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## Research paper

## Presence and process of fear of birth during pregnancy—Findings from a longitudinal cohort study

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## ABSTRACT

**Background:** The prevalence of fear of birth has been estimated between 8–30%, but there is considerable heterogeneity in research design, definitions, measurement tools used and populations. There are some inconclusive findings about the stability of childbirth fear.

**Aim:** to assess the prevalence and characteristics of women presenting with scores  $\geq 60$  on FOBS-The Fear of Birth Scale, in mid and late pregnancy, and to study change in fear of birth and associated factors.

**Methods:** A prospective longitudinal cohort study of a one-year cohort of 1212 pregnant women from a northern part of Sweden, recruited in mid pregnancy and followed up in late pregnancy. Fear of birth was assessed using FOBS-The fear of birth scale, with the cut off at  $\geq 60$ .

**Findings:** The prevalence of fear of birth was 22% in mid pregnancy and 19% in late pregnancy, a statistically significant decrease. Different patterns were found where some women presented with increased fear and some with decreased fear. The women who experienced more fear or less fear later in pregnancy could not be differentiated by background factors.

**Conclusions:** More research is needed to explore factors important to reduce fear of childbirth and the optimal time to measure it.

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## Statement of significance

## Problem or issue

There are inconclusive findings about the stability of childbirth fear over time in relation to maternal characteristics, measurement and treatment.

## What is already known

The prevalence of fear of birth has been estimated between 8–30%, but there is considerable heterogeneity in research design, definitions, measurement tools used and populations.

## What this paper adds

Childbirth fear decreased overall from mid to late pregnancy. Women who experienced more fear or less fear later in pregnancy could not be differentiated by background factors.

## 1. Introduction

In recent years fear of birth has gained a lot of attention, mostly in the Scandinavian countries,<sup>1–4</sup> in Australia<sup>5–7</sup> and UK.<sup>8</sup> The prevalence of fear of birth has been estimated between 8–30%,<sup>1–9</sup> but there is considerable heterogeneity in research design, definitions, measurement tools used and populations. There are some inconclusive findings about the stability of childbirth fear. One Finnish study of 1348 pregnant women found lower levels of fear among women in gestational week 20 or less compared to women of 21 or more gestational weeks.<sup>4</sup> On the other hand, two studies have indicated that levels of childbirth fear decreases from the second to the third trimester.<sup>7,10</sup>

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Swedish antenatal care is offered within the primary health care system with the midwife as the primary caregiver. Usually the woman who self-reports fear of birth to her antenatal midwife will be referred to a counseling clinic, staffed with experienced midwives and sometimes obstetricians and/or psychologists. Screening for fear is used in one third of Swedish hospitals, but different screening methods are used.<sup>11</sup> Some evaluations of the counseling program have been conducted. The results show that counseling has minor effect in reducing fear and change preferred mode of birth. However; women are satisfied with the services.<sup>12</sup>

The 33-item Wijma Delivery Expectancy Questionnaire (WDEQ-A)<sup>1</sup> is the most widely used measure of childbirth fear in pregnant women in research studies but has been questioned regarding its feasibility as a screening tool in antenatal care due to the length of the instrument and translation issues.<sup>5,8,13,14</sup> Furthermore a recent study demonstrated that calculating a total score on the WDEQ-A is flawed due to its multidimensional structure.<sup>15</sup> There was therefore a need for a shorter, easy-to-use unidimensional instrument. A question directly addressing fear of birth using visual analogue scales (VAS) was constructed in 2006 prior to undertaking a large prospective longitudinal cohort study in a northern part of Sweden and labelled FOBS-The Fear of Birth Scale.<sup>6</sup> The FOBS scale consists of two 100 mm VAS-scales that are summed and averaged to get a score. When filling out the scale study participants are asked to respond to the question "How do you feel right now about the approaching birth?" and are instructed to place a mark on the two scales which have the anchor words calm/worried and no fear/strong fear.<sup>6</sup>

Initially FOBS was used in a comparative study of pregnant women from Sweden and Australia where the aim was to develop the scale and test for cross-cultural differences.<sup>6</sup> The Swedish sample consisted of a sub-sample of 322 women from the large prospective cohort study that includes 1200 women. The reason for choosing the sub-sample was primarily to match the geographic area of the Australian sample ( $n = 122$ ) and to get more balanced groups. The two samples showed fairly similar levels of fear, using the midpoint of 50 or more as a logical initial cut point, with 29.5% in the Swedish sample and 31% in the Australian sample scoring 50 or more on the FOBS. The conclusion from this first study was that FOBS could be used as a screening tool to identify women who require further investigation and treatment for fear of birth. After consulting with experienced counseling staff and correlation work in a population with fear measured by both FOBS and WDEQ-A<sup>14</sup> the cut-off point was thereafter set to 60 or more.

FOBS has since then been used in several studies and has been further developed. Building on the first study the level of FOBS and results from a factor analysis on women's birthing attitudes<sup>16</sup> a cluster analysis showed three different profiles of women. Belonging to the 'Fearful' cluster had a negative effect on women's emotional health during pregnancy and increased the likelihood of a negative birth experience. Both women in the 'Take it as it comes' and the 'Fearful' cluster had higher odds of having an elective caesarean section compared to women in the 'Self determiners' group.<sup>17</sup>

FOBS has also been used in a cross-sectional study in a university hospital, with the focus on foreign born women living in Sweden.<sup>18</sup> Women born in other counties are often excluded from research due to language difficulties. In this study FOBS was translated to eight most common languages in the hospital's catchment area. The result showed that women living in Sweden who were born in a country outside Sweden were more likely to score 60 or more on the FOBS scale. The prevalence of childbirth fear in Swedish-born women was 22% and in foreign-born women 37%. However, few background variables were used in this study which was a limitation. Further, FOBS was validated in a qualitative study using think-aloud technique. The result showed that women were able to clearly assess, describe, and discuss fear of birth using

the FOBS which supports its use in clinical settings as a starting point for further dialogue about women's fear of birth.<sup>19</sup> FOBS has also been the screening tool preceding a randomized controlled trial. Of the 4500 women that underwent the screening procedure, 864 (19%) fulfilled the criteria of fear of birth (a FOBS score of 60 or above) and were invited to participate in a treatment study. However, only minor background data was collected in the screening procedure.

Given the specific sample characteristics and study designs (subsamples, treatment samples, and different cut off points) and the lack of background characteristics in the large screening sample there is a need to analyze FOBS-The Fear of Birth Scale over time from the original full cohort of 1212 women in Northern Sweden where the instrument was first used.

The aim of the present study is to assess the prevalence and characteristics of women presenting with FOBS-scores  $\geq 60$  in mid and late pregnancy. Further, to study if there is any change overall in FOBS-scores from mid to late pregnancy. An additional aim is to study changes over time in relation to characteristics of women with increased and decreased levels of FOBS over the course of pregnancy, with and without having received counseling due to childbirth fear.

## 2. Methods

### 2.1. Design

A prospective longitudinal cohort study of a one-year cohort of pregnant women living in a middle-north part of Sweden.

### 2.2. Recruitment

Women were recruited in mid pregnancy, at three hospitals during 2007, with an annual birth rate of 1600, 500 and 350 births respectively. The recruitment was commenced at the routine ultrasound examination offered to all women in gestational week 17–19. To be eligible for participation, a normal ultra sound screening result and mastering of the Swedish language was needed.

Two weeks prior to the routine ultra sound screening a letter of information about the study was sent to all women booked for the examination. After the examination was performed the midwife in charge asked the women about interest in participation and if they agreed, a consent form was filled out with contact details. The first questionnaire was handed out after the ultra sound examination and could be filled out on site or taken home and returned in a pre-paid envelope. Two letters of reminder were sent after 2 and 4 weeks respectively. The questionnaire in late pregnancy was sent to the woman's home address with a pre-paid envelope and similar reminders.

### 2.3. Data collection

Data was collected by two questionnaires during pregnancy, in gestation week 17–19 and gestational week 32–34.

### 2.4. Outcome variables

FOBS-The Fear of Birth Scale was completed twice. The cutoff point of  $\geq 60$  was used to classify women as having fear of birth.

### 2.5. Explanatory variables

Socio-demographic background characteristics (age, country of birth, civil status, tobacco use, level of education, parity) were collected in mid pregnancy.

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