide their care during labour were the four couples who had private medical care. Both women and men found it reassuring and identified that person as a resource:

“A direct line... yes. It was good to have a friend who was at a high level... so he kept an eye for us... you know... it was a bit more reassuring for us that was” (M12, first baby).

**Meaningfulness (motivational)**

The meaningfulness dimension relates to motivation and all participants were motivated by a desire for a safe birth, a good birth experience and to be good parents. Fears associated with this dimension were related to uncertainty about the best way to achieve this and fear of making a wrong choice:

“Everybody tells you something different... and you don’t know what to follow... it’s all conflicting sort of stuff... and you sort of sit and go... what do I do here” (M3, third baby).

Consistent, reliable information from known and trusted healthcare professionals seemed to be the best resources to counteract these fears and guide new parents through the maze of conflicting advice and opinion. As one man explained:

“It’s not that I don’t trust, but I don’t know them enough to know if I can trust them” (M2, third baby).

**Discussion**

These narratives provide a picture of fear of childbirth and challenges faced from the perspective of women and their partners, as well as the coping resources they utilise to meet these challenges in promoting a positive SOC. All participants were motivated (meaningfulness) to engage with the pregnancy and healthcare professionals in order to achieve a good birth and safe transition to parenthood. All participants had made a considered appraisal of the risks (comprehensibility) associated with childbirth and the extent to which they had the necessary resources to make a good transition to parenthood (manageability).

This study shows that the key components of fear of childbirth for pregnant women and their partners in NI are similar to those reported from other countries and confirms previous findings that women fear pain in childbirth (Geissbuehler and Eberhard, 2002; Melender, 2002), lack confidence in their ability to give birth vaginally (rilly et al, 2012; Maier, 2010; Eriksson et al, 2006a) and fear birth injury to themselves and their baby (Faisal et al, 2014; Fenwick et al, 2010). It also confirms previous findings that men have fears about their partner coping with pain (White, 2007) and the safety of their partner and baby during the birth process (Eriksson et al, 2006a; 2006b).

The most frequently expressed fear among the men was that a very painful or traumatic birth would have a negative impact on their partner’s mental health. This is the first time that concern for their partner’s mental health has emerged as the most significant fear of childbirth among men. This may explain why men were keen for their partner to use epidural anaesthesia even though most of the women (65%) wanted to avoid it.

Concern for their partner’s mental health may also explain men’s positivity towards CS, which most perceived as safer, more controlled and easier to cope with than the uncertainties and potential for trauma they associated with vaginal birth. The men also expressed more confidence in their ability to provide practical support following a CS and a clearly identifiable role for themselves in the postnatal period seemed to impact positively on both the comprehensibility and manageability dimensions of SOC for the men. A medically managed birth, therefore, seemed to meet the needs of the men. However, it would also seem that men who are keen to support their partner through a normal birth would respond well to a more clearly defined role during labour and birth. There is a need for more research into how this could be facilitated.

Normal birth was still very alluring for most of the women in this study. It has been reported previously that women idealise normal birth while also rejecting it as dangerous (Maier, 2010). Most women in this study (89%) aspired to a normal birth but more than half (68%) feared they would not be capable of achieving it safely without medical intervention. Gould (2012) contends that this is a consequence of the language of risk that is used when offering birthing choices to women. This perception of riskiness reduces the comprehensibility dimension for women, and increases their need for resources to help manage birth.

Normal birth seemed to be a meaningful part of the transition to motherhood and the women were motivated to try to find resources to help them achieve it. However, it is a significant finding that only four participants identified a midwife as a resource to help them cope. A total of 15 of the women had care provided under the ‘shared care scheme’, where antenatal care is shared between the woman’s GP and the obstetricians at the hospital. The other four women had...
private medical care with an obstetrician. When antenatal care for low-risk women is led by medical staff, pregnant women and their partners seek medical solutions to help them cope with their fears about birth.

There have been concerns for some time that the role of the midwife has been diminished by the way in which maternity services are organised (McCourt et al, 1998). It is not known from the data how much contact any of the participants had with a midwife before the interview, but all women in this study had been assessed as low obstetric risk, making them suitable for midwifery-led care. Better contact with midwives during pregnancy could have allowed alternative resources for managing birth without medical intervention. It is encouraging to see in NI that steps are being taken to increase midwifery-led care (Department of Health, 2012).

Fear of vaginal birth was prominent in this study and the impact of medicalisation of birth was apparent in the more fearful participants’ appraisal of the risks and resources identified as available for coping, such as induction of labour, epidural anaesthesia and elective CS. Salutogenesis offers midwives theoretical pathways towards understanding fear of childbirth and guidance in helping women and their partners overcome fears.

In this analysis, fear of childbirth resides in the margin between the assessment of risk and coping resources. This suggests that to promote normal birth midwives need to reduce the perception of riskiness while increasing availability of midwifery resources to help women achieve more natural births. A two-pronged approach to reducing fear of childbirth and promoting normality in birth is therefore suggested by this study.

**Increasing the comprehensibility dimension**

This would involve reducing the perception of riskiness associated with normal birth. Such strategies could include:

- Better use of positive birth stories that focus on the potential for birth to go well
- Allocating time to review the events that occurred during birth with newly delivered mothers and their partners to allow them to ask questions about the birth

- Increasingly using midwives to provide antenatal care for low-risk women.

**Increasing manageability**

Alternative coping strategies that have been shown to promote normality in birth include interventions such as:

- A known midwife during labour (Sandall et al, 2013)
- Reassurance for all women that they will have continuous support during their labour (Hodnett et al, 2013)
- Antenatal mindfulness-based meditation and education programmes (Byrne et al, 2014)
- The use of complementary therapies, such as therapeutic massage (Smith et al, 2012)
- Hypnobirthing (Phillips-Moore, 2012)
- The use of birthing pools in labour (Cluett and Burns, 2009)
- Alternative birthing positions (Lawrence et al, 2013).

**Limitations**

This was a small qualitative study in a consultant-led hospital and the findings may have been very different if the study had been carried out in a different maternity setting.

**Conclusion**

This study has examined the unique experience of FOC for women and their partners in NI. By investigating the experience of FOC through a salutogenic wellbeing perspective rather than a pathogenic view of risk and illness, new insights have been found.

This analysis has highlighted the importance of offering prospective parents resources to make healthier choices about birth and it has given theoretical guidance about how this might be achieved. From this study, there are three key messages for midwives:

- Perceived riskiness of normal birth needs to be counter-balanced with more positive dialogues about normal birth
- The perception that medical interventions in low-risk pregnancy increases safety for mothers and babies needs to be challenged
- Fearful women and their partners need credible alternatives to medical interventions if they are to cope with childbirth in a more salutogenic way.

### References


References continued


