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Do fear of childbirth or family history affect whether pregnant Dutch women prefer a home- or hospital birth?

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ABSTRACT

Objective: it is a generally accepted idea that women who give birth at home are less fearful of giving birth than women who give birth in a hospital. We explored fear of childbirth (FOC) in relation to preferred and actual place of birth. Since the Netherlands has a long history of home birthing, we also examined how the place where a pregnant woman's mother or sisters gave birth related to the preferred place of birth.
Design: a prospective cohort study.
Setting: five midwifery practises in the region Leiden/Haarlem, the Netherlands.
Participants: 104 low risk nulliparous and parous women.
Method: questionnaires were completed in gestation week 30 (T1) and six weeks post partum (T2).
Measurements and findings: no significant differences were found in antepartum FOC between those who preferred a home or a hospital birth. Women with a strong preference for either home or hospital had lower FOC (mean W-DEQ=60.3) than those with a weak preference (mean W-DEQ=71.0), t (102)= −2.60, p=0.01. The place of birth of close family members predicted a higher chance (OR 3.8) of the same place being preferred by the pregnant woman. Pre- to postpartum FOC increased in women preferring home- but having hospital birth.
Key conclusions: the idea that FOC is related to the choice of place of birth was not true for this low risk cohort. Women in both preference groups (home and hospital) made their decisions based on negative and positive motivations. Mentally adjusting to a different environment than that preferred, apart from the medical complications, can cause more FOC post partum.
Implications for practice: the decreasing number of home births in the Netherlands will probably be a self-reinforcing effect, so in future, pregnant women will be less likely to feel supported by their family or society to give birth at home. Special attention should be given to the psychological condition of women who were referred to a place of birth and caregiver they did not prefer, by means of evaluation of the delivery and being alert to anxiety or other stress symptoms after childbirth. These women have higher chance of fear post partum which is related to a higher risk of psychiatric problems.
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Introduction

It is a generally accepted idea that women who prefer a home birth have less fear of childbirth (FOC) compared to those who prefer giving birth in a hospital. The Netherlands has a long history of home deliveries, and is therefore an ideal place to study this assumption in combination with an examination of its relation to the place where a pregnant woman's mother or sisters gave birth.

Home versus hospital deliveries

In the Netherlands, pregnant women at low risk for complications during pregnancy and birth can decide to give birth either at

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home or in hospital, both under the supervision of a midwife. Childbirth is defined as a normal physiological process and a family event (de Vries, 2004). This perception is reflected in the organisation of obstetric care and supported by the empirical evidence on the safety of home births (de Jonge et al., 2009, 2015; Brocklehurst et al., 2011). However, family history also matters. Women tend to take experiences within the family concerning the place and progress of birth as a model, and harmonise their preferences and choices with their mother's and sisters' experiences.

The preference for home birth, as reported in Dutch studies, is related to the confidence of family and friends in home birth (Wiegers et al., 1998), higher education (in highly urbanised areas) (Kleiverda et al., 1990), the comfortable/familiar surroundings at home and the wish for personal autonomy (ten Haken et al., 2012). Factors associated with a preference for hospital birth are expectations of hospital care when giving birth, the expected safety in the hospital, and the wish to minimise risks (Pavlova et al., 2009; van Haaren-ten Haken et al., 2014).

In rural areas in the Netherlands (Anthony et al., 2005) home birth is still the most common choice for women with a low risk pregnancy. In all other Western countries, hospital birth is the standard choice or even mandatory, whereas giving birth at home is unusual and considered as an 'alternative' option. In other countries than the Netherlands the choice of home birth has been found to be related to having control and continuity (Abel and Kearns, 1991), to being older, married and well-educated (Soderstrom et al., 1990; Waldenstrom and Nilsson, 1993; Hildingsson et al., 2006; Boucher et al., 2009; MacDorman et al., 2010) and to being less anxious about the impending birth (Waldenstrom and Nilsson, 1993).

Fear of childbirth

It has been shown that pregnant women with high pre-partum FOC also have high FOC post partum, no matter what obstetric complications they experience (Zar et al., 2001; Sluijs et al., 2012). The level of postpartum FOC indicates how women look back on giving birth, and high levels of FOC are related to higher risk for psychiatric problems, in particular depression, post-traumatic stress disorder (Soderquist et al., 2009) and difficulties in a healthy mother–child bonding (Areskog et al., 1983).

Women who start labour at home, but are referred to a hospital because of medical complications, have to deal with their cognitive dissonance associated with their preferred and actual place of giving birth, on top of coping with the medical problems.

In the present study we examined how congruence between the preferred and actual place of birth influences postpartum FOC.

In summary, we formulated the following research questions for the study:

1. Is preference for home or hospital birth related to antepartum FOC?
2. Is the participant's preference for place of birth related to the birth experience and the place where mothers or sisters gave birth?
3. How are congruence between preferred and actual place of birth, and referral to the obstetrician related to postpartum FOC?

Materials and methods

Subjects

The study had a prospective cohort design. The participants completed questionnaires in gestation week 30 (T1) and six weeks post partum (T2).

All participants were fluent in Dutch. Eligible participants were nulliparous and parous women in gestation week 30, who had been classified as low risk by their midwife. Apart from experiencing good general health, the participants had uncomplicated family, medical, and obstetric histories according to the Dutch Obstetric Manual (Ziekenfondsraad (Health care insurance board), 1999). The study was co-ordinated by the first author (AS) at the Department of Obstetrics and Gynaecology, Leiden Academic Medical Centre. Five midwifery practices in the vicinity of Leiden participated, two urban, the other three more or less rural. In meetings and a written instruction, midwives were informed about how to invite pregnant women to join the study and how to respond to possible questions from potential participants.

From November 2005 until March 2006, midwives invited pregnant women who matched the inclusion criteria to participate in the study. Potential participants received an information letter, a consent form and paper questionnaires. The midwives explained the purpose and outline of the study, then they asked the women to read the information at home and decide whether or not to participate. Birth characteristics were collected by the caregiving midwives and sent to the research co-ordinator.

Six weeks post partum (T2), questionnaires were sent out to the women who had participated at T1.

The midwives asked a total of 54% ($n=194$) of those who matched the inclusion criteria ($n=358$) to participate. The major reason given by the midwives for not passing the invitation on to all potential participants was that they had simply forgotten. The women who were asked but who declined to participate were registered as decliners ($n=10$, 5%). Reasons for declining were: too busy, not interested, or participating in another study. Fifty-six per cent ($n=108$ of 194) of those invited returned their questionnaires and consent form, some of them after two reminders. Three women were excluded post hoc because they did not match the inclusion criteria. Six women did not receive the questionnaires at T2 because they had moved without reporting their new address. At T2 the response rate was 87% ($n=89$ of 108) of those who responded at T1.

The representativeness of the sample was examined by comparing the characteristics of participating women from one of the participating practices with characteristics of the total patient stock of that practice in 2003. The mean age and ethnicity of the study group turned out to be the same as in the total patient stock in 2003. However, the study group included a higher proportion of nulliparous women, and more women who had been referred to an obstetrician and given birth in a hospital.

Measures

Biographical data

This questionnaire comprised questions on general background characteristics such as educational level, marital status and age. At Time 1, at 30 weeks pregnant, women were asked about their preferred place of birth and reasons for this preference as well as their mother's and sisters' history: place where mothers and sisters had given birth, about pain experience, complications and labour-progress of those deliveries. Possible answers for preferred place of birth were further classified as indicating a 'strong' or 'weak' preference for home or hospital respectively. Six weeks post partum (Time 2), participants answered questions about their birth experience.

Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ)

FOC was operationalised by the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ, version A and B). The W-DEQ is a well validated and internationally used 33-item questionnaire, designed to measure FOC as operationalised by the cognitive

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