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Partner support in the childbearing period—A follow up study

Ingegerd Hildingsson [a,b,*], Maria Tingvall [c], Christine Rubertsson [c]

[a] *Mid Sweden University, Department of Health Science, SE-85170 Sundsvall, Sweden*
[b] *Karolinska Institutet, Department of Women and Child health, SE-17177 Stockholm, Sweden*
[c] *Mälardalen University, Department of Caring and Public Health Science, Box 1020, SE-72126 Västerås, Sweden*

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Summary
Background: Social support is important during pregnancy and childbirth and the partner is usually the main source of support. Lack of partner support is associated with less emotional well-being and discontinuation of breastfeeding.
Research problem: The purpose of the study was to investigate the proportion of women dissatisfied with partner support in early pregnancy, and to identify risk factors associated with dissatisfaction through a follow up 2 months and 1 year after childbirth.
Participants and methods: A national cohort of 2430 Swedish speaking women recruited in early pregnancy and followed up 2 months and 1 year postpartum. Data were collected by means of three postal questionnaires.
Results: Five percent of women were dissatisfied with partner support in early pregnancy. Women dissatisfied with partner support were more likely to be multiparas, not living with their partner in early pregnancy and to report unfavorable timing of pregnancy. They experienced more physical symptoms, and less emotional well-being in terms of more depressive symptoms, more major worries and a lower sense of coherence. One year after childbirth a higher rate of divorces and disappointment with the partner's participation in childcare and household chores and understanding from partner was found in women being dissatisfied in early pregnancy.
Discussion and conclusions: This study shows that it might be possible to identify women who are lacking partner support already in early pregnancy. Women's social network and their support from partner should be investigated by health care providers and women in need of additional support should be refereed to available community resources.
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Introduction

Pregnancy and early parenthood are periods where substantial physical, emotional and social changes take place. Pregnancy is usually a healthy process. Nevertheless, women are

* Corresponding author at: Department of Health Science, Mid Sweden University, SE-85170 Sundsvall, Sweden. Tel.: +46 60 1485; fax: +46 60 1910.
E-mail address: ingegerd.hildingsson@miun.se (I. Hildingsson).

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engaged within the medical system, mainly in the primary health care, with the midwife as the primary caregiver. Almost all pregnant women in Sweden avail of antenatal care which is free of charge. The standard visiting schedule recommends 7–9 visits during an uncomplicated pregnancy. In general, midwives in antenatal care collaborate with nurses working in child health care and with family doctors and obstetricians when needed. There are usually psychologists and social workers connected to the antenatal clinics for women in need of such support.[1] During pregnancy, the woman's partner is encouraged by health professionals to take part in the antenatal visits. In Sweden, gender equality has been in focus for the past 30 years and there have been many governmental initiatives in this area.[2] Parent education classes are offered during pregnancy to all first-time parents.[3] In Sweden, new fathers receive 10 days off from work when their baby is born paid by governmental parent insurance. They are also encouraged by society to participate in caring for the child and to share the parental leave, which in Sweden is 480 days, 2 months of which are exclusively intended for fathers. In 2006, fathers took 21% of the total leave days used by the couples, with regional variations of 13–26% (www.forsakringskassan.se).

Social support has been defined by Cobb[4] (1976) as 'information leading the subject to believe that he is cared for and loved... esteemed and valued...that he belongs to a network of communication and mutual obligation'. Social support is viewed as an important coping factor regarding the individual's ability to handle stressful events and for the recovery after such events, and has a buffering effect against stress.[5] There is no standardized definition of social support, however, House 1981[6] has identified various components of social support. These components include: emotional support, which refers to empathy, caring, love and trust; instrumental support, which includes direct help to individuals; informational support, when significant others provide helpful information for individuals to cope with personal problems and appraisal support – information, which helps individuals to evaluate themselves.

The association between social support and health is well known[7,8] and has been focused upon in studies of pregnant women's physical and emotional well-being.[9–12] One predictor of well-being during pregnancy is women's degree of sense of coherence.[13] Another is support from partner and social network.[11,14] The partner is usually highly valued as a source of support during pregnancy. Previous studies have revealed that support from a partner facilitated women to stop smoking,[15] was associated with a positive birth experience,[11–14] was helpful when considering abortion[16] as well as leading to less need for pain relief during labor.[17] Lack of or disappointment with partner support has been associated with high levels of anxiety during pregnancy[18] and depression.[19,20] Previous studies have also shown that women who lack partner support are more likely to renounce breastfeeding compared to those who receive such support.[21,22]

Aims

The aim of the present study was to investigate the proportion of women dissatisfied with partner support in early pregnancy, to identify the characteristics of women dissatisfied with partner support and to follow up these women's situation 2 months and 1 year after childbirth.

Methods

Design

Selected data from a longitudinal cohort study of a national sample of Swedish speaking women were used. The women were recruited in early pregnancy and followed up at 2 months and 1 year postpartum. Of the 608 antenatal clinics operating in Sweden at the time of recruitment, 593 chose to participate in the study. The 15 antenatal clinics not participating in the recruitment of women reported heavy workload or similar ongoing studies. Swedish speaking women who registered for antenatal care during 3 weeks spread over a 12-month period in 1999–2000 were informed about the study by their midwives and asked to participate. Their personal identity codes and contact details were sent to the research office after which questionnaires were mailed to them. Two reminders were sent to non-responders. Background characteristics of the sample were compared with data from a 1-year cohort of women who gave birth in Sweden in 1999. This information was gathered from the Swedish Medical Birth Register, records that include information on socio-demographic variables, care procedures, and health outcomes. The study was approved by the Regional Research and Ethics Committee of the Karolinska Institutet, Stockholm, Sweden.

Subjects

During the three recruitment weeks approximately 5500 women were booked for antenatal care, an estimation based on data from the Medical Birth Register and the antenatal midwives. After exclusion due to miscarriage (275), inability to communicate in Swedish (550), and attending one of the 15 non-participating clinics (75), 4600 eligible women remained, of which 3293 (72%) consented to participate in the study. The inclusion criteria for the present study were women who reported that they had a partner at 2 months postpartum and had answered all three questionnaires. These criteria were met by a subgroup of 2340 women.

Data collection

Data were collected by means of three postal questionnaires, the first in early pregnancy, the second at 2 months postpartum and the third at 1 year postpartum, with the response rates of 91%, 84% and 88% respectively. The questionnaires covered a wide range of issues related to aspects relevant for the childbearing period, and selected data are included in this study. The majority of the explanatory variables were collected from the questionnaire completed in early pregnancy (mean gestational week 16), which included the women's socio-demographic and obstetric background, as well as physical and emotional well-being.

Support

In Sweden the majority of women work outside the home and are financially independent. Although not made explicit, the definition embedded in the Swedish word for support usually

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