An exploratory study of women's experiences of fear about childbirth

by

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Abstract

Women's childbirth fear is a common phenomenon that has been explored in European and Australian contexts. In Canada, however, only quantitative studies of levels of women's childbirth fear have been undertaken. It is important to explore Canadian women's perceptions of childbirth fear. Using a descriptive qualitative research design, I interviewed 10 nulliparous women from British Columbia. Through concurrent data collection and inductive content analysis, I developed themes that captured women's experiences of childbirth fear.

Most women described fear of childbirth as their perception of childbirth as 'an unknown territory' including their expressed fears about pain of labour, feeling out of control, and parenting. Several factors appeared to influence the women's levels of fear. Their fears were enhanced by external messages about childbirth that emphasized suffering and risk. Women's expression of their childbirth fear was also influenced by the amount and quality of support they believed was available to them. This support included the presence of familiar people , or health care providers during the labour process. Women's previous experience with health care providers during pregnancy influenced their fears when considering childbirth. Negative messages about labour and birth conveyed by the media and stories from others that depicted birth as painful, unpredictable, horrible, and requiring medication affected all of the women. A number of women described actively resisting the medicalization of childbirth and embracing their abilities to successfully navigate childbirth. The findings from this study support considerations of key elements of childbirth fear and factors affecting childbirth fear to

inform healthcare professionals who are offering interventions and support to reduce childbirth fear for women.

Preface

This study is an original, unpublished, and independent work by the author, Nadia Rahmati. This study was approved by the University of British Columbia Behavioral Research Ethics Board and hospital ethics committees: # H13-00281.

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Chapter 1: Introduction

In this introductory chapter, I describe the background, significance of my research, problem statement, and research objectives. At the end of this section, I provide a brief outline of the subsequent chapters.

1.1 Background

In recent decades, rates of caesarean section births have increased in many developed countries; the Canadian Perinatal Health Report (2008) indicated the percentage of women who delivered by caesarean section increased from approximately 5% to nearly 25.6 % between the late 1960s and early 2005. The Canadian Institute for Health Information (2011) reported that caesarean delivery rates continue to rise, with Newfoundland and Labrador and British Columbia demonstrating the highest primary caesarean section rates (31.5% and 31.1% in 2009-2010) in Canada. These high caesarean section rates far exceed the World Health Organization's recommendation for optimal caesarean section rates of 10 to 15% of all deliveries (Chalmers et al., 2001). It has been suggested that rates in excess of 15% are associated with increases in mortality and morbidity in mothers and neonates (Althabe & Belizi, 2006).

As the frequency of emergency and elective caesarean sections has increased, researchers have contemplated several possible explanations for this trend. An earlier Norwegian study likewise found a positive correlation between the desire for a planned caesarean operation and the fear of birth (Nerum, Halvorsen, Sorlie, & Oian, 2006). Laursen et al. (2009) reported that fear of childbirth during pregnancy was associated with emergency caesarean sections and that the association was strongest for Danish women who reported fear in late stage of pregnancy. Research studies from

various countries have demonstrated links between childbirth fear and an increased risk of caesarean birth (Fuglenes, Aas, Botten, Oian, & Kristiansen, 2011; Haines et al., 2012; Karlstrom, Nystedt, Johansson, & Hildingsson, 2011; Kringeland, Daltveit, & Moller, 2009; Laursen, Johansen, & Hedegaard, 2009; Nieminen et al., 2009; Wiklund, Edman, & Andolf, 2007). The majority of these studies examined women's scores on childbirth fear measures such as the Wijma Delivery Expectancy/Experience Questionnaire index rather than investigating women's perceptions and experiences associated with fear of childbirth and its potential effects on women during birth. In the context of growing concern regarding increasing rates of caesarean sections in BC, it is important to conduct research to understand how women experience childbirth fear in the antenatal period and anticipate its effects on their birthing process.

1.2 Significance of the Study

Sydsjo et al. (2012) found that the fear of giving birth affects obstetric outcomes and increases the frequency of emergency and elective caesarean sections. A fear of childbirth is reported as a reason for caesarean sections on request without a medical indication (Nerum et al., 2006; Wiklund et al., 2008), increased occurrences of emergency caesarean sections (Laursen et al., 2009; Sydsjo et al., 2012), and increased risk of labour dystocia (Laursen et al., 2009). Canadian women who undergo a caesarean section have significantly higher risk of severe maternal morbidity, such as postpartum risks of cardiac arrest, wound hematoma, hysterectomy, major puerperal infection, anesthetic complications, venous thromboembolism, hemorrhage requiring hysterectomy, and longer hospital stays, than those in a planned vaginal delivery group (Declercq et al.,

2007, Liu, 2007). Other studies have also implicated that fear of giving birth increases adverse birth outcomes such as preterm labour, shorter gestations, and lower birth weight (Kramer et al., 2009; Orr, Blazer, James, & Reiter, 2007; Sydsjo et al., 2011). Delivering via caesarean section also poses risks for neonates, such as lower APGAR scores, brain and other birth injuries, respiratory problems, or increased risk of illnesses later in life (Sakala, 2006). Fear of childbirth has also been associated with longer term effects, specifically women's mental health problems that can negatively affect maternal-infant attachment (Gamble & Creedy, 2009; Hofberg & Brockington, 2000; Rouhe et al., 2011; Soderquist et al., 2009; Thomson & Downe, 2008).

Exploring women's perceptions of childbirth fear offers opportunities for healthcare professionals to provide interventions and support to reduce childbirth fear for women (Laursen, Johansen, & Hedegaard, 2009; Salomonsson et al., 2010). Because women's fear of childbirth has been associated with negative outcomes for both mothers and their children, the proposed study can help to create a better understanding about Canadian women's experiences of childbirth fear to support nurses' efforts to develop practice and policy strategies programs to reduce women's fear prior to birth.

1.3 Problem Statement

The prevalence of childbirth fear among pregnant women in the Nordic countries has been estimated at 20% among pregnant women (Heimstad et al., 2006; Zar, Wijma, & Wijma, 2001). In Australia, some 25% of all pregnant women suffer from a considerable fear of childbirth (Fenwick et al., 2009). Likewise, a Canadian study conducted in British Columbia described 25% of women with high levels of fear related

to childbirth demonstrating that these occurrences occur around the world (Hall, Carty, Hutton, Fenwick, Hauck, & Stoll, 2009).

Fear of vaginal childbirth is not uncommon, and the number of women requesting caesarean section operations owing to this fear is increasing (Eftekhar & Steer, 2000; Saisto & Halmesmaki, 2003). Fear of childbirth during pregnancy is associated with emergency caesarean sections (Laursen, Johansen, & Hedegaard, 2009), preferences for an elective caesarean section (Fuglenes, Aas, Botten, Oian, & Kristiansen, 2011; Haines et al., 2012; Hildingsson, Radestad, Rubertsson, & Waldenstrom, 2002; Karlstrőm, Nystedt, Johansson, & Hildingsson, 2011; Kringeland, Daltveit, & Moller, 2009; Nieminen et al., 2009), and requests for an elective caesarean section (Bryanton, Gagnon, Johnston, & Hatem, 2008; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Handelzalts et al., 2012; Hildingsson, 2008; Karlstrrőm et al., 2010; McCourt et al., 2007; Ryding et al., 1998; Waldenstrom et al., 2006; Wiklund, Edman, & Andolf, 2007).

Childbirth fear has also been associated with negative labour and birth outcomes. For example, women who feared childbirth were more likely to have an increased risk of a prolonged labour (Adams, Eberhard-Gran, & Eskild, 2012; Laursen et al., 2009), the use of epidural anesthesia (Hall et al., 2012), and a negative birth experience (Alder et al., 2011; Hall et al., 2009; Nilsson, Bondas, & Lundgren, 2010; Nilsson et al., 2012; Rijnders et al., 2008). Mothers who delivered via caesarean section also incurred a higher risk of reproductive consequences such as placenta previa, placenta accreta, placental abruption, and uterine rupture, while future pregnancies were more prone to stillbirth, miscarriage, ectopic pregnancy, and other complications (Sakala, 2006). Similarly, a variety of risks exist for the neonate, including lower APGAR scores, brain and other

birth injuries, respiratory problems, and increased risk of illnesses later in life (Sakala). Other studies also recognized the fear of giving birth as a reason for increases in the rate of adverse birth outcomes such as preterm labour, shorter gestations and lower birth weight (Kramer et al., 2009; Orr, Blazer, James, & Reiter, 2007; Sydsjo et al., 2011). Furthermore, women with fear of childbirth also suffer from mental health problems such as post-traumatic stress, postpartum depression (Gamble & Creedy, 2009; Soderquist, Wijma, Thorbert, & Wijma, 2009; Thomson & Downe, 2008;), and other anxiety disorders (Rouhe et al., 2011).

Prior research conducted in this field was generally in non-Canadian contexts; thus, the findings may not be entirely relevant to British Columbian women. The proposed study can increase our insight and awareness of issues associated with childbirth fear, possibly leading to identification of early interventions aimed at reducing the negative effects of the fear of birth. Given the lack of previous Canadian research about women's childbirth fear, and the potentially negative outcomes for mothers and infants, it is important to explore Canadian women's perceptions of childbirth fear. Thus, the purpose of this study is to describe women's perceptions and experiences of childbirth fear during pregnancy.

1.4 Research Objectives

The research objectives of the study were to:

- Describe how women in British Columbia experience childbirth fear during their pregnancies.
- Examine how women's experiences of fear in childbirth are shaped by the socio-cultural context of their lives.

My research question was: What are British Columbian women's experiences and perceptions of childbirth fear?

In summary, current studies tend to examine women's levels of childbirth fear using specific measures rather than investigating women's perceptions and experiences regarding childbirth. In this chapter, I have described the background to the problem, the significance of my study, the research problem statement and purpose, and the research objectives and questions.

In chapter 2, I review existing research on the prevalence of childbirth fears and its occurrence in multiple international studies, along with the significance of socio-cultural factors. In chapter 3, I describe my research design, and research methods. Chapter 4 covers the five major themes of my findings to specifically address the research question: "What are British Columbian women's experiences and perceptions of childbirth fear?" Chapter 5 includes a discussion of the main findings of my study, the implications for nursing practice in BC, potential research questions, study limitations, and a conclusion.

Chapter 2: Literature Review

In this chapter, I review existing research on the prevalence of childbirth fear and its occurrence in multiple international studies. I review the significance of socio-cultural factors in childbirth fear including the influences of personal connections, the modern technocratic perspective, and media representations of childbirth. I also analyze components of childbirth fear and potentialcontributions of my research for Canadian women.

2.1 The Prevalence of Childbirth Fear

Fear of childbirth is an experience shared by most populations of pregnant women (Zar, Wijma & Wijma, 2001). The prevalence of antenatal childbirth fear has varied from one study to another due to differences in the definition of the concept, the timing of measurement, and the cultural context. Historically, researchers in a Swedish study reported that 6% of women suffered from an intense fear of childbirth around their 32nd gestational week (Areskog, Uddenberg,& Kjessler, 1981), while a Finnish study reported that up to 80% of low-risk pregnant women experienced some fear of childbirth (Saisto & Halmesmaki, 2003). Furthermore, researchers in a British study reported that multiparous women in the United Kingdom seemed to be more frightened of childbirth than their Scandinavian counterparts (Johnson & Slade, 2002).

More recently, in a cross-sectional descriptive survey of six hundred and fifty English-speaking British Columbian nulliparous and multiparous women, between 35 and 39 weeks gestation, Hall and others (2009) found that 25% of women reported high levels of childbirth fear; their childbirth fear was positively correlated with fatigue, sleep

deprivation, and anxiety. Additionally, an Australian study reported a prevalence of high levels of childbirth fear in 26% of 401 women at 36 weeks gestation (Fenwick et al., 2009). Although researchers previously estimated that 20% of Swedish women suffered from a severe fear of childbirth, as measured using the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) (Zar et al., 2001), Nieminen and colleagues (2009) recently reported that fear of childbirth was prevalent in 15.6% of their Swedish sample and very intense fear was present in 5.7% of the sample.

In terms of examining the differences in women's childbirth fear, Rouhe et al. (2009) found that fear of childbirth was more common in primiparous Finnish women than parous women and that fear scores were higher in the late stages of pregnancy. Johnson and Slade's (2002) study of fear and emergency caesarean sections yielded similar results; primiparous British women described a higher level of fear compared to multiparous women. Together, Rouhe et al. and Johnson and Slade's studies suggest that, although primiparous women tend to be more fearful than multiparous women, multiparous women may still experience fear based on their previous operative or instrument deliveries; their conclusion was supported by Nieminem and colleagues (2009) and Zar and colleagues (2001).

In the Canadian context, only a single study conducted in British Columbia has examined women's levels of childbirth fear; 25% of women in a sample of 650 reported high levels of fear related to childbirth (Hall et al., 2009). Notwithstanding this study, in-depth knowledge about British Columbian women's experiences and perceptions of childbirth fear has not been published. British Columbia has the second highest caesarean

section rate in Canada, with 31% of women undergoing the operation, and it is therefore valuable to understand women's childbirth fear experiences and perceptions.

2.2 Socio-cultural Context of Childbirth Fear

It is important to recognize that women's experiences of childbirth are socially constructed. Birth is a process shaped by external cultural forces that affect both psychological processes and physiological functioning (Reiger & Dempsey, 2006). Reiger and Dempsey argued that childbirth is structured and produced, at least partially, through social belief systems that shape the care for childbearing women in the medical system. They noted a decline in women's self-confidence about the birthing process in spite of giving birth in a modern society where their social power, health, and living conditions have improved significantly from those of previous generations. Because complex social systems contribute dimensions to childbirth fear, women's experiences and perceptions warrant investigation.

Fisher, Hauck and Fenwick (2006) defined fear of childbirth as a prospective phenomenon which has social and personal dimensions. Social dimensions related to the context or environment in which women give birth as well as lack of external support, while personal dimensions reflected worries about maintaining personal control (Fisher et al.). The social dimensions can be categorized as "fear of the unknown", "horror stories", and "expectations on the woman from the medicalization of childbirth" (Fisher et al.).

Fenwick et al. (2010) interviewed 14 women in Australia who chose to have a caesarean section without medical indications for their first pregnancy. Main themes that emerged from their analysis included childbirth fear, issues of control and safety, and a

devaluing of the female body and birth process. The personal dimensions of these themes reflected worries about vaginal birth and the women's inability to give birth without intervention. Women perceived vaginal birth was a frightening, unpredictable, and dangerous event that could result in physical damage to the women, their babies, or both. Their comments emphasized that many women have lost confidence in their ability to give birth without intervention. The women's decisions regarding elective caesarean sections as "safe choices" or "responsible choices" were reinforced and validated by medical discourses and health professionals.

2.3 The Interface Between Birth and Medical Discourse

Childbirth has been compared by some authors to the "capitalist class system"[1]: pregnant women are oppressed unskilled workers, women's bodies are viewed as machines, and doctors are the managers (Martin, 1987). By being socialized to view the body as a machine, women can assume that the body can be fixed through technological interventions. Martin suggested that phrases such as "the contractions come on" suggest to women that birth is achieved only by the involuntary contraction of uterine muscles without acknowledging women's active participation in birth. Moreover, expressions like "failure to progress" do not communicate that women and their bodies are the most important part of the labour and delivery process; instead, they imply that their bodies are deficient (Martin). The "technocratic" representation of birth (Davis-Floyd, 2001),

[1] Capitalist class system: a system of industrialization originating from 18th century England, where goods produced on a mass scale in a factory replaced goods created by individual craftsmen. The use of machinery and standardizing of manufacturing processes allowed for modularity in production, allowing a manager to replace unskilled workers and machinery with little variance in the final product (Martin, 1987).

"dictates that birth must be managed by advanced technology" (Lazarus, 1994, p.46), and contributes to women's perceptions of their lack of capabilities to give birth.

Physicians have exerted a significant level of social control over what was once viewed in most societies as a woman-centered, natural event (Stein & Inhorn, 2002). In the dominant medical model of birth, women have been expected to surrender control over their birthing experiences and to subscribe to the medicalization of childbirth (Brubaker, 2007). According to Sawicki (1991), women have become "passive objects of medical surveillance and management" (p. 76). Medicalization has shifted cultural representations of birth from the women's domain to the expert medical domain and decreased women's confidence in giving birth. The medicalization/technocratic approach shapes the social context within which childbirth fear develops and contributes to decreased self-confidence. When women's confidence in their abilities during childbirth is eroded through this medical dominance, women must rely on technocratic and medicalized solutions, which in turn increase their fear of childbirth. Therefore, in addition to learning about women's experience and perfections of fear, it is of critical importance to also examine how such experiences and perceptions are shaped by the socio-cultural context in which they live.

2.4 Loss of Women's Power

Davis-Floyd (1992) argued that the management of birth by medicine has taken away women's power over their bodies without physiological reasons, and alienated women from a potentially empowering experience. In his view, the technocratic model of birth represents one of the most extreme demonstrations of the cultural challenge to use birth to express the dominance of technological management of nature. The technical

skills of physicians have been linked to the ability to "guarantee" a "perfect baby" (Cherniak & Fisher, 2008) , which creates a level of elevated confidence in technology and medicalization of birth, while contributing to the loss of women's power in childbirth.

Women's acceptance of a view of childbirth as "uncontrollable", "unknown", or "threatening" is pervasive and justifies the medical management of birth in Sweden (Wijma, Wijma, & Zar, 1998). Similarly, in other western countries, the perception of "safety" is ideologically produced through discourses on technological and medical progress to manage the inherent "risks" of non-invasive birth (Dietz & Peek, 2004). In the process of medical management, a woman's body, especially while pregnant, is portrayed as " not predictable", " hazardous", and "substandard"; therefore, the body, rather than being viewed as powerful, is viewed as being in need of "control" and "new technologies" (MacLennan, Nelson, Hankins, & Speer, 2005, p. 1689). It has been declared that physicians are using the term *safety* "as a blanket justification for all kinds of interventions that are not proven to be beneficial" (Simpson & Thorman, 2005, p. 140). Defining childbirth as a dangerous and pathological event leads women to believe that they are unable to endure the challenges of childbirth without assistance (Sullivan & Weitz, 1988). The technological approaches to birth are presented and accepted as "safer"; this misguided belief prevents women from recognizing their own natural birthing abilities (Simpson & Thorman). A request for medical interventions may be an ultimate effort for fearful and anxious women to exert power over their situations. Because Canada represents a modern, industrialized nation, it could be regarded as a

technocratic society. Exploratory studies tailored to specific contexts can help to create a better understanding of women's experience of childbirth fear in Canada.

2.5 Media Influence on Childbirth Fear

The emphasis on medicalized birth arises, in part, from media depictions of the inherent risks, lack of predictability, and possible complications associated with childbirth (Morris & McInerney, 2010). The media constructs childbirth by signifying vaginal childbirth as old-fashioned; childbirth is treated as an event marked by women's minimal control of their birth processes (Nilsson& Lundgren, 2009). Reportedly, celebrities are leading the way in a growing movement embracing a woman's right to choose her method of giving birth, usually technologically-focused (Zeldes & Norwegian, 2008). The suggestion that power lies with women is portrayed and influenced by public discourse and is construed as a sign of progress in the care of birthing women. These messages from medical professionals, changing social norms, and trendy messages in the media lead to the possibility that a fear of childbirth can arise. It is important to examine women's perceptions of childbirth fear in the North American context of media portrayals.

2.6 Components of Childbirth Fear

Fear of childbirth has been identified as a significant phenomenon in Nordic countries (Garthus-Niegel et al., 2011), with considerable attention devoted to this topic in the last 40 years (Bourgeault et al., 2009). Initial studies regarding the fear of childbirth were conducted by a Swedish obstetrician named Barbro Areskog (Saisto &

Halmesmaki, 2003); these studies have produced strikingly similar results to studies conducted more recently.

Personal dimensions of prospective fear are labelled by Fisher, Hauck, and Fenwick (2006) as “fear of pain”, and “losing control and disempowerment”. Christiaens, De Velde, and Brakce (2011) suggested that negative experiences related to fear of childbirth consist of four underlying sub-dimensions: fear about the baby’s well-being, fear of labour pain and injuries, personal control-related fear, and fear of being left alone or receiving inappropriate care. Although their definitions seem specific, the social and personal categories are not mutually exclusive. Differences in Wijma Delivery Expectancy/Experience Questionnaire scores representing women’s childbirth fears from the United Kingdom, Australia, and Scandinavia point to variations in how childbirth is conceptualized socially in each country (Fenwick et al., 2009; Johnston & Slade, 2002). Thus, when investigating women’s perceptions about childbirth, it is important to focus attention on the social context in which women live and give birth.

Previous work with women in Scandinavia suggests the most common reasons for fear of childbirth are fear of loss of control and fear of death or injury of the infant (Melender & Lauri, 1999; Ryding et al, 1993; Saisto & Halmesmaki, 2003). Sixty-five percent of a sample of 100 Swedish women who feared childbirth acknowledged their fear of being incapable of giving birth (Sjogren & Thomason, 1997). European studies have found that women’s fears about their lack of birth capabilities can lead to further apprehension about performing poorly or of hurting the fetus during labour (Szeverenyi, Poka, Hetey,& Torok, 1998). Participants in an early study of childbirth expectations by

Beaton and Gupton (1993) felt that the fear associated with childbirth was commonly based on a lack of knowledge or on uncertainty. Studies from Scandinavia also suggest that fear of pain and pelvic floor injuries, and fear of losing one's life, losing self-control and being left without assistance during labour are elements of childbirth fears (Melender & Lauri, 1999; Nilsson & Lundgren, 2009; Ryding et al., 1993; Saisto & Halmesmaki). Given that these quantitative studies suggest very different factors inform women's childbirth fear and are largely located in a European context, a qualitative study can add to the literature by providing in-depth descriptions of Canadian women's perceptions of childbirth fears.

2.7 Influencing Factors in Childbirth Fear

Saisto, Salmela-Aro, Nurmi, and Halmesmäki (2001), and Melender (2002) suggested that the fear of childbirth is associated with psychological, biological, and psycho-social factors, in addition to the personality of each woman. The psychological factors identified by other researchers as contributing to the fear of childbirth include anxiety, depression, and low self-esteem. (Hall et al., 2009; Laursen et al., 2009; Waldenstrom et al., 2006). As a biological factor, aversion to pain of the labour process was suggested as a contributor to the fear of childbirth by Areskog, Uddenberg, and Kjessler (1981). Lack of support, economic uncertainty, and dissatisfaction with life are examples of psycho-social factors that have also been associated with women's fear of childbirth (Saisto et al., 2001). Furthermore, lack of trust in the obstetric staff was found to be related to some pregnant women's tendency to fear childbirth as well (Melender, 2002; Saisto & Halmesmaki, 2003). Researchers have reported that negative stories told

by others about birth have contributed to women's fear of childbirth (Melender, 2002). Munro et al. (2009) described the impacts of socially circulated birth stories in the decision-making processes of numerous Canadian women who requested caesarean sections.

Drawing from literature based largely in other countries, it is clear that the experience of childbirth fear is complex and influenced by social contextual features, contact with others, and factors particular to women. Careful attention must be given to seeking women's perceptions of their childbirth fear experiences in their complex and multifaceted personal and social circumstances.

In summary, the prevalence of antenatal childbirth fear can vary from one study to another due to differences in the timing of measurement, the definition of the concept, and the cultural context. Through tools such as the Wijma Delivery Expectancy/ Experience Questionnaire (Zar et al., 2001), researchers have found that the fear of childbirth was more common in nulliparous women than parous women and that fear scores were higher in the late stages of pregnancy. Fisher, Hauck, and Fenwick (2006) defined fear of childbirth as a prospective phenomenon which has social and personal dimensions, both of which have their own factors and effects on women. Christiaens, De Velde, and Brakce (2011) suggested that negative experiences related to fear of childbirth consist of four underlying sub-dimensions: the baby's well-being, labour pain and injuries, personal control, and being left alone or receiving inappropriate care. Research from Australia by Fenwick, Gamble, Nathan, Bayes, and Hauck (2009) and from Scandinavia by Johnston and Slade (2002) point to variations in how childbirth is socially conceptualized in each country. Thus, when investigating women's perceptions about

childbirth, it is important to focus on the social context in which women live and give birth. To add to this point, Nilsson and Lundgren (2009) detail how through media representations and modern technocratic perspectives, childbirth is treated as an event marked by women's minimal control of their birth processes. In-depth knowledge about Canadian women's experiences of childbirth fear is limited, and in the context of growing concern regarding increasing rates of caesarean sections in BC, it is important to conduct research to understand how women experience childbirth fear in the antenatal period and anticipate its effects on their birth experiences. In summary, this chapter has represented a critical analysis of the literature, which supports the need for a Canadian study of women's perceptions of childbirth fear.

Chapter 3: Methods

In this chapter, I describe the design of my study and all of the elements of the method I used. I summarize my reasoning for my research design. I also include considerations of ethics, participant selection, sampling procedures, data collection, and data analysis. I describe my methods of developing and coding the statements provided in interviews and, finally, I describe my efforts to support the rigor of my study.

3.1 Qualitative Descriptive Research Design

The complexity and context of a research question focusing on women's perceptions and experiences of childbirth fear was best investigated using a qualitative research design. Morse (2003) recommended qualitative methods "when little is known about a topic, when the research context is poorly understood, or when the nature of the problem is murky" (p. 833). The limited knowledge about Canadian women's experience of childbirth fears fits her criteria in that none of the published Canadian studies about childbirth fear have delved deeply into the nature of fear of childbirth. Qualitative studies from Europe may not apply to North American women. Qualitative research methods permit the researcher the flexibility to be guided by the data to develop and extend knowledge of the experience of childbirth fear rather than by a set of fixed a priori hypotheses (Hammersley & Atkinson, 1995).

Sandelowski (2000) suggested a "basic or fundamental" style of qualitative descriptive research is categorical and has the goal of a straight description of a phenomenon. It "entails the presentation of the facts of the case in everyday language" (p.

336), and "is especially amenable to obtaining straight and largely unadorned ...answers to questions of special relevance to practitioners" (p. 337). Because I aimed to produce a straightforward description of women's experiences, my study used the qualitative descriptive methodology as suggested by Sandelowski (2000) to develop knowledge and deepen understanding of the way women perceive and experience childbirth fear.I used an inductive approach because it serves as a systematic method of analyzing women's experiences of childbirth fear; it can provide knowledge and new insight with an accurate representation of the women's perspectives (Sandelowski & Barroso, 2003).

3.2 Ethical Considerations

To protect the rights and privacy of participants, the researcher, and the university, ethical approval to undertake the study was obtained from the University of British Columbia Behavioral Research Ethics Board and hospital ethics committees. I personally contacted several hospitals, doctors' and midwifery offices, and clinics to receive permission to post my advertisement. I was granted permission for each unit, except the Women's hospital since they had no waiting area and the secretary of department indicated that my recruitment would interfere with other research. The participants' rights of self-determination, autonomy, privacy, and confidentiality were respected throughout the study through my adherence to the procedures outlined in the University of British Columbia's Policy #89: Research and Other Studies Involving Human Subjects.

3.3 Confidentiality

I have attended to confidentiality by assigning participants a pseudonym of their choice and used only their pseudonyms, along with the date, to label any data. No real

names were used. The women were assigned numbers for identification to maintain confidentiality during the reporting of findings. The transcriptions of all interviews were kept on a password-protected USB drive and the participants' contact information was kept separately from the audio recordings and transcripts by the principal investigator. All contact information, consent forms, and transcripts of the women's interviews will be destroyed five years after the completion of the study as dictated by University of British Columbia research regulations.

3.4 Informed Consent

I provided the participants with verbal and written information about the study and the opportunity to ask questions concerning participation (see Appendix A). All of the participants were informed that their participation in the study was voluntary and their health care would not be affected in any way if they chose not to participate in the study. It was clearly stated in the consent form that women could withdraw from the study at any time; before, during, or after the interviews, in which case any data collected from them would be deleted. The participants provided written consent to have the interviews conducted and recorded (see Appendix A). They retained a copy of the consent form. During my interviews with participants about private thoughts and feelings, there was potential for participant distress. I provided all of the women with a list of community support services and counselors in case they needed it. If, during the analytic process, I identified the need for further data beyond the initial interview, participants could refuse to engage in any follow-up interviews.

3.5 Recruitment Procedure and Selection of Participants

I recruited participants from the antenatal clinics at several district hospital maternity units, including doctors' and midwives' offices. I also recruited potential participants through posted advertisements in the clinics (see Appendix B). Women contacted me via telephone and email about participating in the study by using the contact information provided on the advertisements. During the initial contact, I answered their questions and arranged for a meeting if they were interested in moving forward with the study.

3.5.1 Sampling procedures.

A purposeful sampling method was used to diminish variation within the cohort (Patton, 1990). Purposive sampling was the method of selecting research interviewees based on their suitability for the study; in this case being pregnant and primiparous due to their first-hand experiences with worries or concerns when anticipating childbirth. Polit and Beck (2008) emphasize that, when researchers have a sense of what they need to know, the use of purposive sampling strengthens the comprehensive understanding of a phenomenon. Because the research topic was focused on pregnant women and could be applied to all members of a population, I conducted interviews only with individuals fitting my purposive sampling criteria in order to select information-rich cases for in-depth analysis of the central issue being studied (Polit & Beck, 2008).

In this study, 10 Canadian primiparous women, between 33 and 39 weeks gestation who lived with the father of their child participated in the study. The rationale for the selected gestational age was based on research suggesting that women are more fearful as childbirth approaches (Rouhe et al., 2009, Ryding 2009).

My criterion for primiparity was based on Rouhe et al. (2009)'s findings that that fear of childbirth was more common in primiparous women than parous women. Other inclusion criteria were: fluency in English, aged between 18 and 46 years, residency in BC, and absence of pregnancy complications.

Women who were known to the researcher either professionally or personally prior to their pregnancy were not asked to participate, due to the potential for undermining privacy or undue duress owing to familiarity between the two individuals. Women with prior mental health challenges such as depression and psychosis, and women who experienced high-risk conditions associated with their pregnancies (e.g. pregnancy-induced hypertension, preterm labour, bleeding, and Type 1 Diabetes) were also excluded from the study to rule out such compounding factors since the research topic focused on fear of childbirth, not fears of pre-existing or concurrent prior physical or psychological conditions.

I ceased purposeful sampling at 10 women because I found no additional data to generate of new categories after the 10th interview. This represented data saturation; data saturation is the point where no new information emerged to support new categories in further interviews (Morse, 2000). Although the sample size was relatively small, it provided sufficient data to support the core themes and answer the study question (Sandelowski, 2000).

3.6 Data Collection

I used interviews to obtain participants' perspectives about their thoughts and feelings (Nieswiadomy, 2002). The strategy of direct interviews was the most suitable data collection method because the voices of the women could provide valuable first-

hand information (Hammersley & Atkinson, 1995). The interviews were conducted from March 2013 to August 2013. I used face-to-face, in-depth semi-structured interviewing. All of the women chose the time and place for their interviews in order to create a relaxed setting. Interview locations included participants' homes, the researcher's home, or coffee shops. Each woman was interviewed only once for the study. The interviews lasted between 52 and 78 minutes each with the average length being 54 minutes. All interviews were audiotape-recorded. Recording each interview helped me to focus on each woman and the dynamics of each specific interview, and it also captured participants' words in a semi-permanent format to be used in the analysis (Taylor et al., 2006).

Following Spradley's (1979) method, I began each interview as a conversation and then transitioned to its purposeful elements; my approach aimed to facilitate participants' comfort and safety; my aim was to increase the depth of conversation. Specifically, I used some techniques advocated by Spradley to facilitate the interviews including: explanations of the research project to the interviewees to further their understanding of my goals and develop trust; a mixture of descriptive, open–ended, and semi-structured questions to guide the interviews to provide relevant data; a reiteration of points using the informants' language to ensure clarity in communication; and a leave-taking of the conversation as necessary to allow the informant to continue at a comfortable pace. Throughout the interview process, I maintained a faithful, respectful, and nonjudgmental attitude.

I began each interview by asking participants to describe their general feelings about childbirth, followed by questions about their fearful feelings and thoughts during

pregnancy, as well as the other influencing factors from family and community members. The initial question was "Please share some of your feelings about childbirth with me. Can you explain what fearful feelings about childbirth might mean for you?" To deepen my understanding about the way women perceive and experience childbirth fear, I also asked questions about how other aspects of their lives affected their experience. Follow-up probes, such as "Tell me more about that" were also askedto increase the depth of data collected.

I encouraged the women to express themselves freely and openly. I asked for clarification of the meaning of any ambiguous or unclear responses. Before terminating the interview, I gave each interviewee the opportunity to add additional comments. The key questions used in the interview are included in Appendix C. All of the women appreciated the opportunity to share their significant personal experiences with an interested listener; none withdrew from the study.

3.7 Content Analysis

I used qualitative interpretative content analysis (Graneheim & Lundman 2004) to analyze statements derived from the interviewees' responses to my questions. Based on rich and detailed descriptions (Morse, 2003), content analysis incorporates a structured method with specific norms and guidelines for data analysis. It is a systematic coding and categorizing approach to investigate large amounts of textual information so that the researcher can identify trends and patterns in words, develop codes that are then collapsed into themes, and explain relationships among the themes (Gebrich, 2007). Due to the limited knowledge about childbirth fear in British Columbia, an inductive approach

enabled me to explain and interpret the data by developing dominant and major themes that captured women's experiences (Granheim & Lundman, 2004).

The inductive content analysis approach requires interpretative reading of the fundamental data presented in the women's interviews to uncover "the deep structural meaning conveyed by the message" (Berg, 2004, p.226). Inspired by Graneheim and Lundman (2004), the coded material is arranged in categories that are developed into themes to obtain further understanding of the respondents' statements. This analytic process made it possible for me to obtain a sense of interactions between the parts of the body of data and the whole, and to become immersed in the data. As recommended by Glaser and Strauss (1967), I performed my data collection and analysis concurrently, which allowed me to fluctuate between ideas about the existing data and creating strategies for gathering new data. The analysis was performed manually; no qualitative software was used.

Granheim and Lundman (2004) defined content analysis as a procedure that can be classified into the following stages:

(1). Transcribing the interviews:

The interviews were transcribed word-for-word and I reviewed the transcripts several times to obtain a sense of the whole narrative and to become immersed in the data.

(2). Choosing the unit of analysis:

I selected the unit of analysis by coding parts of the transcript, specifically particular words or phrases in the transcript, which were related to the research question (see Table 1).

(3). Coding:

Codes are tools that allow us to consider data in various ways by unifying similar ideas; many different kinds of phenomena understood in their own contexts can be labeled by codes (Graneheim & Lundman 2004). As I reviewed the transcripts, I recorded in the margin of the text keywords or phrases that seemed to capture women's perceptions of childbirth fear, using the participant's own words. I created codes which were clustered into categories to capture the core ideas described by women about their fear of childbirth (see Table 1). For example, one woman's comment of "So I just don't want anything to go wrong" was coded as "Fear of things going wrong", which was further combined into the theme of "Fear of childbirth as an unknown territory". Another woman's comment, "when you are the person who is the only person giving birth at that moment, then it causes more fear for me" was coded as "Fear of being the one giving birth" then clustered the code into the category of "Fear of inability to give birth" which was further combined into the theme of "Fear of childbirth as an unknown territory".

According to Coffey and Atkinson (1996) "codes are tools to think with" and "heuristic devices" (p. 32). Granheim and Lundman (2004) suggested that codes are discrete objects or phenomena that allow the data to be thought about in new and different ways. After coding two transcripts, I reviewed the codes I had created with my supervisor and revised them based on our discussions. I coded the remaining transcripts using some of the codes I had previously identified and added new codes when I encountered data that did not fit into an existing code. Throughout the process, I based my codes directly on phrasing from the transcripts.

During the coding process, I constructed a series of notes, in effect analytical notes-to-self that described my ideas about the data, definitions of codes and their properties, and ideas for further sampling (Appendix E). Using these techniques I was able to improve the depth of my emerging ideas (Pope et al., 2006).

(4). Categorizing and Thematizing:

Because categories comprise the heart of qualitative content analysis developing them comprised the fourth stage of my data analysis (Granheim & Lundman, 2004). After I coded all of the transcripts, I compared the codes on the basis of similarities and differences, sorted them into sub-categories (threads of meanings), and clustered them in categories, which were the core feature of my analysis (see Table 1). Each category that I created represented content that shared a commonality and served to represent mutually exclusive conditions (Krippendorff, 1980). For example one woman's comment, "I don't know the pain, I don't know my tolerance, that is the part that scares me" was categorized as "Not knowing pain tolerance", and contributed to the overall theme of "Fear of pain".

In the final step of my analysis, I worked at a more abstract level of conceptualization. I clustered the categories under themes based on my interpretations of the codes and categories as suggested by Granheim and Lundman (2004). In contrast with a category that can be identified as a thread throughout a number of codes, a theme can be described as a thread of an underlying meaning shared by categories; it operates at a more abstract level (Polit & Beck, 2008). For example, the specific categories of "fear of routine caregiving", "fear of responsibility", "fear of loss of self", and "fear of financial difficulties" were collapsed together into a higher level since they shared a common theme: fear of parenting.

Table 1 Examples of quotations, codes, categories and themes after analysis of interviews with 10 women about fear of childbirth

Theme	Fear of childbirth as unknown territory	Fear of parenting	Fear of pain
Category	Fear of death	Fear of loss of self	Not knowing length of pain exposure
Code	Fear of death due to family experience	Fear of life change with loss of what is wanted in life	Fear of having long and painful labour
Quotation	Because I have seen one of my family members die during delivery of a child, and it was in Canada, not in a third world country or anything like that. So, hopefully, nothing will happen to me. (#1)	Just the fears of changing your life and, for me, that means that I actually give up a lot of myself… Because you've already kind of established yourself and you know what you like in life. (#5)	So I'm worried that it might take long and it might be really painful. (#4)

3.8 Rigor

Similarly to other qualitative approaches, my study must be evaluated in relation to the procedures that were used to generate the findings (Polit' & Beck, 2008). Onwuegbuzie and Leech (2007) identified a variety of techniques that are applicable to assessing the legitimacy of qualitative findings and interpretations. In this study, I used investigator triangulation, developing an audit trail, member checking, and weighing the evidence.

3.8.1 Investigator triangulation.

Investigator triangulation is attributed by Onwuegbuzie and Leech (2007) to assessing the true value of qualitative research. Denzin (1978) defines investigator triangulation as the "use of several different researchers in the course of obtaining and analyzing qualitative data". My supervisor assisted me with interpreting the data to develop my themes. Her participation increased the credibility of the findings by reflecting the relativistic nature of truth claims in the data and attending to "the data speak[ing] to the findings" (Lincoln & Guba, 1989). Investigator triangulation also increased the clarity of my interpretations and interpretive validity; the extent to which my interpretation of an account represents an understanding of the women's perspective and the meanings attached to their words and actions (Onwuegbuzie & Leech, 2007).

To assess the relevance and credibility of the analysis, the categories I developed from the data were reviewed with my supervisor and revised. I also assessed all categories under a particular theme to ensure that they were mutually exclusive. My supervisor reviewed all of my analytical and interpretive pathways.

3.8.2 Developing an audit trail.

I provided an audit trail to support the plausibility of my findings so that readers could evaluate whether or not the research findings represent a credible conceptual interpretation of the data, as suggested by Horsburgh (2003). I maintained documentation of my data collection decisions and analytic process (Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007). Using the audit trail supported the confirmability of my study because observers could trace the course of the research at each stage as a measure of how well the study findings are supported by the collected data (Lincoln & Guba,

1985). My audit trail consisted of the following six categories of records as defined by Lincoln and Guba (1985):

(a) raw data (recorded interview notes);

(b) data reduction and analysis products (coding in transcripts);

(c) data reconstruction and synthesis products (tables with structure of categories and themes);

(d) process notes (methodological notes, trustworthiness notes, audit trail notes);

(e) materials related to intentions and dispositions (research proposal, personal notes); and

(f) instrument development information (interview schedules).

Tracking my procedures contributed to the transparency of my analytic methods and data interpretation. Illustrating the creation and linking of codes and categorization improved the credibility of my research findings because readers could follow my reasoning to support the research themes (Granheim & Lundman, 2004). The credibility of my research findings was also related to how well the categories and themes I developed represented the data; specifically, that "no relevant data have been inadvertently or systematically excluded, or irrelevant data included" (Granheim & Lundman, 2004, p.110). While coding and categorizing the data, I preserved original vocabulary and grammatical elements. These actions linked the categories and themes I constructed to the original transcripts.

3.8.3 Member checking.

Member checking is another technique described by Onwuegbuzie and Leech

(2007) to assess the legitimacy of qualitative findings and interpretations. I confirmed the data directly with the interview subjects by restating any unclear responses to confirm accuracy; Lincoln and Guba (1985) pronounced this action as "the most critical technique for establishing credibility" (p.314). According to Maxwell (1996), member checking is the most effective way of eliminating the possibility of misrepresentation and misinterpretation of "voice". By paraphrasing and summarizing the women's responses, I supported the accuracy of my translation of the women's viewpoints into the analysis.

3.8.4 Weighing evidence.

In any qualitative study, researchers' assumptions can shape the interpretive process (Onwuegbuzie, 2003a). As a form of weighing evidence in order to minimize effects of researcher assumptions and bias, I placed higher priority on analyzing the more common themes based on my coding from the interview transcripts (Onwuegbuzie & Leech, 2007).

Because self-reflection should operate as a natural and necessary process when doing data analysis (Onwuegbuzie & Leech, 2007), I was reflective about my knowledge and responses to the data and remained faithful to the participants' accounts. In addition, I maintained the intent of qualitative research by giving consideration to negative cases to ensure that I incorporated all relevant views about the research topic (Lincoln & Guba, 1985).

In summary, in this chapter I described my use of a qualitative descriptive research design to analyze data of women's perceptions and experiences of childbirth fear for this study. This method allowed me to be guided by the data to develop and extend knowledge of the experience of childbirth fear rather than by a set of fixed a priori

hypotheses (Hammersley & Atkinson, 1995). Specifically, I used some techniques advocated by Spradley (1979) to facilitate the interviews including: explanations of the research project to the interviewees to further their understanding of my goals and develop trust; a mixture of descriptive, open-ended, and semi-structured questions to guide the interviews to provide relevant data; a reiteration of points using the informants' language to ensure clarity in communication; and a leave-taking of the conversation as necessary to allow the informant to continue at a comfortable pace. The initial question of "Please share some of your feelings about childbirth with me. Can you explain what fearful feelings about childbirth might mean for you?" was elaborated upon with questions about their life experiences and other attitudes toward childbirth. I analyzed data using a coding approach inspired by Graneheim and Lundman (2004), which made it possible for me to obtain a sense of interactions between the parts and the whole, and to become immersed in the data. Finally, to address the rigor of the study, I used a variety of techniques including investigator triangulation, developing an audit trail, member checking, and weighing the evidence.

Chapter 4: Findings

In this chapter, I describe the characteristics of my sample and present the inductive qualitative interpretative content analysis of my data, represented in five major themes. I present each theme with the supporting categories, and quotations from the women.

4. 1 Sample Characteristics

Briefly, the average age of my participants was between 25 and 35 (See Table 2). The women's educational levels ranged from college to university. Two-thirds of the women were Asian and the remainders were Caucasian. Most of the women described their paid occupations, with the remainder describing themselves as housewives or students. All of the women resided in Vancouver. The women reported that they were healthy and had normal pregnancies at the time of the interviews. Background demographic information was collected using a separate data collection tool (See Appendix D).

Table 2 Demographic characteristics of sample (n=10)

Demographic Variable	n	%
Age categories		
< 25	1	10
25-35	7	70
> 35	2	20
Relationship Status		
Married	6	60
Common-law	4	40
Education		
College	2	20
University degree	8	80
Ethnicity		
Asian/Chinese	6	60
Canadian	3	30
American	1	10
Annual Income		
50,000-100,000	4	40
>100,000	1	10
20,000-49,000	5	50

4.2 Results

The themes that I developed from the data were characterized as (see Table 3):

Table 3 British Columbian women's experiences and perceptions of childbirth fear

Themes	Categories
Fear of childbirth as unknown territory	Fear of things going wrong Fear of death Fear of being alone Fear of inability to give birth
Fear of pain	Not knowing pain tolerance Not knowing length of pain exposure Fearing effects of the fetus's size Fear of negative physical outcomes
Fear of being out of control	Fear of loss of control over birthing experience Fear of loss of control over being exposed Fear of behaving "badly"
Fear of parenting	Fear of routine caregiving Fear of future changes in marital closeness and sexual relationship Fear of long-term commitment (responsibility) Fear of loss of self Fear of the financial difficulties
Influencing factors in childbirth fear	Information about childbirth Media impact Support from health care providers Support from personal relationships Negative birth stories Contextual influences on fear of birth Resisting the medicalization of birth and preferring vaginal birth

4.2.1 Fear of childbirth as unknown territory

"Fear of childbirth as unknown territory" was one of the major themes supported by the data. Most women in this study felt that their fear of childbirth was primarily based on the unknown journey they were contemplating. Women made comments like: "walking into the unknown is the next scary part… there are lots of fears because again it is the unknown… It's that sense of unknown is what I think makes women really scared." (#5) The construction of childbirth as 'unknown' created the conditions for fear being generated because the women had not had previous exposure to actual birth. For example, one woman's response to the meaning of 'childbirth fear' was: "I think I would circle it around the unknown… the whole not knowing is what scares me." (# 5) Another woman stated, "Fear for me is fear of the unknown." (#1) The participants linked their fear of the unknown with their difficulty in knowing what to expect given their lack of experience: "I haven't experienced it firsthand. So I guess the fear is coming from the fact that it's my first time experiencing … and I don't know what to expect." (#9) One participant compared the fear of childbirth to the unknown of walking in the dark

"But when it's the first time you are doing something, obviously you don't know. I always say you walk in blind and you walk in the dark. So, imagine going into a house that is completely pitch black and you don't know what is going to happen next. That is what I feel childbirth is like." (#5)

The theme fear of the unknown comprised a number of categories: fear of things going wrong, fear of death, fear of being alone, and fear of an inability to give birth.

Fear of things going wrong

Fear of the unknown in childbirth was experienced by some participants as fear that things would go wrong for them. They focused on all of the potential technological interventions and physiological events that could go awry. "The negative things are all the things that can go wrong, like improper epidural insertion point, timing was off, no progress in dilation, induction." (#5)

The women felt compelled to explore their possibilities for incurring risk during pregnancy and birth. Many participants believed that childbirth was a risky process that would inevitably go wrong and treated it as a high risk medical event. For example, one woman's experience in a prenatal class left her terrified:

> "I took a prenatal class and in the prenatal class they talk about all these complications that can happen with the birth, with the umbilical cord coming out first or the baby being breech ...I'm scared something's going to go wrong and I'll be put into a c section situation …from what we were told …and that terrifies me." (#7)

Another participant constructed her childbirth as a pathological process, happening to a few women causing her fearful thoughts of things that would go wrong:

> "I fear that I am going to be in a small percentage of those women who have things go wrong, either an anoxic brain injury to my child, an abruption of placenta, emergency C-section that needs to be done in the room. So those are my fears." (#1)

Fear of death

Part of the women's sense of childbirth as an unknown and fearful territory was their lack of security about what the outcomes might be for them and their children. Fear

of death was an issue for many of the women. They described being terrified about losing their own lives. One woman described her preoccupation with this fear:

> "That's one of the childbirth fears. I could die or the baby could die in the middle of giving birth …When you are giving birth, one foot is under the grave already because it's either you both live, one of you dies, or both of you die, right." (#8)

Some women emphasized childbirth as occupying a place between life and death.

> "Fear also with myself. It's like they say, that when you're going to have a baby, your life is like 50-50, you know, like life and death. I don't know. That's our belief. When you go to delivery, it's like life and death factor." (#10)

Fear of the unknown in childbirth was also experienced by the women as fear of their babies dying. They could not know how their journey would end for their babies. As one woman stated," I was scared to lose the baby … I'm not going to deny that, it's in my journal… And the third would be kind of scared that the baby is stillborn." (#9)

Because the women started from the position that something would go wrong, they assumed no sign could be a bad sign. A participant indicated there was no way of absolutely knowing that her baby was fine and ready for the birth experience. "…I am more fearful because I really don't know. I mean, is the baby still alive, you know? I mean, 'cause you really don't have any idea, right, 'cause you don't feel anything." (#8)

Fear of being alone

Many women described their fears about being left alone on this journey through unknown territory. They expressed a strong desire to have other people around them to serve as guides. In addition, they recognized a need for connections to others to decrease the feeling of loneliness during their deliveries. Their fear of loneliness was partly a

response to feeling they did not know how to make the journey through labour and birth. As one woman mentioned:

"I know that if I'm in that situation with no moral support cause your spouse is out of the room, that you know your mind is going to be racing like crazy, you're going to be freaking out and stressing and hoping everything is okay." (#7)

Another woman expressed her concerns as: "It's sort of scary to be alone I guess because I don't have any experience, I don't know what I should do." (#10) Because giving birth was an unknown and unfamiliar territory, with which they had no experience, their sense of loneliness was tied up with no one being there with them on this journey or having gone there successfully before. Women were fearful because they felt that they and they alone had the responsibility for birthing. "I do feel quite alone because I am the one who has to do it all…But when you are the person who is the only person giving birth at that moment, then it causes more fear for me." (#5)

Fear of inability to give birth

Journeying through unknown territory, with doubts about their abilities to navigate it, created horror for some women about facing childbirth. They started from a conviction they were not up to the task. "I can't do it, that I won't be able to manage I guess is my biggest fearful feeling. That the pain is going to be too unbearable that I'm just going to give up, is my biggest fear." (#7)

By perceiving birth as too difficult and unachievable, women expressed skepticism about their performance in labour and their bodies' abilities to give birth. For example, one woman stated:

"Even though there are many things I can do, this is one thing I found that eats me. I say I can jump out of a plane and skydive, I can jump off a mountain with a parachute, but yet I am scared of childbirth." (#5) Many participants expressed fear about their bodies' abilities to push during the actual birth process. "I am not strong enough to push my baby out." (#10)

4.2.2 Fear of pain

Most participants in this study expressed some fear of pain. Because they had not previously experienced childbirth they did not know what the pain would be like. They were unsure about how long they would be exposed to the pain of labour and what their tolerance for the pain might be. The women linked the possibility of having a big baby to a more intense experience of labour pain and the fear that giving birth would not only be very painful but would also result in physical damage that would create ongoing pain.

Not knowing pain tolerance

Most women voiced concerns about not knowing their pain tolerance during labour. "You don't know how strong you are with pain tolerance till you've experienced it." (#7) It was also common for women to worry not only about the process of labour and contractions but also the pain of pushing. As can be seen from Participant #5, many women cited fear of pain and not knowing their pain tolerance as the main reasons for fear of childbirth, "So the unknown of pain, of your own tolerance is the part that really scares me for childbirth."

Most of the participants envisioned labour pain as being unbearable and intense. They had no descriptions of being able to ride the wave of the contraction or coping

techniques. “When I think of childbirth fear I think of the whole process of labour and I think of the pain of labour…. That the pain is going to be too unbearable.” (#7)

The women had a tendency to view labour pain as the central feature of childbirth. “The pain is my big fear as towards the end of my pregnancy now … When someone says childbirth, the first thing I think about is pain… The fear of pain, that's probably my only fear.” (#1)

Because women did not know what kind of pain to expect and had no sense of how they could manage it, they viewed labour and birth as the worst kind of pain. “Am I going to have to go through this most painful day of my life? And I think when women say that it just makes it more scary.” (#5)

Not knowing length of pain exposure

Many women had fears about how long the pain of labour would last. Their fear of pain was, in part, based on their fears of a prolonged labour, as well as the fear of long-lasting pain even after the delivery. Because they were contemplating unbearable pain and long labour the women imagined that medication would be the only way they could cope but that could potentially result in a caesarean section.

> “If I’m thinking about pain and thinking that oh this is going to take forever and it’s going to be really painful and I’m going to have to take medication, then you know there’s a good chance that I’ll end up in that [caesarean section].” (#7)

Fearing effects of the fetus’s size

Women’s concerns about the size of their fetuses contributed to their fear of

childbirth. They had been exposed to views that large babies would inevitably lead to problems with the birth and increased pain. One woman stated that a large fetus was one of the causes for her fear of a caesarean section: “Then I also worry about having a hard time because if the baby is big and couldn't get out there, then I have to do C-section. Then what if halfway, you can't do C-section and you can't do natural birth?” (#3)

One woman linked labour pain directly to having a large baby. It was as if she envisioned her baby as being bigger than her body: “It’s probably going to be a lot more painful for me considering the baby is full size and is a lot bigger and I'm also a lot smaller than her.” (#4)

Fear of negative physical outcomes

Most women were not only concerned about the pain of labour and giving birth but were also concerned about pain from physical damage in the aftermath. They feared pain from episiotomy, perineal lacerations, hemorrhage, and caesarean section. Some participants linked their fear of pain to damage to their uteruses, specifically rupture, laceration and caesarean section. They were concerned about the pain associated with a prolonged healing process from caesarean surgery. The following three quotes highlight examples of concerns about being injured during childbirth: “I'm just worried about tearing and stitches.” (#4)

> “I have read this research that your vagina is actually going to, there's going to be a rupture in your vagina, so like the head of the baby can come out. Like just the thought of it scares me because there's going to be so much blood.” (#9)

Because many women expressed fear of pain associated with caesarean section they described vaginal birth as the preferred mode of delivery. Many of them were torn

by indecision. Pain during labour was a cause of uncertainty for one participant who demanded a caesarean section as a way to circumvent the pain of childbirth. “I don't think [people in my culture who have option to choose a C-section] would worry about labour, long labours, painful labours and delivery, because they have an option of doing a C-section right from the beginning.” (#4)

4.2.3 Fear of being out of control

Another reason women expressed for fear of childbirth was their fear of being out of control. A number of aspects of control were described. The participants feared an absence of control over their birthing experiences, feared a loss of control over being exposed, and feared they would lose control and not behave properly. They indicated these fears were linked to the location of birth and the numbers of people involved in the process.

Fear of loss of control over birthing experience

Fear of loss of control was often mentioned by the participants. In part, the women were reflecting on control being taken by others. For example one woman expressed: “I think some things are going to be out of my control, and nobody likes to be out of control, and really, in labour and delivery you are out of control a lot of the time. So, that's my fear.” (#2)

With control being taken by others, women felt their bodies were not their own and under their control: “And losing control of my body was a big fear. Like, Why does this hurt? Why am I so grouchy?” (#5)

Another woman expressed her fear of losing control as follows: “Yeah, loss of control of who you are as a person… you know you’re put in a situation that you might not have much control of and you lose all control of yourself and I think that if you-in the moment I don’t think you’d realize it but then you look back at the moment I would feel guilty and I feel horrible that I wasn’t able to control myself.” (#7)

Fear of loss of control over being exposed

Women expressed their concerns about maintaining modesty or their fear of losing privacy in front of others. As one woman described, “But I don't want a lot of people inside. In Burnaby Hospital, they said that, oh, you can have the whole family inside, but I don't really prefer that. I just want my husband there. But not the whole family 'cause you know, they are going to be seeing everything.” (#8) Another woman was afraid of losing her privacy in front of others as follows, “There's so much emotion going on…so you probably don't want to see other people yet...” (#9)

Fear of behaving “badly”

The women in this study considered being able to behave appropriately to be important during labour. Because women felt their loss of control over their bodies and their birthing experience were inevitable, they feared their behavioral responses would be interpreted as being silly and crazy during the delivery. Their fear of uncontrollable pain with feelings of helplessness about how to manage pain during labour created worries they would behave inappropriately toward others. They were afraid that others would judge them and find them wanting. “You don't know, right, like how much swearing or how much shouting. You become a different person during labour, for sure, because

you're in so much pain. You might even have a fight with your husband or you might even feel irritated." (#9)

Another woman stated: "Am I going to be the one who's obnoxious and yelling and screaming in the hospital and saying horrible things to my partner and making him feel bad when I don't mean it. And you know just treating people horribly and not being the person that I am. And being this crazy monster in labour. I think that's what comes to mind when I think of childbirth fears that will this other thing shine out during labour that you have no control of because of the pain. And I would associate all the reactions and what we see because of the pain that the woman can't deal with." (#7)

4.2.4 Fear of parenting

Women's transition from pregnancy to motherhood involved personal and interpersonal transitions, which, for them, generated fear, uncertainty, and worry. The pregnant women expressed fears about their abilities to manage routine caregiving, the responsibility, and the long-term commitment. They were fearful about their sexual relations, marital relationships, financial problems and work issues. Their fears appeared to mirror their fear of labour and childbirth because they doubted their abilities to manage, viewed the transition to parenting as moving into unknown territory without a map and felt parenting responsibility was going to be too much for them to handle. The women also described fears about the effects of parenting on their work and possible loss of a good life.

Fear of routine caregiving

Most of the women in this study were worried about maternal tasks and appraised themselves critically as future mothers. Their ambivalence about their abilities to manage maternal roles led them to express their fear of future parenting. The participants regarded their transition to parenthood as an overwhelming experience that required them to face the unknown of how they could take care of their babies. One woman said, “And after birth, how to take care of the baby, I guess. So that's one, because we are inexperienced. So that's one of the worries.” (#10) Another statement was: “I’m scared of what’s gonna come when the baby arrives, like will we know what to do? Can we manage a baby?” (#7)

Because women were worried about being incompetent at managing the care of their infants they felt a lack of confidence about becoming a parent. “I think the majority of my fears come like once that baby is out and I am holding it, then it's what do I do, oh my God. So that's the part that freaks me out for sure.” (#6)

The women’s fear of routine care giving invested their comments with hesitation to meet the unknown. Their fears caused them to consider whether they would become depressed because they would feel overwhelmed. One woman stated, “I think that fear of being overwhelmed and not having the time to do the projects that I want to do and just not knowing what my life is going to be like for the next year basically.” (#6), and another added that, “I’m going to be too overwhelmed with the baby that it could cause a depression or something you know cause it’s a different state that you’re in.” (#7)

Women’s doubts about their capabilities for being mothers partly arose from a lack of clear direction about what to do. As one woman stated “There’s absolutely no

guideline about what to do when your baby comes home and I'm scared that when the baby pops out I'll have no idea what to do at all and I'll be flustered and might affect how I care for the baby and I'm hoping that it might come naturally." (#7)

Another participant was less definitive but raised the possibility of fear: "Women could have fears about how their life is going to change now they are providing for another person and being a mom." (#2)

Fear of future changes in marital closeness and sexual relationship

Another reason that women feared parenthood following childbirth was the possible disruption that it would cause to their relationships, which would place a strain on their partners' appreciation of them, and closeness, and sexual relations. Some women feared disagreeing with their partners about parenting, ongoing conflict resulting from different parenting approaches, and a decreased cooperation between partners. As one woman expressed:

> "I'm scared that things are gonna change and things are gonna be more stressful and we're gonna argue about how to raise the child properly and it might affect our relationship and I don't wanna lose what we have and what we've gained." (#7)

Some women feared their inability to engage in sexual activity after their births would result in their partners feeling excluded from their relationships. One participant suggested lack of capacity to manage their time with the baby would cause a decline in the quality of their sex life. "If you can manage everything with work and your relationship and I think it's very important to form a relationship-to keep the relationship with your partner but also you know have the family and trying to manage everything." (#7) She described fears about decreased sexual functioning and quality following

childbirth and feeling guilty about not being sexually available to her partner after childbirth:

> "And again your whole vagina, will it come back to normal after pushing a huge head out of it? Will sex be the same between you and your partner after it and I've heard stories that sometimes it takes up to three months before you can form that bond again. For women I don't think it's as important, the whole physical contact but for men it is. And I don't want my partner to think I don't love him anymore and I love the baby more because I'm just not ready to be physical with him." (#7)

Fear of long-term commitment and responsibility

Study participants also expressed fears about parenting after childbirth because it represented long-term commitment and responsibility. They had difficulty with contemplating a lifelong commitment to raising a child:

> "The scariest thing I've done in my life is committing to having a child. I just signed up for a lifetime of worry …a child is worse than a mortgage a mortgage I can get rid off, a child I cannot …you fear raising a child and the lifelong commitment." (#5)

Several participants felt fearful about their abilities to deal with the responsibility associated with long-term caring for their infants. This was partly because this was a journey into unfamiliar territory with everything being new to them. These women indicated that messages about responsibility that accompany motherhood create fear:

> "I've never had something that is 100% dependent on me before, so this is a big step. I am really fearful about... No matter what, she's still going to be that huge responsibility that I need to be able to juggle with everything else." (#6)

The women linked their fear of taking responsibility for motherhood to potential hesitation during their labours in order to avoid passing through the threshold to motherhood.

> "And especially with the whole fear of the baby coming out at the end and not knowing what to do that maybe I'll, you never know but I could stop, try to stop the labour process and be like no I'm not ready yet I you know I'm scared I don't want this baby yet I'm not ready to take care of it. So instead of pushing like I should be I'm not pushing and I'm causing conflict between me and my midwife." (#7)

Fear of loss of self

More than half of the women who participated in this study expressed fears that becoming parents would result in a loss of themselves. They linked their future responsibilities to their fear of giving up their established selves, fear of ending their lives as individuals, and fear of managing the feelings of loss that engendered. They were concerned about setting a lower priority on personal needs and a higher priority on their children's needs. One woman stated, "So now I am going to have even less time for myself I am going to be taking care of a baby full-time." (#6) One of the interview participants said that being born into motherhood was like a journey to the unknown in terms of who she was as a mother.

Specifically, women were worried about sacrificing their personal interests related to entertainment and recreation. One woman said:

> "Just the fears of changing your life and, for me that means that I actually give up a lot of myself. You've already kind of established yourself and you know what you like in life. You have to take care of this kid for the rest of your life. I just signed up for a lifetime of worry… The end of you as an individual, but the beginning of something that is together as a unit with your partner and your child

> and you. So I guess that is also a fear… Fear, like we just gave away ourselves for this child. So, I think that part of my life has influence on my fear." (#5)

The women were partly reflecting on their lack of ability to devote time to their selves regardless of whether their lives had space for that time. In other words, they imagined that part of motherhood was feeling it would not be acceptable to create time for their needs. "I am apprehensive about being able to give myself that time, or the time that I need for myself as well, so that's the scariest part for me, I think, with this little baby process." (#6)

Fears of financial difficulties

One of the reasons that women feared childbirth was anticipated financial strain that created an uncertain future. For example, one woman stated that her fear was compounded by financial and career instability, as well as lack of affordable housing. Women were fearful about being unable to meet personal financial responsibilities and concerned about the financial ramifications of raising a child. One participant reported being:

> "Overwhelmed about my ability to make enough money for us and have a roof over our head and take care of her and take care of me at the same time. … Yeah, how to take care of the baby and still make money and still feel like I have my own time to do the things that I need to do." (#6)

The women linked their financial concerns to their inabilities to manage caring for their babies and themselves. "Of course finances has become a huge concern and worry for us if we're gonna be able to manage to do everything for our baby and for ourselves." (#7)

4.2.5 Influencing factors in childbirth fear

Women's expressions of their fear of childbirth were influenced by many factors. The women lived in a society where they constantly received messages from a variety of sources about childbirth. Often these messages were framed in ways that emphasized the suffering and risk associated with childbirth. Women also expressed an increase or decrease in their perceptions of childbirth fear depending on the nature of support they believed was available to them at the time of their births. Support could include the presence of people familiar to the women or health care providers during the labour and birth process.

The participants' comments supported factors that mitigated or enhanced childbirth fear including: information about childbirth, the nature of their supportive relationships, and negatively framed information.

Information about childbirth

Most participants sought information about birth through books, magazines, the Internet, or discussions with others. Some of the women described gaining access to information as important means of mitigating their fear: "But the fact that my husband and I went to a prenatal class, it helps us be informed. So the fear of labour or lack of preparation thereof will be diminished because you get significant information." (#9) In other cases, women linked their lack of information about labour and childbirth to increased fear. The following quote highlighted examples of their concerns about a lack of information: "Reading about the pregnancy book and childbirth book. So, educate myself more. I think then, for sure, I'll have less worry." (#3)

Other women suggested information about childbirth enhanced their fear about childbirth. Some women described increasing their fear of childbirth as a result of reading about risks in books and magazines. One woman commented:

> "Yeah. Because the more you learn about all the different things that could go wrong or that could affect your baby negatively, then I guess it could add to your worries. Right? So maybe there is such a thing as too much information. I don't know." (#2)

Another woman indicated specific information about potential negative events enhanced her childbirth fear.

> "After we found out that I'm pregnant, I started to subscribe to like websites, so that I would have letters or tips on, you know, 'cause it's my first time, right. So, um, and then fears started to come in, like what if this happened or what if that happened." (#8)

Some women suggested that information shared during prenatal classes contributed to their fear:

> "Even when we went to our prenatal classes, the nurse gave us different scenarios of what would happen and explained different things. And was I scared? Yeah, of course. Like what if I have to have a c-section, or what if I have to make the decision about using forceps or vacuum, or what if a complication comes up? Does that create fear? Yes, of course it does." (#5)

The participants also linked their experience of fear of childbirth to the content and quality of the information that they obtained on birth. For example, one woman stated: "I got even more worried when I read it online and I read through some parenting books and they showed the different degrees of the stitches, because it looks very painful." (#4) Another woman expressed similar concerns: "The Internet has considerable dose of information that can either help you or make you scared in childbirth." (#9)

Media impact on the fear of vaginal birth

Participants specifically singled out media portrayals of birth as important influences on women's childbirth fear. Many of the women stated that their fears had developed because of negative messages about labour and birth that were conveyed by the media. They viewed the media as only depicting birth as painful, unpredictable, horrible, and requiring medication in many reality birth shows. Media portrayals of childbirth that emphasized pain enhanced women's fears about giving birth. As one woman stated:

> "How we portray things and view ourselves is from the TV and the movies and they you know they portray birth, as something horrible and something that is like not natural and something that is suffering and I don't think it's right, portraying it that way." (#7)

Participants also attributed the media focus on inappropriate behaviour and loss of control during birth to heightening their sense of childbirth fear. They felt media depictions left women feeling that they had no control over their births. The following quotation illustrates the negative effect of media consumption:

> "And specifically I think of the movies. You know in the TV shows and when they portray it in the media you always see the women screaming and yelling and you know there's you know they're treating their partner badly and yeah it's just it's not a pretty picture at all." (#7)

Some participants stated that their fear of childbirth partly stemmed from the media's depictions of its inherent risks, unpredictability, and possible complications for the baby. For example, one participant, after seeing childbirth in a movie, expected a painful and deadly labour:

> "It scares me because in the movies they show how hard it is. They are kind of swearing, they are shouting. Their back is so painful… I was kind of scared because when I watch movies, like people have a hard time breathing, so like people die and stuff like that. So I was scared to die, basically." (#9)

Another woman expressed her concern about the possible complications for her baby: "The only thing is that if I watch movies, like about child delivery, child deformities during delivery, that's the only thing." (#10)

Support from health care providers

Participants indicated their perceptions of their caregivers' attitudes, support, and their relationships with them were important factors influencing childbirth fear. Some participants indicated their fears were caused by the unsympathetic and evasive attitudes of caregivers. They would have been more reassured if they felt their worries were being taken more seriously, received answers to direct questions, or if caregivers had taken time to respond to their inquiries. One participant described the effects of just being told not to worry: "And then you have an obstetrician who's not answering your questions and just telling you don't worry about it, it makes you worry about it because you'd like to feel comforted." (#7) Another participant described the effects of being given no time to share worries with her care provider and having questions deflected:

> "No, not a lot of worry to share with him [obstetrician], because his time per visit is pretty short. Yeah, I didn't tell him so many details about my worries. So I ask him, what is the risk of epidural? He said, okay, did you take a prenatal class yet? I said next week. Then he would say, oh, the class will tell you. So I didn't share a lot with him." (#3)

Some participants who were fearful about having an absence of support during labour took steps to reduce their childbirth fear by seeking alternative care providers:

> "I was with an obstetrician until my seventh month and because the obstetrician is there for the birth and then leaves and then you get nothing afterwards it kind of scared me that I need a bit more support. So I went and found a midwife." (#7)

Participants who had used information about the birth process to recognize the likelihood of being surrounded by unfamiliar people and having unfamiliar procedures done to them indicated their fears were connected to their lack of trust in health care providers:

> "You have to trust these strangers with your well-being and with the well-being of your helpless child who is just being born into the world that is scary. We put a lot of faith into our medical system. We have to trust they make the right decisions for us …So you trust them. But here, we walk into a hospital, this is your nurse, this is her name, this is the first time you've met them. There have been mistakes made in the medical field about the improper prescriptions being made and given, and that doesn't make me feel very good, it's not in my control." (#5)

One woman reported that a lack of trust in her support from her obstetrician had contributed to her fear of childbirth, in part by being excluded from decision-making during labour:

> "My obstetrician said we don't do birth plans at all, like this is what we do kind of thing. And it's the fear to not being able to have the birth that you envisioned. And so by the culture being so narrow minded I think it increases the fear because you're not given much allowance in what you want to do." (#7)

Support from health care providers could also ameliorate childbirth fear. Some participants linked the quality and nature of the care and support they received from the providers as alleviating their fear of childbirth. In some situations, this occurred during a shift from obstetric care to midwifery care because women felt they were not being

understood or taken seriously. Participants described midwives as providing reassuring care, support, and help that was tailored to their individual needs and wishes. The following two quotations are evidence of a trusting relationship with their midwives: "And with the midwife there's a lot more comforting and she takes the time to listen to you and answer all your questions and explain things a little better and so definitely my fears and worries dropped a lot." (#7) "I chose a midwife over a doctor, just for a more holistic approach and being more aware, so I feel like I have done as much as I can in order to reduce that sort of fear." (#5)

Participants linked caregivers' demonstrations of valuing their perspectives and respect to their satisfaction and sense of safety and control in their relationships. Believing the quality of the birth experience would be preserved reduced their childbirth fear: "I have my midwives who have a much more holistic approach and allow me to make some decisions, so that makes me feel less fear." (#5) Participants also described trusting and supportive relationships with physicians as reducing their childbirth fear: "When I am in the hospital, I feel like I am safe. That's my feeling, I guess. Maybe I trust the doctors or the medical staff I guess." (#10) The following statements provide evidence of the trusting relationship between the doctor and the woman:

> "I trust my doctor a lot, so when she tells me the baby is healthy and he is a good size and he will be fine, then that puts a lot of fear I had at ease, about his well-being at least, for now." (#4)

Support from personal relationships

The study participants emphasized the important role of personal support in dispelling or alleviating the fears associated with childbirth. Personal support could be

provided by partners, parents, sisters, friends, and doulas. The women perceived that the presence of someone they trusted to have their best interests at heart would reduce threats to them and thus decrease their childbirth fear. For example, one woman stated, “My husband is actually one of the things that would make me less fearful, I mean that's true because he is very supportive, I think that's one of the good things because there is a support group.” (#8)

A woman’s mother present made it possible for one woman to contemplate going into the labor: “I don’t want to go into delivery until she’s [her mother] here to help me out and have that extra support from her.” (#7)

Some of the participants wanted an additional presence of supportive companion (doula) during labour to reduce their fears and improve their childbirth experience. This was particularly important in situations where the women believed their partners would be as fearful, or more fearful, than they were. For example, one woman stated, “Even your partner's role can add to the fear of the birthing day in the pregnancy …And I think that scares me too when my partner is more scared than I.” (#5)

The presence of a support team was an important source of help and preparation for the women in this study. The following quotation highlights one woman’s efforts to put support in place:

> “And for the labour, I think I have a pretty good support system …I managed to find a doula, who is a volunteer, who also I am really excited about. And then my husband is awesome, so I have a good relationship. And then my mom will also be there too. So I feel like I got labour pretty much covered, you know.” (#6)

Some of the women attributed support from their own network of social support

to strengthening their self-confidence and improving their self-esteem for childbirth. All women expressed a strong need for support or a trained coach to reduce fear because they felt that everything was new to them, as was the case for this woman: “If it's the first time for you to do something new and you can do it with somebody who is trained and who can coach you, why wouldn't you do it with somebody?” (#5)

Three participants suggested that care from a support person, such as a doula, was very important for dispelling or alleviating their fears by providing information and answering their questions. One woman describes her need for such support: “Yeah, having a birth partner really helps, and I'm going to have a doula as well, like my coach, maybe a nurse is going to be there too, the fact that I'm not going to be there alone.” (#9)

The women described their supports as offering advice, encouragement, companionship, and reassurance, as evidenced by the following quote: “And I can't share them [fears] with my husband anyways. So there is no point. I just look at my sister, and she is like, ‘Oh well. You'll do it. You'll be fine.’ So that's a good reassurance.” (#1)

One participant attributed her increased fear to what she perceived as a lack of available emotional support: “My mom is not going to be there, that's one of my worries as well…'Cause when you're pregnant, you need emotional support somehow.” (#9)

Some women attributed their increased childbirth fear to a lack of available support from their partners. They either expressed dissatisfaction with their partner’s understanding of their concerns and fear of childbirth or felt that ultimately their partners would not be able to handle the labour. One woman described her sense of isolation:

> “So I think that's the best way that I can describe what childbirth fear is. To me, there is no human interaction in my life really… I could talk about these things

> with my husband but there's really only so far that he would completely understand what I am going through, what I'm feeling." (#6)

Another woman was concerned about her partner's inability to handle the experience: "My fear is he [my husband] won't do well with the delivery and I might have to him [husband] home, and it kind of sucks. I'd rather my husband be there." (#1)

Some participants reported feeling isolated from other women who were having similar experiences and feelings:

> "I don't know any other pregnant mothers or really any women that are my age that are even interested in having kids… So I didn't really have anybody to relate to …So I think that's a big reason why somebody like me would feel overwhelmed and not supported." (#6)

A number of women expressed fears about the absence the role of extended family and community in raising their children. The following quotation is another indicator that the women felt they were alone on a journey without a place to turn for support.

> "In North America at least, I think, the sense of community has really switched from lots of human interaction to lots of digital interaction on the couch, not leaving anywhere. So I think that's a big reason why somebody like me would feel overwhelmed and not supported … they say it takes a village to raise a baby, and I don't have a village, I just got me and my husband. So it's daunting to think about." (#6)

Negative birth stories

Almost all of the women in this study were exposed to very negative and horrible birth stories, which enhanced their fear of childbirth. Most women stated that their fears

had developed because of negative birth stories from others. For example, a participant stated:

> "I find a lot of the interactions I've been having with friends, families, and strangers that I meet are frustrating because people just don't listen to you. It's all very opinionated all negative twists on birth, in my experience anyways has been a lot of negative things… it seems like everybody that I know and strangers that I meet on the bus or at school that have had babies tell me horrible labour stories. Nobody has a happy labour story …and the more opinionated people are the more negative twists they put on labour and birth and pregnancy, it increases all your worries and your thoughts right?" (#7)

Some women described trying to resist the negative stories told by friends, family, strangers, and coworkers: "They [friends and family] would tell me some stuff that are fearful as well, so okay, I don't want to entertain that part. I have my own fears. I am going to deal with this on my own." (#8)

Some participants tried to reduce their fear of birth by framing the negative stories they heard as a subset of birth experiences. In other words, they perceived that they were unfortunate and unlucky to know only people who had negative and frightening experiences with childbirth, as evidenced by the following quotation: "Like I said, it's really unfortunate that everyone I know has had bad experiences or worrisome experiences." (#4)

In particular, negative stories that emphasized severe and long-lasting pain enhanced women's fear of childbirth. This participant referred to a friend's experience of pain: "But my friend said if you don't take epidural, then really, really painful. It sounds like almost everyone did have injected -- epidural -- but I am a little worried about the side effects." (#3)

Another participant received a negative story about vaginal birth combined with a positive story about a caesarean birth from her mother: “My mom said it was the most painful thing she ever experienced. She said with my sister it wasn't so bad because they had the scheduled C-section.” (#4)

Some women expressed fear that they would lose their babies based on the negative stories that others told them:

> “And a coworker has actually told me that they know people that delivered and the baby is dead. But, once you hear that kind of story, it resonates with you, like you don't forget it. I even my bus-mate, the person I go on the bus with to work, she tells me the same story. So that scares me, really.” (#9)

Some participants indicated the birth stories involved significant physical damage to mothers during the birth or removal of a uterus as a result of the birth.

> “There are some women who are like, ‘I won't have another baby,’ because it was so traumatic, either pain or physically they needed other surgeries. I have friends who needed reconstructive surgery after their labours and deliveries. I've had one woman who something happened to uterus during the delivery where she's no longer able to have children. So there is a bit of resentment, not towards the child, but just towards pregnancy in general.” (#1)

Negative birth stories that are available on the Internet also contributed to increasing the level of fear of childbirth, as was the case for this woman:

> “The whole world of blogs on the Internet can be quite overwhelming. You read a lot of stories and sometimes it can be a very negative experience …And you hear of these terrible stories once in a while, and so again, that pushes us to have more fears.” (#5)

Socio-cultural influences on fear of birth

The concept of fear of childbirth exhibited by women in this study was linked to cultural values, beliefs, and expectations. In other words, women's cultural backgrounds affected the way that they felt about childbirth fear. The medical culture's shifts from representations of birth as a normal bodily function to its depiction as a pathological event provided a possible explanation for their fear of childbirth.

The women in this study emphasized that the cultural changes in Western society have diminished the significance of and admiration for the natural processes of women's reproductive lives. Instead, the general medicalization of pregnancy and childbirth is now the dominant force shaping childbirth, now depicted as a pathological event that is associated with inevitable catastrophe. The women went further by arguing that childbirth should be constructed as a positive experience for women and their babies rather than a procedure that needed to be completed. As one woman stated,

> "They [Canadian medical culture] don't portray birth as a natural process…also our culture doesn't see childbirth more for the benefits of the mom and the baby but more of a medical practice, and strict guidelines and this is what has to bed one and there's no openness and it's just slowly starting to get that way now." (#7)

Women noted that much of medical care (health care culture) in Canada focused on representing childbirth as an inherently fearful process. For example, one woman stated,

> "My culture represents the ideas of fear or worries about birth. Well, I guess I feel in Canada there are many sides and representations. In one way, there are a lot of negative feelings that are just talked about and are always out there." (#2)

Resisting the medicalization of birth and preferring vaginal birth

Many participants expressed opposition to what they described as a medicalized context of Western birth culture. They criticized the medical model of birth because they argued it ignored the natural ability of women in childbirth. The women's critique of this practice was centered on the loss of their power in the birthing process. They objected to an increasingly higher rate of technologically-oriented procedures of childbirth, and maintaining policies that rule the individual. The following statement emphasizes participants' concerns about the medicalization of birth and is evidence of childbirth fear that is generated from care providers within the cultural context of organizational constraints:

> "Hospitals actually are starting to have goals of 'we want to have 50% or 60% caesarean rate'. And I guess it has to do with American culture and everybody getting sued and the doctors don't want to get sued and you go in a route that is more medical then. But you want to keep things natural. Then you will have a doctor saying, 'Well, if you don't want to go through with this procedure, then you have to sign this waiver so you don't sue me because you and your baby might die.' And so it's like all about fear really." (#2)

Some women openly disagreed with the medicalized birth culture that maintained an unnecessary cascade of medical interventions:

> "I think a lot of North Americans definitely are all for scheduling the C-section. So it's like people will pick and choose what's convenient versus what is scientifically best. So they are happy to rely on the science for what is practical but not necessarily for what's good. But I really believe that our bodies are made to do exactly what they do." (#6)

Participants who were more fearful accepted the view that the medical model of birth required women to surrender control over their birthing experience. Participants

who questioned those messages were less fearful. The following quotation illustrates some women's questioning of this practice:

> "I do wish that women are more connected to the birth process I do think it is kind of sad, because I do kind of think that it is wrong how far removed we are from the birthing process and how little faith we have in the birthing process. I would like to see that changed and I would like to see women and the birthing process be more respected." (#2)

Some participants linked the medicalization of birth to creating and reinforcing their fear of childbirth. They argued that the system of medicalization constructs childbirth as a pathological process, which perverts the natural reality and alienates women from what was once viewed as a natural process in women's reproductive lives. The following quotation highlights an example of this concern for the medicalization of birth:

> "I think that women are so far removed from giving birth. Every animal can do it better; any woman can do it, but it is like women don't even know they can do it anymore. They don't understand that they are totally capable and they can do this and every other animal does it…that has been really a negative thing because being pregnant isn't being about sick. It's not the same. It's a beautiful, natural thing, so you don't need to be treated." (#2)

One participant directly linked fear to an inflation of risks that were not real.

> "I feel like childbirth fear is kind of misunderstood in today's world because I think a lot of women are scared about silly things …Like I think the labour part of it, people are unnecessarily afraid of it because I don't really feel like it's worth being afraid of that, and our bodies have been doing it for thousands of years, so I don't see why you would be scared of birth itself." (#5)

A number of participants placed fear of birth in a larger social context. They argued that societal views of low tolerance for risk and medical interventions to reduce

any risk exposure changed the focus from accepting birth as a natural and normal event to viewing it as an illness in need of treatment. One woman stated:

> "I just feel that our society is over medicalized and just wants to diagnose everything and tell you, you have like 7 disorders now. There is this, and this, and this, and this. And they are too quick to try to operate or give you drugs and stuff like that, and so I think all of that and those beliefs are translating into the kind of childbirth but I think that the way our culture has taken birth away from women really and given it all the power to doctors and hospitals." (#2)

Participants expressed a desire to experience normal, natural vaginal birth where they embraced their bodily experiences. Unfortunately, their lack of confidence in their abilities to achieve their desires added to their fear in some cases. One woman put it this way: "So, I think that's one of the amazing things about childbearing, like you are really designed to do it. I really wanted the normal delivery. So that's one of my fears as well." (#8)

In the context of the medical model of childbirth, participants expressed specific concerns about pain medication. They viewed the medical model as relying on pharmacological forms of pain relief, which made them fearful they would not be able to fully experience the birth process:

> "To me that's silly to want to take drugs but if it is something your body needs to endure because it is part of the process of your everyday and your body is learning to cope, I don't think we should always use drugs." (#6)

Another woman confided:

> "I have actually mentally tried to prepare myself for a drug-free vaginal birth, yeah, because I don't like depending on drugs. And in many ways, I said I want to embrace this. I want my body to go through what it is supposed to do, as scary as it is going to be." (#5)

Some women also mentioned that they would sacrifice their own needs for the well being of the baby, such as tolerating pain without analgesia. As one woman stated,

> "I am like, no, I'm not having narcotics. I'm not doping myself up and I'm not doping my baby up. If I have to work so hard at keeping this baby healthy in the 9 months, why am I going to get to this point to dope it up and dope myself?" (#5)

In the context of technology-oriented settings of childbirth with the increased risks for surgical operations, participants expressed their fears of the surgery itself or the associated healing process. The following statements are evidence of their concerns about caesarean sections: "So this fear that I'm having, like for example fear of having the caesarean section and then having 6 weeks of healing process…makes me want to have the courage to really go for the normal vaginal delivery." (#8) "Then I worry about having to do a C-section, and so, that part of labour." (#3)

In summary, the five major themes described in this paper specifically address the research question: "What are British Columbian women's experiences and perceptions of childbirth fear?" Each theme was supported by categories, codes, and quotations from the women were used to verify the results from the analysis. To some degree, many of the themes were interrelated with women who experienced one likely experiencing the others as well. Their concerns could be described as fears of unknown journey, pain, parenting, and loss of control. Women also linked factors to increased or reduced childbirth fears: the impacts of having support from personal or healthcare sources, media depictions, and cultural influences. Women also expressed an increase or decrease in their perceptions of

childbirth fear depending on the quality of information and negative birth stories that they obtained about birth. These findings will be discussed in greater depth in the next chapter.

Chapter 5: Discussion

This chapter is composed of a discussion of the main findings in the study, the implications of my findings for nursing, further research possibilities, limitations, and a conclusion. I also speculate on implications to healthcare professionals as a result of this study since it includes further insight into the process for offering specialized care, interventions, strategies, and support to reduce negative effects for women.

5.1 Summary of Study Results

The findings of this study indicate that childbirth placed women in a journey to the unknown territory, which can cause fear of childbirth. Their reasons for characterizing birth as unknown territory included general fear of the unknown, fear of things going wrong, fear of death, fear of being alone, and fear of inability to give birth. Women interviewed for this study felt that their fears were connected with their inability to cope with pain and a self-suspected low pain tolerance. Primiparous women in this study were also worried about length of time exposed to pain in childbirth. The fear of pain further described by the possibility of having a big baby can lead to negative physical consequences of childbirth with constant pain. Women were fearful and hesitant to meet the unknown in transition to parenthood. Sources of fear were expressed inabilities to manage routine caregiving, responsibility, and long-term commitment of parenting. Fear of parenting was also linked to women's fears about compromised sexual relations, marital relationships, and finances and fears about losing their identities (selves). Women feared their lack of capacity for self-control, such as the inability to refrain from swearing or shouting, as well as the fear that they would not be able to

maintain self-control in the presence of caregivers or their support network. All of these factors involve distinct aspects of control.

The participants in this study reported that having an expectation of control over their labours contributed greatly to reducing childbirth fear. Narrative analyses of in-depth interviews identified that lack of control, type and quality of information available, and support from others including health care providers were the four most important domains that influenced fear of childbirth. The lack of available emotional support was an important contributor to fear as women indicated they needed to have familiar, supportive friends and family around them during labour. They revealed that gaining information about childbirth could allow them to anticipate and understand their experiences, which would alleviate their fear. In the absence of self-control during delivery, supportive care providers and family members, and valuable information about the birth process, women can feel helpless due to elevated childbirth fear and a diminished sense of control. The fear of childbirth exhibited by the women in this study was also linked to the medicalization of birth and risk perception. These women felt inadequate in giving birth, which resulted in heightened fear when they were threatened by medical interventions that took away their power over their bodies.

5.2 Discussion

Many of the participants in the study who expressed fear of childbirth self-reported Asian ethnicity. The women's expressed fears in this study support recent findings of Stoll et al. (2013) who examined attitudes towards birth among 3680 non-pregnant students. The authors found that Asian women had significantly higher fear of birth scores compared to Caucasian women (Stoll et al.).

Many parallels were visible between my study and previous literature, but new information relevant to British Columbia surfaced such as women's attitudes toward a natural as opposed to medicalized birth culture in contrast to previous studies. In addition, other causes of fear of childbirth emerge from this research, including concerns about fetal well-being, future parenting responsibility, and the woman's ability to maintain control.

Surprisingly, all participants in this study were highly educated women who expressed at least some fears associated with childbirth. This finding is in contrast to results obtained by Laursen, Johansen, and Hedegaard (2009). In their study, childbirth fears were explained by low educational levels. The findings in this study also contrast with the results from Gurung et al. (2005) and Geissbuehler and Eberhard (2002); they found that more highly educated women experienced less fear of childbirth and had more positive attitudes toward pregnancy.

"Fear of unknown territory" captured fear reactions among the women in this study. Fear of the unknown seems consistent with participants indicating they had no previous birth experience on which to base their expectations. My findings support those findings from Australia by Fisher and colleagues (2006) who conducted a qualitative study focusing on the social context of women's fear of childbirth. Fisher et al. (2006) identified "fear of the unknown'" about birth as a social dimension of childbirth fear among 22 fearful women. My nulliparous participants indicated their childbirth fears arose from the expectation of an unknown journey and linked their fear of the unknown to their lack of previous childbirth experience. This is consistent with the findings of

earlier European research, which showed that nulliparous women feared the unknown (Zar, Wijma, & Wijma, 2001). Nilsson and Lundgren (2009) also claimed that women experience fear of childbirth in response to the unknown nature of the birth event. This study's participants' reasons for characterizing birth as an unknown territory included fear of things going wrong, fear of death, fear of being alone, fear of inability to give birth, and fear for the health of the unborn child.

Part of the sense of childbirth as an unknown and fearful territory was the underlying concerns and fears about things that could go wrong during birthing. Women repeatedly mentioned their concerns about potential obstetric complications and negative outcomes. The women were also preoccupied with all of the potential technological interventions that could go awry; therefore, the anticipation of a bad outcome increased the women's fear when they faced an uncertain future. This finding echoes Ryding's (1990) report that noted pregnant women's stress was typically generated by anticipatory fear of ''splitting down below", and fear of obstetric complications during childbirth. My findings provide additional support for the link between fear of the unknown and fear of things going wrong. In my study, women also experienced fear of the unknown in childbirth as a fear of their deaths or of perinatal loss. Findings from my research indicated the link between the unknown in childbirth and fear of death and of perinatal loss and are echoed in previous research studies. Two Swedish studies on childbirth anxiety reported that fear of death and injuries to the infant are often mentioned as also consistent with the findings from earlier research, which showed that many pregnant women were afraid of death or injury either to the infant or themselves (Lowe, 2000; Melender, 2002; Ryding et al. 1998).

In this study, elements of fear of the unknown were also fear of being alone, and fear of inability to give birth. My findings for Canadian women concur with those of European studies that have reported similar findings. In those quantitative studies, pregnant women commonly reported high scores on fear of the labour process, losing self-control, being incapable of giving birth and being left without assistance during labour (Melender, 2002; Saisto, & Halmesma, 2003; Sercekus & Okumus, 2007; Sjögren, 1997; Szeverenyi et al., 1998). My findings highlighted women's concerns about being incapable of giving birth on this journey through unknown territory. This occurred in the context of many women indicating their strong inner desire for a natural vaginal birth experience. The women linked their lack of trust and confidence in their abilities as childbearing women to their fears. Women described doubting themselves and hesitating to meet the unknown. Their fears may reflect growing up in a culture where an actual birth is seldom, if ever, witnessed by young women which creates a void in their expectations about childbirth.

In my study, the women's descriptions of their lack of trust in their abilities to give birth is consistent with the findings from Sjögren and Thomassen's study (1997), which showed that in a sample of 100 Scandinavian women with intense childbirth fear, the second most common reason for fear, expressed by 65% of them, was the fear of being incapable of giving birth. Similarly, Melender (2002) described high scores on fear of being left alone among 329 antenatal Finnish women. This finding was also reported by Christiaens, De Velde, and Brakce (2011) who described fear of childbirth as including fear of being left alone.

Women in this study also expressed negative feelings about loneliness during

childbirth. Some women indicated they felt totally alone in their childbirth endeavor. In fact, they were fearful and anxious about the lack of an alternative to being totally responsible for giving birth. In Nilsson and Lundgren's study (2009), the description of women's experiences of the fear of childbirth as 'to lose oneself as a woman into loneliness' indicates that nulliparous women experience loneliness when facing childbirth. The emphasis by the women in my study on being totally responsible for giving birth brings a new dimension to the literature because it implies that women feel available support is not relieving them of any part of their responsibility for birth.

The fear of pain was a major component that women in the present study described in their fear of childbirth. This is consistent with the findings of earlier research, which showed that fear of labour pain was among the most common reasons for fear of childbirth (Eriksson et al., 2006; Melender, 2002; Nilsson & Lundgren, 2009; Sasito et al., 2001; Saisto & Halmesmäki, 2003; Sercekus & Okumus, 2009). Fear of pain and low pain tolerance has been documented in 40% of women from Switzerland and Australia (Geissbuehler & Eberhard, 2002; Fisher et al., 2006).

In this study, the women's rationale for fear of pain included: intolerable pain during contractions or while pushing, prolonged pain in labour and delivery, incapacity to manage labour, and fear of negative outcomes leading to pain, specifically, perineal lacerations, hemorrhages, and caesarean section. My findings fit with those of previous studies. Several studies have supported fear of labour pain as an element of fear of childbirth (Eriksson, Westman, & Hamberg, 2006; Geissbuehler & Eberhard, 2002; Sjögren & Thomassen, 1997), rupturing (Sjögren, 1997; Ryding, 1993), operative delivery (Sjögren,1997; Szevere'nyi, Po'ka, Hetey & Török , 1998). Similarly, Lederman

(1990) stated that primiparous women are more often worried about labour pain, pain in the context of prolonged labour and delivery, and episiotomy pain. Kerr-Wilson (2001) stated that the fear of pain during vaginal birth is an important factor behind maternal requests for caesarean sections.

The women in my study indicated they experienced uncertainty about their pain tolerance and negative outcomes involved with labour leading to pain. This finding is similar to the outcomes reported in previous studies, wherein women's fears of childbirth were concerned with the process of labour with the pain of contractions (Fenwick et al., 2008; Hildingsson et al., 2002; Melender, 2002; Sercekus & Okumus, 2007).

The comments by participants in this study about pain in connection with dystocia during labour due to large babies have not been reported in other studies. My findings raise important concerns regarding the emphasis placed on fetuses' size as a potential impediment to labour rather than as an indicator of a healthy fetus.

Most women in this study revealed parenting fears, specifically being overwhelmed by routine caregiving, long-term commitment, and giving up elements of their selves, as well as changes related to their lifestyles, sexual relations, and marital relationships. The women also described financial fears. The fears increased their doubts about their capabilities as mothers and contributed to anticipatory ambivalent feelings towards parenthood. My findings contrast with those of Spradley and colleagues (1979). They defined prenatal anxiety as anxiety about routine caretaking, and ability to feed the infant. In contrast, participants in my study were more concerned about the baby's effects on their lives as opposed to their ability to care for the babies. Although no participants in my study mentioned any fears of coping with their babies, Barnett and Parker's (1986)

study suggested pregnant women who were anxious and fearful felt less confident about parenting and estimated that their abilities to cope with their babies would be low. In addition, Saisto and Halmesmäki (2003) argued that the fear of future parenthood was part of the psychological dimensions of fear of childbirth in Finish women, who were doubtful of their own capability to take care of the newborn due to the lack of actual models of motherhood in the 21st century. My study participants described lacking role models for parenting. In addition, my findings extend the literature because the participants worried about their loss of self after their children were born.

Compared to Vancouver's average total annual income of $69,000, half of the participants in my study were from a lower socioeconomic level (Statistics Canada, 2013). Socioeconomic factors, such as low income, have been found to play a role in women experiencing fear of childbirth (Ryding, Wirfelt, Wangborg , Sjogren, & Edman, 2007; Saisto, Salmela-Aro, Nurmi, & Halmesm, 2001). Many women in my study were fearful about the financial responsibilities of raising a child. An earlier study of European women described socioeconomic level as having an important effect on the emotional experiences of women during pregnancy (Rofe et al., 1993). This finding is in line with Schneider (2002) and Ricci's (2007) studies showing that financial status is a support structure that influences woman's emotional experiences during pregnancy and childbirth.

In this study, women expressed fears about future changes in their marital closeness and sexual relationships, including decreased sexual function and quality following childbirth. A similar finding was reported by Reamy and White (1987). Likewise, other researchers have reported that women prefer elective caesarean sections

because they are concerned about the long term risks of vaginal delivery, including the loss of "vaginal tone" and sexual pleasure; women also believe that surgery will prevent future pelvic support or sexual dysfunction problems (American College of Obstetricians and Gynecologists, 2003; Beckett, 2005). In addition, non-medical research also suggests that maternal preference is a factor driving increasing caesarean sections due to concerns about postpartum sexual functioning (Lin & Xirasagar, 2005).

My findings add to the extant literature by suggesting pregnant women were fearful of future changes in marital closeness and sexual relationships following childbirth, stemming from the inability to engage in sexual activity after birth and guilt about not being sexually available to their partners.

Women in this study were afraid of behaving inappropriately, losing self-control or losing control over the birthing process during the delivery of their baby. Likewise, in a study of 329 antenatal women in Finland, Melender (2002) identified that common expressions of fear of childbirth were appearing silly and not being involved in decision-making. The study participants viewed control exerted by others as contributing to their feelings that their bodies were not their own leaving them unable to behave appropriately during labour. The finding that women in the present study were afraid of losing control of their bodies during birth aligns with several other studies that identified fear of losing control as contributing to childbirth fear (Eriksson et al., 2006; Fenwick et al., 2009; Fisher et al., 2006; Geissbuehler & Eberhard, 2002; Lowe, 2000; Melender, 2002; Ryding et al., 1993; Saisto & Halmesmaki, 2003; Wiklund, Edman, &Andolf, 2007). Studies from the United States and Sweden link the prospect of losing control over their environments or their bodies to women's fears of labour (Lowe, 2000; Saisto &

Halmesmaki, 2003).

The women in this study emphasized the importance of information about childbirth such as general childbirth procedures, the amount of pain involved, and post-birth lifestyle changes as a factor affecting their fear of childbirth. The findings from this study support related findings of an association between a lack of knowledge and fear of pregnancy and childbirth (Melender, 2002; Sercekus & Okumus, 2007). The study participants expressed a strong need to be informed about pregnancy and birth. They linked fear of childbirth to a lack of information about birth. Similarly, Beaton and Gupton (1993) reported that participants felt fear associated with childbirth due to uncertainty or lack of knowledge.

Although information about pregnancy and childbirth alleviated fear for some participants, it led to increased fear for others. For example, information gained from the Internet or during prenatal classes was described as contributing to fear of birth for some women. These women in my study linked their fears about childbirth to information that focused on obstetric risks. Likewise, Sorenson (1990) reported that fear was commonly based on information gained during childbirth education. Similarly, Geissbuehler and Erberhard (2002) claimed that birth preparation classes could compound women's fears. In contrast, Stoll (2009) argued educational strategies could alleviate fears of vaginal birth in women. This suggests that the type and delivery of information provided has considerable power to positively or negatively affect a woman.

Women in this study revealed that media depictions of birth increased childbirth fear. According to these women, the media frames birth as painful, unpredictable, and

horrible with a risk of obstetric complications, as well as focusing on inappropriate behavior and loss of control during birth. These findings echo Morris and McInerney's (2010) criticism of the media for emphasizing and over-representing the risk of obstetric complications, as well as their representation of women as childlike or helpless in the birth process, thereby highlighting the need for medical intervention. The media's representations of childbirth necessarily frame it as a high-risk medical event. These negative messages from the media have contributed to increased levels of fear and expectations of an adverse outcome among the women in this study.

In this study, childbirth fear was increased by negative and horrifying birth stories that friends, family, strangers, and coworkers told. The birth stories emphasized pain and highlighted the negative aspects of vaginal birth. An exploratory descriptive study of twenty-two women in Australia similarly found that "horror stories" about birth were a salient social dimension of childbirth fear (Fisher et al., 2006). The same findings were reported by Ryding et al. (2007), who identified "horror stories" as an important cause of fear in primiparous women. Likewise, a study of nineteen nulliparous women in Turkey described childbirth fear as arising from alarming information that was mainly disseminated by friends, family and the media (Serçekuş & Okumuş, 2007). Munro and colleagues (2009) highlighted the impact of negative and frightening stories of birth on women's attitudes toward surgical childbirth in their study of seventeen women in British Columbia who had a caesarean section on maternal request. In their study, women explained that their preference for caesarean sections was based on birth stories told by friends who depicted vaginal birth, as a hazardous and painful journey while caesarean delivery was generally presented as a safe procedure. These negative stories about birth

helped to construct the notion that caesareans are medically justified and birth as medical event is an acceptable position.

Women also claimed that the evasive and unsympathetic attitude of their health care providers and receiving less support than they anticipated as contributing to childbirth fears. The link between poor treatment by maternity staff and women's fears surrounding birth is supported elsewhere in the literature (Melender, 2002; Fisher et al., 2006; Fenwick et al., 2009). Nevertheless, some women in this study described close and trusting relationships with their midwives, resulting from reassuring care and support tailored to their individual needs; they indicated positive relationships with their midwives were one of the essential factors easing their fear of childbirth. Anderson (2000) also described the influence of midwives when a woman is in labour, and the importance of a sensitive and wise approach to deal with women's needs. Another researcher noted that women who felt supported by caregivers not only benefited through enhanced psychological well-being but also through increased endurance in parenthood (Larsen et al., 2009). This was further supported by Hodnett (2002), who determined that the most powerful influence on women's perceptions of their birthing experience was the caregivers' attitudes, support and relationships to birthing women. My findings provide additional support for the importance of a positive, supporting and trusting relationship between women and their health care providers.

More broadly, women in this study indicated the importance of receiving support from their health care providers in order to dispel or alleviate the fears they had about childbirth. Previous research has linked professional support to women's reduced fear associated with pregnancy and childbirth (Sercekus & Okumus, 2007; Fenwick et al.,

2008; Melender & Lauri, 1999; Melender, 2002; Sorenson, 1990).

Some women in this study reported that a lack of trust in their obstetricians added to their fear of childbirth. This finding was also reported by Melender (2002) and Fenwick et al. (2009). The link between lack of trust and fear of childbirth was also supported by Sjogren and Thomassen (1997), who claimed that a lack of trust in obstetric staff was the most common reason for a fear of childbirth among their sample of 100 Sweden women. Likewise, according to Mathews and Callister (2004), an essential factor in the women's experiences is the behaviour of caregivers, which demonstrates their value and respect for a woman's dignity during childbirth.

The women in the present study also stressed the importance of support from their social network as a source of help while dealing with their childbirth fear. All of the women expressed a strong need for advice or emotional support, such as encouragement, companionship, and reassurance. Some women also linked lack of support in their lives to greater childbirth fear. Fisher and colleagues (2006) also reported that positive relationships from midwives and their informal networks, such as partners, family members, and close friends, can mediate childbirth fear among Australian women who were afraid of birth. More importantly, the women felt that sharing their labours and births should enhance the experiences for them.

Almost all of the women in this study identified birth as a natural event, despite their fear of the birth experience. They openly opposed what they described as a medicalized birth culture and were worried about subscribing to the medicalization of childbirth. Many participants emphasized that the cultural shift from representing birth as

a normal bodily function to a pathological event diminished the significance of and admiration for the natural processes expressed through women's reproductive abilities. Instead, the women in this study indicated medicalization of pregnancy and childbirth has triumphed because childbirth is depicted as a pathological event that is associated with inevitable catastrophe. This explains Wijma, Wijma, and Zar's (1998) assertion that the construction of childbirth as "uncontrollable", "unknown", or "threatening" necessitates medical intervention and ignores the natural ability of women to give birth. Such constructions of birth enhance fear through emphasizing the negative and unpredictable consequences of the natural practice of birth (Wijma et al., 2002).

A number of participants in this study believed that fear of birth is socially constructed. Similarly, LoCicero (1993) argued that the technological birthing system is a phenomenon structured and produced at least partially through social belief systems and the medical system. Study participants who questioned the medical model of birth were less fearful. They argued that society's view that childbirth is a pathological process emphasizes not only the requirement of medical expertise in pathology to treat it but also minimizes women's power over their bodies. Thus, the doctor is seen as a professional who, owing to his expertise, is far better qualified to control the birth process than the woman. When birth was constructed as an uncontrollable event, women were more vulnerable to medical influences (Lazarus, 1994) that compounded their fears (Wijma et al., 2002). This is consistent with results from an Australian qualitative study focusing on the social context of women's fear by Fisher, Hauck, and Fenwick (2006) who defined "fear of the unknown" as an alienation from the birthing experience. The discourse of medicalization enhances fear of childbirth by depicting childbirth as a pathological

process and a high-risk medical event. According to this perspective, women are expected to surrender control of their birthing experience to medical professionals and subscribe to the medicalization of childbirth (Brubaker, 2007).

The participants in my study stated that the solutions provided by the medical model increase women's fear of childbirth. Similarly, Bryers and Teijlingen (2010) argued that medical models of birth and science trigger more uncertainty as women attempt to navigate their own chance of risk and complications. Participants in this study who were more fearful accepted the medical model of birth and expressed uncertainty about their ability to birth. A number of participants also stated that the conversion of childbirth into a disease that is in constant need of correction and modification reinforced their fear of childbirth through their perception of risk.

The expectations of obstetric complications, probability of a bad outcome, and perception of risk were main foci of participants in this study. The anticipation of bad outcomes caused the women in this study to be afraid when facing an uncertain future. The women were preoccupied with the risks associated with childbirth, which suggest that there is something inherently wrong about the process of having a baby. Similarly, Possamai-Inesedy (2006) highlighted the role of perceived risk during pregnancy in a Western context as a contributor to childbirth fear. Her study revealed that Australian women were constantly attempting to navigate their individual probabilities of risk. These findings are similar to those of Heaman, Gupton and Gregory (2005) who described risk perception in a descriptive qualitative study among 205 Canadian women. The authors reported fears of the unknown as a contributory factor in risk perception among pregnant women. Similarly, Cherniak and Fisher (2008) asserted that emphasizing

obstetric risk and risk scoring has shifted women's attention away from the normality and positive aspects of childbirth.

It is intriguing that some of the study participants linked childbirth fear to an increased likelihood of postpartum depression. Ayers (2003) asserted that women's perception of risks and lack of control can alter a 'normal' birth to a traumatic experience. My findings highlighted that participants who were more fearful had more focus on expectations of obstetric complications, probability of a bad outcome, perception of risk, and fear of mental health challenges following birth.

My findings extend the current literature by supporting many existing studies, but also add a new dimension to current work as the women expressed their feelings that available support was not relieving of any part of their responsibility, described their self-doubt and hesitation of meeting the unknown, and were anxious about other possible effects of a large fetus size as an impediment to labor.

5.3 Implications and Recommendations

5.3.1 Education

In addition to women's fears of pain and the unknown territory of childbirth, other causes of fear emerged from this research, including concerns about future parenting responsibility, and ability to maintain control. Each of these concerns can contribute to childbirth fear. These influences emphasize the importance of educating nurses to provide a consistent professional approach for meeting women's needs. It also suggests nursing students ought to learn about best practices and current evidence that stresses the normalcy of birth. Moreover, the findings point to areas of support that nursing students

caring for women during childbirth can offer to diminish childbirth fear. The findings also suggest students' availability to women during labour and their support could reduce childbirth fears.

The findings from this study also reflect a need for childbirth education on basic birth preparation, pain management, methods to gain control over fear of labour and the childbirth process, as well as parenting classes to increase maternal confidence, self-efficacy, and women's preparedness for the transition to motherhood. Much less emphasis on potential complications in labour and birth could be offered in prenatal classes.

5.3.2 Nursing practice

Findings from the current study increase our awareness of Canadian women's experiences of childbirth fear. The findings point to the importance of early interventions that reduce the negative effects of the fear of birth. The elements described as contributing to women's fears of childbirth offer opportunities for healthcare professionals to develop interventions, strategies and support to mitigate the negative effects of the childbirth experience. The study conducted by Salomonsson et al. (2010) highlighted the need for early identification of women who have fears about childbirth so that they could be given individual care and counseling to mitigate negative social messages about women's capacities for natural birth. This practice can result in a positive birth experience by providing optimal support and a basis for psychological well-being in the future (Laursen, Johansen, & Hedegaard, 2009).

Findings from the current study also suggest that, providing women with psychological support, obstetric guidance and education substitute care and attention

focused on unnecessary medical surveillance and interventions. Specialized care and support from healthcare professionals can reduce childbirth fear, especially when professionals are aware of the negative effects of fear of childbirth. Maximal effort to assist women in developing self-confidence in their abilities to give birth can reduce childbirth fear and potential trauma for women. The study findings sensitize healthcare professionals to the nature of women's childbirth fears so they can be more capable of providing supportive and sympathetic care to these women (Leap et al, 2010; Lyberg & Severinsson, 2010; Maier, 2010).

The women in this study also expressed a need for professional activity in areas such as emotional support, information, advice, and positive relationships. It was vital for these women to discuss their fears, access information, and have positive, supporting and trusting relationships with their healthcare providers to dispel or alleviate their fears associated with childbirth. Nurses should be involved in prenatal care to be in a position to identify, assess, and treat childbirth fear. As professional caregivers, nurses could to take women's concerns seriously by listening carefully to their fears, reassuring and encouraging them to take control of their births, and providing information in the clinic. Models of maternity care that offer a one-to-one continuum of care to enhance women's chances of establishing supportive and positive relationships with healthcare professionals can contribute to dispelling their fears of childbirth. Homer et al. (2002) suggested that most Australian women who received an intervention directed at delivering continuity of care during labour had a significantly higher sense of control during birth. In prenatal classes- nurses can provide evidence-based information, place more emphasis on a woman's normal vaginal birth, or less emphasis on the risk factors of

childbirth to reduce fear.

The results of this study suggested that the presence of support during labour was for diminishing the fear of childbirth. In their response to these needs, nurses should assume leadership in providing support for labouring women as well as their support networks. Nurses in primary care settings are on the front lines and in a position to identify and assess women with a fear of childbirth, and help them to feel in control during childbirth.

My findings highlighted that a major source of women's fears was from external messages about childbirth, many of which were framed in ways that emphasized obstetric risk associated with childbirth. A further challenge for nurses is enhanced recognition of the role of risk perception on influencing and provoking unnecessary fear among pregnant women. A Canadian study by Hall, Tomlinson, and Klein (2012) of nine pregnant women and 56 maternity care providers revealed that a growing risk-adverse social climate has prevented many care providers and pregnant women from resisting the discourse on obstetric risk. In responding to the need for attention to risk perceptions, the researchers challenged care providers to raise awareness among pregnant women of the iatrogenic risks associated with routine obstetric interventions during the birth process. In order to offer emotionally supportive care in the present medical models of birth, nurses should shift fearful women's focus away from fetal and maternal risk factors by giving comprehensive and sensitive clarification about the nature of risk, as well as providing clear and adequate information about the natural ability of women to give birth. This solution was also alluded to by Davis-Floyd's (1992) description of childbirth. He claimed that the ideal birth is one in which the woman actively participates. Under this

model, women are seen as the most qualified people to make decisions regarding the management of their birthing experiences. Perinatal nurses can provide pregnant women with evidence-based information that does not frighten them and educate them about what to expect during childbirth. The study by Chalmers and Kingston (2009) speaks to this role as it highlighted that care providers are the most important source of birth and pregnancy-related information for most Canadian women.

My findings revealed that media exposure to information about birth was linked to increased women's fear of childbirth. These findings also shed light on the influences of inaccurate data and frightening stories about birth on childbirth fear. As pregnant women are bombarded with negative and frightening birth stories that are propagated inaccurately by mass media, a media campaign that reconstructs birth as a normal event and celebrates natural birth is urgently required.

The findings from this study suggest that educational interventions would be the most practical way to address prenatal care to alleviate fear among pregnant women. The study by Chalmers and Kingston (2009) showed that women who attended prenatal education classes had a higher sense of control and confidence during labour and birth, higher likelihood of satisfaction with birth, better communication with their maternity care providers, and decreased need for analgesic medication during labour. Previous research (Fenwick et al., 2009; Melender & Lauri, 1999; Melender, 2002; Sercekus & Okumus, 2007) also showed that professional support and childbirth education were very important for removing or alleviating the fear of childbirth.

In the present Canadian system consisting of a standardized set of risk-oriented

practices based on medicalization of birth, continuous one-to-one support by nurses may not achieve desired goals in the absence of other changes to bureaucratic institutional policies and routines. New policies for care during labour and birth should facilitate women's positive experiences when giving birth. Nurses are proud of having continuous contact with and responsibility for patients, which allows them to play a significant role in the development and implementation of health care policies that provide women with greater control over their birthing experience (Simpson & Thorman, 2005).

Furthermore, the findings from the present study indicate that health care professionals, such as nurses, need to be more aware of the adverse effects of the dominant medical model in childbirth that elevate fear. As professional caregivers, nurses should assume leadership roles in redesigning childbirth care, and also in shifting the focus from implementing the blanket of technology and medical care to offering authentic support to fearful women.

Based on the study findings, nurses can identify women as the most important person in the birth process and focus on their abilities and positive potential to give birth and enhancing their self-reliance. Bate and Robert (2006) supported this concept by reporting that listening and responding to what women say plays a key role in redesigning healthcare processes. This point is underscored by the present study, which demonstrated that pregnant women who received warm, responsive, and sensitive care from healthcare professionals had greater trust in their care providers and less fear about childbirth.

5.3.3 Research implications

There is an urgent need for more research to examine the efficacy of different

models of maternity care interventions on diminishing childbirth fear. Studies re also needed to investigate appropriate interventions focused on the goal of establishing supportive and secure relationships between pregnant women and health care providers. Developing and testing effective therapeutic interventions and applicable education programs that seek to dispel or alleviate the fear of childbirth also represents an important area for future study.

To address the concerns of the study participants on the culture of medicalization of birth, policy makers must better appreciate that the dominant medical model is built on evidence-based interventions that were originally developed to treat obstetric complications but instead are now used routinely during normal and natural labour. My findings offer a glimpse into women's beliefs about the effects of recognizing danger signs and perceiving the need for using technology and the medical model on their fear of childbirth; however, this topic is somewhat unexplored among researchers in Canada. Rather than implying that technology has no role in advancing women's health, these findings point to a need to re-examine the dominant medical model, which privileges medical discourses that impact the fear of childbirth.

Every effort should be made to ensure that women are given supportive care and information that promotes a positive birth experience that is not characterized by routine interventions that add risk without clear benefit. Further studies are needed to assess institutional policies that contribute to the fear of childbirth.

The present findings suggest that fear of childbirth is closely linked to the content and quality of the information that women obtained on birth. Future research is needed to explore the type and quality of information that would support women by reducing their

fear. The study by Chalmers and Kingston (2009) showed that women who attended prenatal education classes had a higher sense of control and confidence during labour and birth, higher likelihood of satisfaction with birth, better communication with their maternity care providers, and decreased need for analgesic medication during labour. Previous research (Fenwick et al., 2009; Melender & Lauri, 1999; Melender, 2002; Sercekus & Okumus, 2007) also showed that professional support and childbirth education were very important for removing or alleviating the fear of childbirth. However, in a Swiss survey of 8000 pregnant women by Geissbuehler and Eberhard (2002) who found childbirth preparation classes did not have a clear-cut benefit in reducing childbirth fears. Since the evidence supporting the benefits of prenatal education is mixed, it needs to be examined in greater detail to maximize its effectiveness. Clearly, further research should seek to identify and compare the effect of different types of childbirth education strategies for mitigating women's fears.

The women in this study identified a need for more childbirth guidance, support, and instruction to reduce their fear of childbirth. Interventional studies from several countries that specially addressed women's fear of childbirth have shown positive outcomes, including a decline in the rate of caesarean sections and an improvement in women's childbirth experience (Lyberg & Severinsson, 2010; Nerum et al., 2006; Saisto & Halmesmaki, 2007). Sydsjo and colleagues (2012) reported that despite psychological counseling, fear of childbirth was a predisposing factor for emergency and elective caesarean sections. However, they conceded that maximal effort was necessary to ensure that women, especially nulliparas, did not have traumatizing deliveries and negative experiences. A recent study revealed that nulliparous women with severe childbirth fear

who were randomized to psycho-educational group therapy had a lower rate of caesarean section and a higher level of satisfaction with their birth experiences than women who did not undergo therapy (Rouhe et al., 2013). Studies that replicate this assessment could provide compelling evidence in favour of therapeutic interventions for women with a fear of birth. Most of the research in this field has been conducted in European populations so that findings may not entirely be relevant to the British Columbian context. The findings from this study could be used to inform interventions offered to Canadian women.

My findings highlighted the importance of the task of risk perception on influencing and provoking unnecessary fear among pregnant women. As health care providers, it is our responsibility to work tirelessly to conduct and use research that aims to eliminate etiological risk factors that, if changed, may prevent or reduce childbirth fear. Nurses are ideally suited to furthering research to understand the complex interplay between pregnant women and their contexts in the development and maintenance of childbirth fear.

5.4 Limitations

The primary limitation of this study was small sample size within a single context. The participants in the study over-represented well-educated Asian women with partners, in comparison with the overall child-bearing population in British Columbia (British Columbia Perinatal Health Program, 2010). The study also sampled women prospectively about their fear of childbirth. There was no indication of whether women's fears were altered by their actual birth experiences.

5.5 Dissemination of the Results

I intend to share a summary of my findings with the pregnant women who participated in the study, health care providers, and organizations. I will also plan to publish my findings and share my results through conferences.

5.6 Conclusion

In this study, I aimed to explore British Columbian women's perceptions of childbirth fears. In the context of growing concern regarding increasing rates of caesarean sections in BC, it was important to conduct research to understand how women experience childbirth fear in the antenatal period and anticipate its effects on their birth experiences. My study of primiparous women allowed me to explore their experiences and the influence of outside factors including personal stories shared by others, the women's own research or media influences, and cultural impacts. Most women perceived childbirth as an "unknown territory" including pain of labour, feeling out of control, or parenting, and that measures such as education, and the quality of available support can help to alleviate their concerns.

The study participants emphasized the consequences of inaccurate data and frightening stories about birth in childbirth fear and also suggested that educational interventions are the most practical way to address fear in the course of prenatal care to alleviate women's concerns. Despite their fear of the birth experience, almost all of the women in this study identified birth as a natural event, and openly opposed what they described as a medicalized birth culture. They expressed a need for more maternity guidance, support, and instruction to reduce fear of childbirth.

Women giving birth are directly affected by the social and cultural forces that shape health care policies in the childbirth environment. Taking control over some aspects of their labours would contribute greatly to reducing childbirth fear.

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Appendix A

The University of British Columbia
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T201-2211 Wesbrook Mall
Vancouver, BC Canada V6T 2B5

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Participant Information and Consent

An Exploratory Study of Women's Experiences of Fear/Worry During Childbirth

STUDY TEAM

Principal Investigator:
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The study is being conducted for the purposes of completing a graduate degree. It is the basis for a thesis (public document).

INVITATION AND STUDY PURPOSE

The purpose of this study to explore women's views about their childbirth fears/worries. You are being invited to take part in this study because you have responded to our posted advertisements seeking women in their first pregnancy who are experiencing worries about their childbirth.

Your participation in this study is entirely voluntary. Before you decide, it is important for you to understand what being a participant involves. This consent form will explain the study, why the research is being done, what will occur during the study, and any potential risks, benefits, and discomforts.

STUDY PARTICIPANTS

Our sample will consist of women in their first pregnancy who are between 33 and 39 weeks gestation. Other inclusion criteria will be: fluency in English, aged between 18 to 46 years, resident in BC, and free from any diagnosed problems in pregnancy; these include: prior mental health challenges such as a depression, and psychosis and high-risk conditions associated with their pregnancies (e.g., pregnancy-induced hypertension, preterm labour, bleeding, and Type 1 Diabetes). Because the research topic focuses on worries/fears about childbirth itself, having any prior physical or psychological conditions could complicate the research.

STUDY PROCEDURES

If you decide to participate in this study, you will be interviewed by Nadia Rahmati about your experiences of worries related to childbirth. The interview is expected to take 1-2 hours, and, if you agree, a follow-up interview may be scheduled. Your interview will be audio-taped and transcribed. All names will be removed from the transcription to protect confidentiality. The transcripts will be stored on a password protected computer and hard copies will be stored in a locked filing cabinet. Participation in this study will not affect the provision of your health care.

4. STUDY RESULTS

The results of this study will be reported in a graduate thesis and may also be published in journal article. You will be provided with a summary of the results.

5. POTENTIAL RISKS OF THE STUDY

There is the potential you may feel some discomfort discussing your feelings about childbirth. You do not have to answer any questions if you do not wish to do so. We will provide you with a list of community support services and counselors if you feel that would be helpful.

6. POTENTIAL BENEFITS OF THE STUDY

You may find that an opportunity to talk about childbirth is beneficial. The results from this study will generate an increased awareness and understanding about the fear of childbirth by bringing women's perspectives to health professionals.

7. CONFIDENTIALITY

All information gathered for this study will be treated confidentially. Your identity will be secured in that you will all receive a pseudonym of your choice. Only pseudonyms will be used in the transcripts. The transcriptions of all interviews will be kept on a USB drive and the participants' contact information will be kept separate from audio-recordings and transcripts by the principal investigator. The list of participants which matches your name to your unique identifier will not be released at any time. No information that discloses your identity will be released or published. All contact information will be destroyed on the day the thesis is submitted, and the transcript of your interview will be destroyed as dictated by University of British Columbia research regulations.

Any information that leads us to strongly suspect that you may cause serious risk of harm to either yourself or another person may result in immediate action to protect your safety and may require your information and circumstances to be disclosed.

8. PAYMENT

We are very grateful for your participation and would be happy to compensate you with a one-time stipend of $30.

9. CONTACT FOR INFORMATION ABOUT THE STUDY

If you have any questions or require further information about the project you can contact Dr. Wendy Hall, principal investigator (604-822-7447) or Nadia Rahmati (Co-investigator) at (778)242-7841.

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line

in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

10. PARTICIPANT CONSENT AND SIGNATURE PAGE

You understand that your participation in this study is entirely voluntary. You have the right to refuse to participate in this study without giving a reason and without any negative effects on your health care. You also understand that you may withdraw from this study at any time by contacting Nadia Rahmati or Dr. Hall. Upon withdrawal from this study, all data collected with your consent will be destroyed.

Your signature indicates you consent to participate in this study. Your signature below indicates you have received a copy of this consent form for your records.

Participant's Signature Date

_____

Printed Name of Participant

Appendix B

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Thinking of your upcoming childbirth?

Hello,

I am a student conducting my Master's thesis at the UBC School of Nursing and performing a study on women's experiences of childbirth in BC. I am interested in what you have to say! In particular, I would like to know your thoughts on getting ready for your baby's birth and any worries/concerns you might have.

If this is your first pregnancy, you are between the ages of 18-46, and you are 33-39 weeks pregnant, I would appreciate about one hour of your time to hear about your thoughts about your worries and concerns. Please contact me so that we can arrange a convenient time for you.

In appreciation for your time, I am happy to compensate you with a one-time gift of $30.

CONTACT: Nadia Rahmati 778-242-7841 Nadia1349@yahoo.com

Appendix C

Interview Questions

Please share some of your feelings about childbirth with me.
Can you explain what fearful feelings about childbirth might mean for you?
Can you describe any worries/fears about birth you have had during your pregnancy?
What aspects of your life and experience do you feel have influenced your feelings about your birth?
Do you have any thoughts about potential effects of your current feelings about your birth?
How has your interaction with others affected your feelings toward birth?
Can you describe what the word 'childbirth fear' means to you?
How does your family address the idea of fears/worries about birth?
How do you think your culture represents the ideas of fear/worries about birth?
Probes for the interviewer:
Is there anything else you think is important for me to know?
Tell me more about that. Encourage examples/illustrations.

Appendix D

Demographic Questions

Age

<25

25-35

>35

Partner

Yes/No

Single, married, widowed, common-in–law

Children

Step-children?

Ethnicity

Aboriginal

African/Caribbean

Asian/Chinese

Canadian

European

Latin

Annual Income

<$20,000

$20,000-$49,000

$50,000-$100,000

>$100,000

Highest Level of Education Completed

Primary School

Secondary School

College

University Degree

Post Graduate Degree

Appendix E

Example of coded analysis:

Codes	Categories	Theme
Childbirth pain is only the start of fear The fear of pain is linked with not knowing×2 Concentrating on the pain increases fear The fear of pain×6 Anticipating physical pain and mental exhaustion Seeing labour as pain management Wants to embrace pain although afraid Fear of pain and medical issues is the negative part of giving birth Fear of not knowing pain and the level of tolerance×4 Not knowing her pain tolerance Fear of intolerable pain and possibly giving up Fear of intolerable pain Fear of unbearable pain and taking medication that could potentially cause caesarean section Fear of incapacity to manage long and painful labor Not knowing her pain tolerance Fear about how she will manage the pain Induced labor is usually more painful than spontaneous labor Epidurals not always effective Requesting for caesarean section to avoid fear of pain Doesn't like taking drugs The imposing of drugs is fearful Fear of the procedure of the epidural Childbirth fear is the whole process of labour and the pain of labour Anticipating a painful labour Fear of incapacity to manage labor and in response to pain	Fear of pain with not knowing pain tolerance	**Fear of pain**

Codes	Categories	Theme
Fear of pain during the delivery and after the delivery Fear of pain after the birth Fear of pain and what comes after Fear of having long and painful labour Possibility of long and painful labour Anxiety anticipating most painful day of life Fear of pain and long labour due to family experience Fear of long and painful labour×3 Anticipating pain throughout labour Fear of length of recovery after birth Anticipating physical pain after the birth based on reading	Not knowing length of time exposed to pain	
Fear of having painful labour due to the large baby Fear of having big baby that cause more pain in labor Fear of the baby getting big and having painful labor Expecting long and painful labour due to her weight gain Commenting on size creates fears×2	Not knowing effects of size of fetus	

Codes	Categories	Theme
Fear of episiotomy ×2 Fear of perineal lacerations Fear of bleeding and haemorrhage Fear of laceration×2 Fear of infection or lots of blood Fear of changing her personality after birth Fear of changing her personal characteristics Has an ideal vaginal birth in mind and is afraid of surgery Fear of caesarean section× 7 Fear of ending up to an operative delivery Concern about the risks of prolonged healing process and depression from caesarean surgery Fear of having C-section due to malpositioned baby ×2 Being worry of having C-section Fear of being cut open×4 Fear of pain due to caesarean section Fearful about baby position Fear of getting infection Fear of making decisions to accept interventions Seeing bad outcomes increases fears Letting fear take over leads to bad outcomes	Fear of negative childbirth outcomes	**Fear of pain**

Codes	Categories	Theme
Fear of inability to take care of her baby×2 Fear baby care will take up all her time ×2 Fear of not knowing how to care for the baby×2 Fear of getting overwhelmed to take care of baby and possibility of depression Fear of not knowing how to care for the baby could stop her labor process Fear of facing unknown how to take care of her child×2 Anxiety anticipating to care for a child Fear of being overwhelmed Fear of not having the time and energy for newborn requirements Fear of becoming a parent and routine caretaking Fear due to not experiencing about babies Fear of not being prepared for having baby Fear of holding the baby due to hurting the baby Afraid to hold the baby Afraid of being fully responsible for another life Fear of lack of social support to raise a baby×2 Fear of lack of social support to raise a baby Fearful about lack of support to raise a baby Lack of big supportive system create fear Fearful of not having enough support to raise a child due to modern technology and smart phones	Fear of routine caregiving	**Fear of Parenting**
Messages about responsibility create fear×2 Fear of holding her labor back due to avoid passing through the threshold to motherhood Fear of lifetime responsibility to take care of her child×2 Fear for responsibility of becoming a mother Fear of inability to fulfill her motherhood responsibilities on	Fear of long-term commitment (responsibility)	

Codes	Categories	Theme
top of everything else Fear of parenting responsibilities and style Fear of getting overwhelmed to fulfill parenting responsibilities All responsibility for growing a healthy baby but nothing is known Fear of future parenting×2 Fear of making a lifelong commitment to raise a child Fear of raising a child Fear from committing to having a child Fear of being lifetime martyr for her child Fearful about future of her child Fear of parenting Parenting is scary Fear of lifelong commitment		
Fear of ending as an individual and beginning as a unit Fear of losing herself in her child Fear of setting a lower priority on personal needs and a higher priority on child needs Fear of losing time for herself Fear of sacrificing personal interests, particularly those related to entertainment, and recreation Fear not being able to have time to herself Fear of not able to find time for the things she wants and needs to do Fear of the loss of time and personal freedom Fear of giving up her established self Not knowing how to manage her time with a baby×2 Fear of sacrificing a good life for the child adds to fear Anxiety anticipating not being able to continue working Fear of not able to find time to balance work,and household chores with a new baby Fear of changing the life process×2 Childbirth is a life-changing situation Fear of not able to find time to work Fear of how to manage her time with a newborn and work Fear of sacrificing personal interests, particularly those related to work	Fear of loss of self	

Codes	Categories	Theme
Fear of not able to find time to balance work, and personal needs with a new baby Fear of changing life forever in her transition to parenthood×4		
Fear of changing her socioeconomic level Fearful for her financial instability to take care of her baby and personal needs Fear related to the financial burden of raising a child Fear of changing financial status due to raising a child Fear of financial ramifications of raising a child×2 Fear of lack of financial stability×2 Fearful about not able to fulfill parenting and financial responsibilities Fear for the financial difficulties Fear of financial responsibility to raise a child Financial and career instability and lack of affordable housing can contribute to emotional unpreparedness surrounding a pregnancy that causes fear Fear related to the financial burden of raising a child Fear of not being able to find a healthy balance between spending time with her baby and securing her economic needs	Fears for the financial difficulties	**Fear of Parenting**

Codes	Subthemes	Theme
Fear of being disconnected from her partner when baby born Fear about future changes in her relationship with her partner Fear of incapacity to manage her time with baby, work and relationship with her partner Fear of losing her sexual intimacy with her partner Fear about the birth's effect on her sexual relationship with her partner. Fear her partner may feel that she has only love for the baby and not for him Feel guilty not to be sexually available to her partner after childbirth Fear the partner feeling left out or being excluded from the relationship, as she is unable to engage in sexual activity after birth Fear of changes in the marital relationship across the transition to parenthood Fear of changes in the sexual relationship during the transition to first time motherhood Fear about having a newborn will place a strain on her relationship with her partner Fear of increasing the amount of conflict between her and her partner due to different approaches to parenting Fear of changes related to sexual relations Fear of a decline in the quality of sex life	Fear of the future changes in the marital closeness and sexual relationship	**Fear of Parenting**