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FIRST-TIME DELIVERING WOMEN'S FEAR OF CHILDBIRTH AND IT'S RELATION TO DELIVERY OUTCOMES AT A UNIVERSITY HOSPITAL IN LITHUANIA

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Keywords: fear of childbirth, tokophobia**,** childbirth, first-time, pregnancy.

Summary

Introduction. Fear of childbirth (FOC) is a common women's health problem. It might affect the mother's and the fetus' health, complicate and prolong the birth. Women with tokophobia (clinically significant FOC) are more likely to suffer poor birth outcomes. FOC can increase Caesarean section rates with no medical indications. There is no worldwide consensus on the diagnostic protocol and care algorithms for FOC.

Material and methods. A prospective study was performed at the tertiary care university hospital (Kaunas, Lithuania). The survey included 110 first-time delivering women at the time of entering the labour ward. A scale and Fear of Delivery Questionnaire (FDQ) questionnaire were used. Medical data were collected from the hospital's database and analyzed using Microsoft Excel and IBM SPSS software for statistical significance ($p < 0.05$).

Results. According to a subjective scale of FOC (range min 0 - max 10), 37.3% (n = 41) of women stated they experienced FOC. The majority (25.5%; n = 28) rated their fear with 3 points. Absence of fear was indicated by 8.2% (n = 9), and 4.5% (n = 5) felt tokophobia with panic attacks. The majority were worried about newborn health (89.1%; n = 98) and labour pain (79.1%; n = 87). Based on the FDQ questionnaire slightly less than half of the respondents experienced FOC (44.5%; n = 49). No strong associations were found between FOC and neonatal parameters ($p > 0.05$). Pain relief methods were more frequently chosen by women with FOC ($p = 0.032$). Patients with FOC gave birth significantly longer than those without FOC ($p = 0.047$). As FOC increased in score, the time of childbirth also increased ($p = 0.02$). The method of delivery did not depend on the strength of FOC ($p = 0.443$). FOC in score was higher for women with a history of abortion ($p = 0.036$).

Conclusions. Nearly half of the interviewed women were experiencing FOC. Newborn health and labour pain were the main reasons for FOC. History of abortion was related to FOC. No strong associations were found between tokophobia and negative newborn outcomes or method of delivery. Significantly longer labour duration was found in women with FOC.

Key Message – Fear of childbirth has a great impact on pregnant women's health and birth itself. Further research is crucial to find effective diagnostic and treatment methods for women with FOC to recognize and help before or even during childbirth.

First-time delivering women's fear of childbirth and it's relation to delivery outcomes at a university hospital in Lithuania.

Introduction

The term 'fear of childbirth (FOC)' describes a specific spectrum of anxiety disorders related to pregnancy and childbirth [1-3]. It varies from reasonable worrying to severe anxiety and life-altering fear [4].

The early signs might range from sleep disorders and panic attacks to somatic symptoms with no organic explanation [5]. The percentage of women experiencing FOC in different countries varies due to different ways of measuring FOC and it's evaluation [1;5] - research suggests that up to 25% of pregnant women will develop FOC [6] and 5-10% of them will develop tokophobia [4]. Term 'tokophobia' was introduced by French psychiatrist Louis Victor Marcé and depicts a clinically significant and life-altering FOC [1;4].

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It is important to note that there are no common diagnostic protocols and standard questionnaires, as well as care algorithms for women with FOC [1; 3; 6]. The absence of a consensus might origin from scanty research on this topic and the fact that FOC is still a relatively new issue in the obstetric field. However, FOC has been traced to be provoked by stressors, such as previous aggravated obstetric history and traumatic events, fear of pain in general as well as socioeconomic factors - lack of support, absence of the partner and economic instability [7; 8]. All things considered, we found the topic of FOC to be of great importance since it has become a growing focus of research and debate. Furthermore, antenatal fear symptoms were proven to not only cause problems for the woman (f.e. psychological damage, relationship and breastfeeding problems) but it might affect the fetus' health as well [5; 6; 9-12]. FOC can disrupt the pregnancy as well as prolongate and complicate the labour causing the increase in Caesarean section (CS) rates with no medical indications ('section on request') [13-15].

The research aimed to evaluate first-time delivering women's FOC, it's reasons and to examine FOC's relation to childbirth duration and outcomes.

Material and methods

A prospective study was performed in the Hospital of Lithuanian University of Health Science Kaunas Clinics, Department of Obstetrics and Gynecology from February 1st - October 10th, 2020 (excluding the period of strict quarantine due to Covid-19 March 16th - June 16th, 2020).

Based on the previous literature on FOC, a qualitative type of research was conducted - a questionnaire survey. The questionnaire comprised three parts: socio-demographic and obstetric details, a scale of subjective evaluation of FOC and the standardized Fear of vaginal delivery scale (FDQ). A socio-demographic information was collected, including: age, marital status, education, residence and partner support. Obstetric questions included: gestational age, previous obstetric history, method of conception, complications during the current pregnancy, and women's preference for pain relief methods (PRM). Women were asked to indicate whether they felt FOC, mark the main causes and to express their opinion about their partner's participation and support during childbirth. In addition, they were asked whether they have participated in maternal classes, courses, or other activities that could have relieved FOC.

In the second part of the questionnaire a scale of subjective evaluation of FOC was used. Regarding the current pregnancy, women were asked to rate FOC on a 10-point scale, where 0 points indicated absence of fear, 3 points – a fear requiring additional means of calming (meditation, massage, etc.), 6 points - fear when normal calming measures do not help and 10 points – fear leading to panic attacks and health problems.

Nowadays, there are no standardized criteria for the diagnosis of tokophobia in European countries, thus, for the third part of the questionnaire, FOC was measured by FDQ - a revised version of the FOC questionnaire (Table 1), developed by Saisto et al. in 2001 [16]. We considered FDQ to be a more appropriate measurement because it is easily understandable and quick to fill out. The FDQ questionnaire consisted of 10 "yes" or "no" questions; answering 5 or more questions "yes" and/or by answering "yes" to the tenth question is an indication of FOC.

Participants were first-time delivering women who were hospitalized for childbirth. Questionnaires were handed out to all women at the time of entering the labour ward. Altogether 110 women (95.9%) agreed to join the study. An experimental group was formed among women who showed an indication of FOC according to FDQ, and all results obtained were compared with a comparison group, which consisted of women without prevalence of FOC (based on FDQ). Data on the deliveries (delivery duration in minutes, pain relief methods, childbirth and neonatal parameters) were collected from the Delivery department's registry database.

Statistical analyses. Data were analyzed using IBM Statistics SPSS for frequencies, T-test and χ^2 test. Results with values of $p < 0.05$ were considered as statistically significant.

Ethical approval

The study was approved by the Hospital of Lithuanian University of Health Science Bioethics Center (December 5, 2019 No. BEC-MF-151). All women in the study signed the informed consent forms.

Results

110 pregnant women between 31 and 41 weeks of gestation (M 38 ± 1w.) were included in the study. The mean age of the participants was 27.8 ± 4.5 years (ranging from 16-39 years). Nearly half of the respondents had a university degree, most of them resided in the city and were married. The majority of respondents were pregnant for the first-time (79.1%, n = 87), 7.3% (n = 8) became pregnant after assisted reproduction procedures. Detailed socio-demographic data of the participants are presented in Table 1.

According to the questionnaire, 37.3% (n=41) of women answered the question "Do you feel fear of delivery?" with "Yes" and only 17.3% (n=19) of women stated that they did not feel fear. The main causes of first-time delivering women fear during childbirth are presented in Figure 1.

The study sought to find out whether the presence of a

partner during childbirth could help reduce the FOC. The majority of respondents (77.3%; n = 85) believed that partner's participation and support in childbirth is important (p = 0.001). Respondents expressed that "it is important to know that you are not alone", "the presence of a loved one nearby provides a sense of security, confidence, and emotional calm", "it is an opportunity to share happiness and anticipation". However, no significant links were found between FOC and respondent's opinion on the importance of partner's participation (p = 0.766).

As a part of the study, the respondents were asked if they have participated in classes or other activities that would help overcome the FOC during pregnancy and delivery. Only 17.3% (n = 19) indicated that they have participated in pregnancy courses, online seminars, or hospital classes. Other respondents emphasized that participation in such activities was limited by the national quarantine for Covid-19 infection in the country.

According to the subjective evaluation of FOC by scale, the majority of pregnant women (25.5%; n = 28) rated their FOC with 3 from a maximum of 10 points. Absence of fear (0/10 points) was indicated by 8.2% (n = 9) of respondents, and 4.5% (n = 5) identified a fear which can cause panic attacks (10/10 points).

Based on the FDQ questionnaire, slightly less than half of the respondents had experienced FOC (44.5%; n = 49). There were no significant links between FOC by the FDQ questionnaire and maternal age (p = 0.261).

57.3% (n = 63) of respondents planned to choose analgesia during the labour, 19.1% (n = 21) - wanted to give birth without PRM, and 23.6% (n = 26) chose the "I have not decided yet" answer option. 62 from 63 (98.4%) patients were planning to choose an epidural analgesia, besides, women were also interested in non-medical PRM - nitrous oxide gas inhalation (25.4%; n = 16), massage (47.6%; n = 30), and music (25.4%; n = 16). However, during labour PRM, such as opioids, nitrous oxide gas inhalation, and epidural analgesia were used in most patients (78.18%; n = 86); 45 (52.3%) of them experienced FOC. Epidural analgesia was applied to 54 of 62 participants who planned to choose it; 28 (51.9%) of them were experiencing FOC. Delivery PRM (p = 0.032) as well as epidural analgesia (p = 0.043) were more frequently used in women with FOC.

Table 1. Fear of vaginal delivery scale (FDQ)

1. Do you have difficulties relaxing because you are thinking of the labour?
2. Are you afraid of being seized with panic at the labour?
3. Are you afraid that you will scream uncontrollably during the labour?
4. Have you always been afraid of giving birth?
5. Have you sometimes thought of the labour as something unnatural?
6. Have you had nightmares about the labour?
7. Are you afraid of rupturing during the labour?
8. Are you afraid of painful injections during the labour?
9. Are you afraid of losing control of yourself at the labour?
10. Do you prefer a CS to an ordinary labour?

Table 2. Detailed socio-demographic data of the study population

	Respondents, n (%)
Education	
Elementary	2 (1.8)
Secondary	20 (18.2)
College	36 (22.7)
University	52 (47.3)
Settlement	
Urban	98 (89.1)
Rural	12 (10.9)
Marital status	
Married	76 (69.1)
Cohabitant	27 (24.5)
Single/divorced	7 (6.4)
Pregnancy	
1	87 (79.1)
2	17 (15.5)
≥3	6 (5.4)
Assisted reproduction procedures	
Yes	8 (7.3)
No	102 (92.7)

Table 3. FOC and birth outcomes.

	Respondents with FOC, n	**Respondents without FOC, n**	**Significance, p**
Maternal factors			
CS	7	9	0.443
Vaginal delivery	42	52	0.476
Genital and perineal rupture	26	30	0.574
Neonatal parameters			
Apgar score <7	2	3	0.353
Premature delivery (Gestational Age <37 weeks)	3	3	0.868
Small for gestational age	2	4	0.945

Women suffering from FOC gave birth significantly longer than those without FOC (p = 0.047). Average duration of delivery for women with FOC was 798 min (SD ± 326) and 661 min (SD ± 332) for those without FOC. As the fear increased by scale, the duration of childbirth prolonged (p = 0.02) (Figure 2).

21% (n = 23) participants had a history of abortion (19 patients experienced misscariage, 4 terminated pregnancy for social reasons). A significant association between prevalence of FOC (based on FDQ) and a history of abortion was found (p = 0.036). FOC in score (based on subjective score in the scale) average was 6.09 (SD ± 2.35) for women with negative pregnancy experiences (21%; n = 23) and it was significantly higher compared to an average score of 3.97 (SD ± 2.21) for those in first-time pregnancy (79%; n = 87) (p = 0.012). Neonatal and maternal birth outcomes had no significant links with FOC, data are presented in Table 2.

Discussion

According to the questionnaire, we found that slightly less than half of the first-time delivering women may experience FOC. Consistent with previous studies, [4; 9; 10; 17] the results of our study showed no significant association between maternal age and higher levels of FOC. Contrarily, a Swedish study with a population of 410 women and 329 men [18] found an increased risk for first-time delivering women whose age is <32 years.

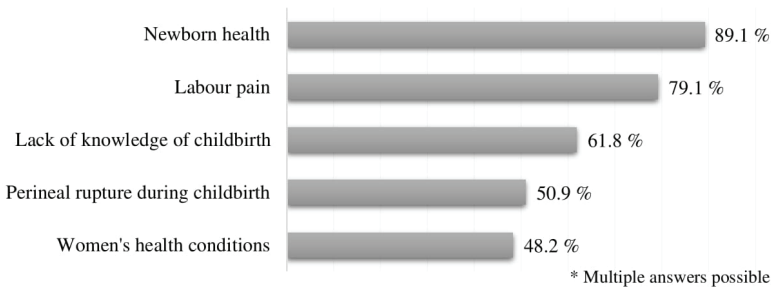

Figure 1. The main reasons for first-time delivering women's fear during childbirth.

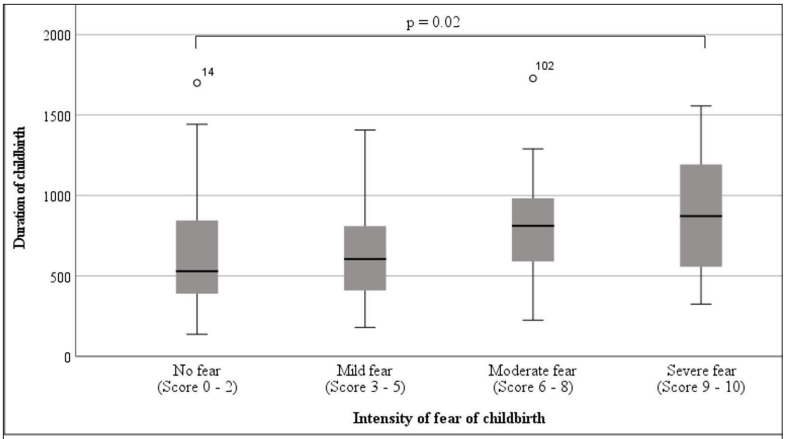

Figure 2. Box plot graphic illustrating the association between duration of childbirth and the intensity of fear of childbirth.

In the present study, the most common reasons for FOC were newborn's health (89.1%), labour pain (79.1%), and lack of knowledge about labour (61.8%). Child's health and labour pain were identified as the most frequent reasons for FOC among pregnant women in a prospective Polish study [2]. Lack of proper knowledge as a cause of high level fear was listed by Saisto and Halmesmaki [8]. Among tested women, only 17.3% participated in antenatal classes or other activities that would help to gain reliable knowledge and reduce the FOC. Polish research performed in 2016 shows that participation in such activities reduced FOC and influenced greater preparation for childbirth including an active attitude of the father who provided emotional support and helped reduce FOC [19]. However, current low attendance may have been due to the national quarantine for Covid-19 infection and public restrictions in the country.

Our research showed that previous negative pregnancy experiences were related to a higher risk of developing FOC. In line with the literature [20] we found that those women are more likely to suffer from FOC than women without this experience. It is known that fear activates a hormonal stress response in pregnant and labouring women. High levels of plasma catecholamines may weaken uterine contractility and become a reason for prolonged labour [21]. There are some findings that FOC may influence fetal circulation and result in fetal distress [22]. In our study, we did not find any FOC association with negative fetal and newborn outcomes. Some studies conducted in France and Denmark [23; 24] have also stated no impact on neonates.

The results of our study showed a significant association between women experiencing FOC and a longer duration of labour. Finnish, Swedish and British data show that up to 22% of CS births are due to maternal request or FOC [8; 25]. Although FOC increased labour duration, we found that the majority of women (85.5%) achieved vaginal delivery independent of FOC, and 55.32% of them were experiencing fear. The study

showed that FOC was not the indication for planned CS, and it should be performed only when there are medical or obstetric contraindications for vaginal delivery.

Based on the results, we found that women with FOC (45 out of 49) were 1.7 times more likely to request pain-free labour than the ones without FOC (41 out of 61) . Epidural analgesia was significantly more frequently used among women with FOC. Other studies have also demonstrated the influence of FOC on PRM with epidural analgesia during labour [9; 12; 24].

Small sample size was the main limitation of this research. Furthermore, we did not evaluate all of the demographic factors, history of depression, pregnancy planning, sexual abuse, etc. In addition to individual limitations, we found that a major drawback in FOC evaluation waslack of diagnostic standardisation. While our questionnaire implies that almost half of the women experience FOC, other authors might suggest different criteria [1-3; 16; 17]. A multicenter clinical study with different questionnaires should be performed to compare different diagnostic methods and questionnaires' eligibility.

Unbiased selection of first-time delivering women leads us to believe that the amount of women with FOC in the population might be greater than expected. Further large scale investigation is required to reflect the majority of women in Lithuania. Tokophobia is a severe topic that needs to be taken into consideration more seriously. FOC should be evaluated and detected prior to delivery with a structured data continuum between different hospitals to avoid miscommunication. Women with FOC should be investigated, provided with a well-timed psychological therapy or treatment and given all of the necessary information and support.

Conclusions

1. This study analysed the frequency of FOC among first-time delivering women. According to the results, nearly half of the respondents were suffering from FOC.

2. Newborn health, labour pain and lack of proper knowledge were found to be the most frequent reasons for FOC.

3. History of abortion was related to a higher prevalence of fear.

4. No strong associations were found between FOC and negative newborn outcomes, mode of birth.

5. We determined that women with FOC had a significantly longer duration of labour and were more likely to request PRM.

6. Hence, it is always important to take an interest in women's concerns during pregnancy and birth time, to identify pregnant women with tokophobia, to use empirical knowledge of FOC and to appoint the appropriate therapeutic and prophylactic management.

Author contributions

Authors Mantile Juotkute and Akvile Papievyte interviewed the respondents and collected the data. Author assoc. prof. Egle Machtejeviene was the supervisor of the research. All authors contributed to the analysis of the data and writing of the manuscript.

Conflicts of interest

All of the authors have no conflict of interest to declare. Co-authors have seen and agree with the contents of the manuscript and there is no financial interest to report. We certify that the submission is original work and is not under review at any other publication.

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PIRMOJO GIMDYMO BAIMĖ IR JOS RYŠYS SU GIMDYMO REZULTATAIS LIETUVOS UNIVERSITETINĖJE LIGONINĖJE

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Raktažodžiai: gimdymo baimė, tokofobija, gimdymas, pirmas kartas, nėštumas.

Santrauka

Įvadas. Gimdymo baimė (GB) yra dažna su nėščiosios sveikata susijusi patologija. Ji gali paveikti motinos ir vaisiaus būklę, apsunkinti ir prailginti gimdymo trukmę. Moterims, patiriančioms tokofobiją (kliniškai reikšmingą GB), gimdymo baigtis neretai būna prastesnė. Dėl GB gali išaugti cezario pjūvio operacijų dažnis, nesant medicininių indikacijų. Šiuo metu pasaulyje nėra priimto bendro nutarimo dėl diagnostikos ir priežiūros algoritmų moterims, patiriančioms GB.

Metodika. Tretinio lygio universitetinėje ligoninėje (Kaunas, Lietuva) atliktas perspektyvusis tyrimas. Tyrime dalyvavo 110 pirmakarčių gimdyvių, jos apklaustos patekusios į gimdymo skyrių. Tyrimo metodas – anketinė apklausa, sudaryta iš bendrųjų klausimų, subjektyvios baimės vertinimo skalės ir objektyvaus GB klausimyno. Medicininiai duomenys surinkti iš ligoninės duomenų bazės ir analizuoti naudojant Microsoft Excel ir IBM SPSS programas ir statistinį reikšmingumą $p < 0,05$.

Rezultatai. Pagal subjektyvią 10 balų GB skalę, 37,3 proc. (n = 41) moterų nurodė, jog patiria GB. Dauguma (25,5%; n = 28) vertino savo baimę 3 balais. Baimės nejuto (0 balų) 8,2 proc. (n = 9) tiriamųjų, 4,5 proc. (n = 5) patyrė tokofobiją su panikos priepuoliais. Didžioji dalis tiriamųjų bijojo dėl naujagimio sveikatos (89,1%; n = 98) ir gimdymo skausmo (79,1%; n = 87). Pagal objektyvų GB klausimyną kiek mažiau nei pusė tiriamųjų jautė GB (44,5%; n = 49). Neatrasta reikšmingų sąsajų tarp GB ir naujagimių būklės (p > 0,05). Skausmo malšinimo metodus dažniau rinkosi GB patiriančios moterys (p = 0,032). GB patiriančios moterys gimdė ilgiau, lyginant su nebijančiomis (p = 0,047). Didėjant subjektyviai tiriamųjų baimei balais, ilgėjo gimdymo trukmė (p = 0,02). Gimdymo būdas neturėjo sąsajos su GB (p = 0,443). Subjektyvi GB balais buvo didesnė prieš tai nesėkmingai pasibaigusius nėštumus patyrusioms moterims (p = 0,036).

Išvados. Beveik pusė apklaustųjų patyrė GB. Naujagimio sveikata ir gimdymo skausmas buvo dažniausios GB priežastys. Buvusių nesėkmingų nėštumų istorija buvo susijusi su GB. Nerasta reikšmingų sąsajų tarp naujagimių būklės ir gimdymo būdo. GB patiriančios moterys gimdė reikšmingai ilgiau, nei nebijančios.

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