

## Fears associated with Pregnancy and Childbirth among Kurdish Women in Iran

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**Abstract: Objective:** The purpose of this study was to describe the fear and causes associated with pregnancy and childbirth among Kurdish women in Iran. **Design:** A qualitative design was chosen and grounded theory was used for data analysis. **Setting:** Three health care centers in Sanandaj, the capital of Kurdistan province, west of Iran. **Participants:** 22 pregnant Kurdish women were interviewed during their third trimester. **Findings:** All women expressed at least some fears associated with pregnancy and/or childbirth. The women's fears were related to their babies' well-being, process and procedure during labor and childbirth, family life, criticism of husband's family, and the attitudes of hospital personnel. The reasons for their fears included previous negative experiences, lack of knowledge, maternity environment and hospital personnel, sex of their baby, and financial status. **Conclusion:** Our findings suggest that more attention should be paid to childbirth education and healthcare services. The findings also highlight the need for a careful review of the existing labor and delivery units and procedures. Midwives need further training in how to meet and support pregnant women with fear related to pregnancy and childbirth.

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### Introduction

Women may experience a variety of fears in association with pregnancy and childbirth. Fear can cause significant problems during childbirth and post partum. Fear has been associated with more reported pain during childbirth (Saisto et al. 2001, Alehagen et al. 2005), longer first and second stage of labor, and dissatisfaction with the childbirth experience (Saisto et al. 2001). Ryding and colleagues found that fear of childbirth during the third trimester of pregnancy can lead to emergency cesarean section (Ryding et al. 1998). Fear of childbirth has been reported as a common reason for requesting an elective cesarean section (Penna & Arulkumaran. 2003, Wax et al. 2004, Fisher et al. 2006, Nerum et al. 2006, Sercekus & Okumus. 2007, Fenwick et al. 2008). The most common fears associated with pregnancy focus on the baby's well-being (Sercekus & Okumus. 2007, Melender & Lauri. 1999, Melender. 2002, Mercer. 2004, Angeja et al. 2006, Kasai et al. 2008, Da Costa et al. 1999), the course of pregnancy (Melender & Lauri. 1999, Da Costa et al. 1999), labor and delivery (Sercekus & Okumus. 2007, Melender & Lauri. 1999, Kasai et al. 2008, Henderson & Macdonald. 2004) and issues related to the spouse or partner (Kwee et al. 2004). Women who experience significant fear during antenatal period run an increased risk of suffering severe emotional imbalance after childbirth (Saisto et al.

2001), which can have a negative impact on the relationship with their child (Lederman. 1990). Numerous studies have been published from various countries documenting women's fear related to childbirth. These studies report that women's fear related to childbirth is multidimensional and detailed, concerned with pain, obstetric injuries, their own incapability, loss of control, insufficient support and loss of the baby's or their own life (Melender. 2002, Lowe. 2000, Eriksson et al. 2006). Fear associated with pregnancy and childbirth may be based on previous negative experiences (Melender & Lauri. 1999, Melender. 2002, Miller et al. 2002), fear of death during the previous delivery (Hughes et al. 1999), and history of miscarriage (Nikcevic et al. 1999) or stillbirth (Hughes et al. 1999). They may also be based on negative stories heard from others around them (Sercekus & Okumus. 2007, Melender. 2002, Saisto et al. 1999, Moffat et al. 2006) or alarming publications (Levin. 1991).

Studies have also explored the sources of fears related childbirth and found that factors such as a negative mindset, having pre-existing illnesses (Melender. 2002), knowledge deficit (Sercekus & Okumus. 2007, Melender. 2002), receiving too much information, and beliefs such as thinking they are unlucky (Melender. 2002) were all reported frequently. In one study, women with gestational diabetes reported greater worry about health during pregnancy compared with the controls (Sjogren,

1997). Also, fear of childbirth was expressed more frequently by primiparas than by multiparas (Areskog. 1981). However, Saisto and Halmesmaki (2003) found that fear of childbirth was as common in nuliparous as in multiparous women. Lederman states that primiparous women are more often worried about labor pain, the responsibilities that accompany motherhood, being injured during delivery, the whole childbirth experience, whereas multiparous women are more likely to be worried about managing their duties in the family (Lederman. 1990). Bernazzani and co-workers (1997) observed that low income, and older age had a direct effect on the level of maternity-related ambivalence and fear. Melender (2002) claimed that fear of childbirth was related to depression, vulnerability, lack of social support, and lack of trust in the healthcare staff. There are also fears related to hospital environment, personal behavior, and quality of care that women might receive from midwives and doctors (Sercekus & Okumus. 2007, Melender .2002, Saisto et al. 1999). Iran is located in southwest Asia and has a population of around 70 million people, making it the second most populated country in the Middle East. The health status of Iranians has improved over the last two decades. Iran has been able to extend its public healthcare services through the establishment of an extensive primary healthcare network. As a result, infant and maternal mortality rates are significantly low and life expectancy at birth has risen remarkably (Tork zahrani. 2008). Presenting pregnancy care services in Iran started in 1939. The first purpose of these services was increasing the knowledge and demands of pregnant women and providing pregnancy care services, 79.8% of mothers are now included in pregnancy care programs (Iran MOH. 2003). Typically, pregnant Iranian women receive their care from physicians or midwives during pregnancy and when they give birth. Prenatal care is provided free of charge in public health services. Women attend antenatal check-ups every month until the 28<sup>th</sup> week of gestation, then every fortnight from the 28-36<sup>th</sup> week and every week after the 36<sup>th</sup> week. However, Women may choose to have their own private obstetricians or midwives and hence have antenatal check-ups in their doctor's private clinics. Despite every woman's access to prenatal care in Iran, almost no type of childbirth education program exists in Iran's prenatal care system. Iranian pregnant women briefly receive information about pregnancy during their 5-10 minute routine prenatal visits, and they may receive an additional two or three 15-20 minute sessions of extra classes (Tork zahrani. 2008).

In Iran, more than 95% of births take place in hospitals (Akbari, 2005). Because of the Iranian

religious and cultural values, men do not attend labor and birth. Usually, pregnant women arrive in the labor ward accompanied by other women who stay with them in the same room during labor. Midwives are the women's only source of support in labor and birth (Tork zahrani. 2008). To date, no studies have reported fears related to the experience pregnancy and childbirth among Kurdish women in Iran. In order to plan and provide effective and appropriate care, it is important to understand issues of concern to women and in particular their common fears and the sources of these fears. Therefore, we aimed to describe the fear and causes associated with pregnancy and childbirth.

### Methods

A qualitative approach was chosen as most appropriate for the determination of an individual's feelings, interactions, perceptions, and behaviors (Holloway & Wheeler. 2002). As this study was designed to seek understanding of the fears of women regarding pregnancy and childbirth, a qualitative design and data collection through personal interviews was selected to allow participants to freely express their thoughts and feelings (Nieswiadomy. 2002). The setting for the study was three public health care centers of Kurdistan University of Medical Sciences in Sanandaj, center of Kurdistan province, west of Iran. Theoretical sampling was used. Sample size was not predetermined but was determined when interviewing reached saturation, that is, when no new data emerged regarding a category and categories (Strauss & Corbin. 1998). The sample was restricted to 22, as no new data were generated after the 20<sup>th</sup> interview. The study was approved by the Ethics Committee of Kurdistan University of Medical Sciences.

Potential participants were approached in public healthcare centers by the researcher after their regular appointment and asked to participate in the study. They were given verbal and written information about the study, and given the opportunity to ask any questions concerning participation. All of the women were informed that their participation in the study was voluntary and they were assured that all information would be treated confidentially. The participants were anonymous and are reported using interviewee assigned numbers (#). Each woman was also notified about the time needed for the interview. The date of interview was arranged to suit the participant. All interviews were conducted in the Kurdish language by the researcher who is a Kurdish midwife. Each interview was tape-recorded. The interviews lasted between 50-100 minutes. Most women were interviewed once. The women were individually interviewed in their own homes or a private room in

the healthcare center. Data were collected using a semi-structured interview technique. This method allows for flexibility and makes it possible to ask additional and more detailed questions (Holloway & Wheeler, 2002, Morse & Field, 1996). All interviews started with the same question: "Please tell me what you are thinking about childbirth?" Two focused questions were then asked: "What are your fears about childbirth?" and "What are the causes of your fears about childbirth?" Further questions were used to clarify or elaborate on the women's responses (Crabtree & Miller, 1999).

All interviews were transcribed verbatim in the Kurdish language. Transcription accuracy was checked by a colleague who read randomly chosen transcripts while listening to the audio tape. The analysis was also undertaken from the Kurdish transcripts and only verbatim quotations presented in the writing publication were translated into English. The researchers have attempted to translate the women's descriptions to loosely correspond their meaning in Kurdish whereas making them grammatically correct for the English reader. Data analysis took place at the same time as data collection. A grounded theory approach was used to analyze the interviews (Strauss & Corbin, 1990). In the first stage of the analysis (initial coding), the interviews were read line by line, and the codes were identified and labeled. The coding process helped the researcher to remain close to the data. Sometimes 'in vivo' quotations were picked up directly from the text and used as open codes (Strauss & Corbin, 1990). The second step was to scrutinize the open codes and make decisions about which codes to keep as the most relevant for the aim of the research. The chosen codes and quotations were then repeatedly compared and sorted into categories according to their content and meaning. Between the open codes and a category, the dimensions were identified, which helped to describe what a category was about. During this process, the emerging categories and their dimensions were continually compared with the original text to exclude the risk that some findings might be based on misunderstanding.

### Findings

The participants ranged from 20-35 years of age, including 15 nuliparous and 7 multiparous who had one child. All women were in their third trimester of pregnancy and married. Most of the women described themselves as housewife (77%). They were differed in educational level, ranging from primary school to university, most of which were high school graduates (73%). In the following section, we present two main categories of our findings according to the interview questions addressed to the women. In order to maintain

confidentiality the women's questions used to illustrate the categories are identified with pseudonym.

### Fears about pregnancy and childbirth

Fears described by the women were grouped into five main categories: baby's well-being, process and procedure during labor and childbirth, family life, criticism of husband's family, friends, and husband, and attitudes of hospital personnel.

#### Baby's well-being

The most important fear associated with pregnancy and childbirth was fear of the baby's health. The women had been concerned that the baby would be handicapped or die during pregnancy or delivery. I am continually frightened and horrified about my baby's health. (#3), I think about the baby's health all the time. (#11). Some women expressed fear of doing something wrong and harming the baby through an inappropriate procedure during labor or childbirth. I fear that at the time of delivery a hand or foot of the baby is plucked. (#5).

#### Process and procedure during labor and childbirth

All women were afraid of the process and procedure related to the labor and delivery including: pain, prolonged labor and delivery, episiotomy, vaginal examination and being incapable of giving birth. The most commonly reported was fear of pain. Women described their fear of pain as follows:

I'm very afraid of labor pain. (#7)

I have fear all the time. What will I do if I have a prolonged labor? (#5)

I am afraid of snipping. (#10)

I'm afraid about the pain of childbirth. (#17)

These quotes indicate the level of fear related to labor and delivery events that these women expect to be a natural part of the labor and childbirth experience. Most women often feared about what would happen to them during labor and delivery. The fear from pain and delivery was common among the women who experienced this process once before, but it was different for nuliparous women. I didn't want to become pregnant again because I am scared of childbirth. (#1, Multiparous woman). My friends told me that vaginal examination is so painful, I'm scared of that. (#5, Nuliparous woman)

#### Family life

Some women were afraid of inability to fulfill their responsibility. They feared being unable to give birth to the baby. I'm afraid I won't be able to deliver the baby. (#9). I fear I cannot do my responsibility towards the baby well after my childbirth. (#18). I sometimes think of my inability to bring up a fine child and cope with the task of caring for the baby. (#4). Most women were afraid of the thought of possible loss of their husband's affection.

I am sometimes afraid of not being alone with my husband, when the child is delivered...I think I'll lose him. (#8).

#### **Criticism of husband's family, friends, and husband**

Some women were aware that they were not alone in their mothering endeavor. In fact, there was always an audience and critic in their relatives. They were fearful and anxious for their inability to take care of their babies or responsibilities and being criticized and blamed for that. One woman mentioned that she was afraid of the possible criticism by her husband's family and other relatives. I am afraid of the complaints of my husband's family and their criticism if I'm not capable to bring up the child properly... (#20)

#### **Attitudes of hospital personnel**

Most women stated that they were afraid of hospital environment, personnel behavior and the quality of care they might receive from the midwives and doctors. Some nuliparous women mentioned their fears were because of the environment of the delivery room and healthcare staff because they had heard comments on the unkindness of the staff from other women. Some of my friends told me delivery personnel shouted at them and insulted them during their labor. (#3, nuliparous woman)

However, all multiparous women were afraid of being ill treated by the delivery staff. They felt that the midwives and doctors were rude to women during labor and delivery. I'm really afraid because some of the midwives and doctors don't pay attention to you and yell at you. (#21, Multiparous woman)

#### **Causes of fear associated with pregnancy and childbirth**

All women expressed at least some fears associated with pregnancy and/or childbirth. Their response to questions on the causes of fear was divided into five categories: lack of knowledge, previous negative experiences, financial status, baby's sex, and maternity environment and hospital personnel.

#### **Previous negative experiences**

Some multiparous women had previous negative experiences during pregnancy or childbirth. For some, childbirth had been a painful or otherwise unpleasant experience. I have bad memories from my previous childbirth. Lots of pain, being bed bound for a long time for childbirth and cold delivery room... (#17)

Others women's negative experiences had also caused fear for some nuliparous women. My friends who have experienced childbirth say their childbirth were very painful...I'm really afraid. (#10)

#### **Knowledge**

During the interviews, most nuliparous women stated that their fears had developed because of negative stories about childbirth by friends and family. They blamed their friends and relatives to be the main source of transferring this fear. I've heard from my friends that when the baby was delivered it was painful. Therefore, I'm afraid of delivery. (#10). Some nuliparous women feared childbirth and its pain because of negative information they had heard about childbirth on TV or from books and magazines. Also, some nuliparous women mentioned that their lack of information about labor and childbirth caused fear. If you know about at least some of the things, it becomes better. I'm afraid; I don't know how I'll get through labor and how this process will go. (#8).

Most women mentioned that they had no training about pregnancy and childbirth. However they believed that education during pregnancy by midwives is necessary for adapting with pregnancy and reducing their fear.

#### **Maternity environment and hospital personnel**

Most women stated their fears were due to the environment of the maternity ward and the personnel's behavior. The nuliparous women had heard about this matter from other women, while the multiparous women had previously experienced that situation. I am afraid of hearing other women screaming in the maternity ward, I think it is so awful. (#9). One of the reasons that I didn't want to become pregnant again and is annoying me in this pregnancy is the fear of bad behavior from the hospital staff. (#13, Multiparous woman)

#### **Baby's sex**

Some women stated that the sex of the baby was important to them. This importance was mostly because of the husband or his family's request for a baby boy. Therefore, the sex of the baby was one of the causes for the mother's fear. Whenever I talk about the sex of the baby, I feel that my husband wants us to have a baby boy. I think the sex of the baby is more important to him...I feel a strange fear when I think about this issue. (#5).

#### **Financial status**

Financial status means the role of a woman's financial condition in creating fear for her during pregnancy. Some women pointed to the role of their financial condition on their emotion. After I realized that I'm pregnant, I became worried. I didn't want to be pregnant at all because we have a lot of problems. My husband doesn't have a good job, we have to pay for rent and we owe a lot of money. (#9)

When I knew that I'm pregnant I became afraid because I thought we can't afford the baby's expenditure...As you know babies need especial facilities that are very expensive. (#7)

## Discussion

This study was undertaken with a small group of women and we cannot claim that the women in the study represent all Kurdish women with fear of pregnancy and childbirth in Iran. However, there are some conclusions that can be drawn from the findings. The findings of our study indicate that the most important fears associated with pregnancy and childbirth are those associated with the baby's well-being. This is consistent with the findings of earlier research, which shows that pregnant women are often concerned about the possibility that the baby may be injured or die (Sercekus & Okumus. 2007, Melender. 2002, Mercer. 2004, Angeja et al. 2006). Some women had been concerned about doing something wrong and harming the baby through an inappropriate procedure during labor and inability to give birth (Melender. 2002, Szeverenyi et al. 1998). Most of the fears associated with childbirth were fears of pain; this is consistent with earlier findings (Sercekus & Okumus. 2007, Melender. 2002, Kasai et al. 2008). All women stated they expected to have pain and that they were afraid as a result. The women also described fears relating to the procedure during labor and delivery. These findings were similar to those found in previous reports (Sercekus & Okumus. 2007, Fenwick et al. 2008, Lee et al. 2001, Hildingsson et al. 2002). Some of the women expressed fear related to the change in the relationship with their husband and losing their attention. Klossener (2006) also reported that woman can feel fear by the probable loss of attention and special privileges given during their pregnancy. Some women described their fear of criticisms and blames from the husband's family. They were fearful and anxious for their inability to take care of their babies and being criticized and blamed for that. This finding was not reported in other studies. This is perhaps because of the cultural norms and reflects the lack of support from the husband's family. Most of the women expressed fear related to attitudes of hospital personnel. Other studies also found that women were afraid that childbirth personnel would not treat them well (Sercekus & Okumus. 2007, Melender. 2002, Saisto et al. 1999, Sjogren et al. 1994).

The main source of fear was different among nuliparous and multiparous women in this study. For nuliparous women the source was information from other women or media and lack of knowledge about childbirth. However, in multiparous women this cause was related to their previous experiences. Therefore, the findings of this study indicated that many fears associated with pregnancy and childbirth were based on the negative childbirth experiences of other women or on a previous experience of one's own. Melender (2002) reported

that negative experiences with childbirth cause fear, and that women share these experiences among other women. In addition, the nuliparous women in this study indicated that knowledge deficit or type and quality of information about pregnancy and childbirth led to fear. Some studies have shown an association between knowledge and fear of pregnancy and childbirth (Sercekus & Okumus. 2007, Melender. 2002, Levin. 1991, Cleeton. 2001).

The findings of this study showed that maternal environment such as seeing other women in pain or hearing the voice of other women in labor caused fear. This finding was reported in Sercekus and Okumus's study (2007). In most hospitals in Iran women do not have private rooms during labor and childbirth, and they are all together in one large room where they see and hear other women in the ward. The behavior of maternity personnel was also identified as a source of fear in this study, consistent with previous studies (Sercekus & Okumus. 2007, Melender. 2002, Saisto et al. 1999, Sjogren et al. 1994). In this study, concerns about the baby's sex were found to be important in the development of women's fear of pregnancy and childbirth. Most women preferred to have boys since they thought it was the desire of their husbands and husband's family. This matter could be related to the attitudes of Kurdish people regarding the importance of boys. Previous research (Chandran et al. 2002, Patel et al. 2002, Ekuklu et al. 2004, Dhillon & MacArthur. 2008) has shown that gender preference exists in many cultures in south Asia, the Middle East, and East Asia. Dhillon and MacArthur found family preference for a male child among Asian pregnant women who lived in the UK (Dhillon & Mac Arthur. 2008). Fear could also be traced to financial problems. The women in this study reported that their financial problems were the cause of worry and fear for them. This is consistent with the findings of Rafe and colleagues (1993) which showed that the socioeconomic level has an important effect on the emotional experiences during pregnancy. Schneider (2002) and Ricci (2007) claimed financial status is a support network that may influence women's emotional experiences of pregnancy. This study indicates that fear associated with pregnancy and childbirth is commonly based on a woman's previous experience, lack of knowledge, maternity environment and staff behavior, baby's sex, and financial problems. Some studies showed that using health care services, professional support and childbirth education remove or reduce fear associated with pregnancy and childbirth (Sercekus & Okumus. 2007, Fenwick et al, 2008, Melender & Lauri. 1999, Melender. 2002). It is recommended that further studies should be conducted in order to explore the

perceptions of midwives concerning women's fears and their suggestions for effective actions and responses. Midwives are optimally positioned as educators for women during the experience of pregnancy, childbirth, and motherhood. Research needs to explore how they perceive their role as an educator and facilitator for women's with fear through pregnancy, birth, and early childbearing.

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