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# Factors that generate fear of childbirth: An integrative review

Fatores geradores do medo do parto: revisão integrativa

Factores que generan miedo al parto: revisión integradora

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**Abstract: Objective:** to identify, in the scientific evidence, factors considered by women to trigger fear of childbirth. **Method**: an integrative review with the following question: What factors do women consider triggering or influencing fear of childbirth? Searches were carried out in the Portals of the Virtual Health Library and in the Journals Portal of the Coordination for the Improvement of Higher-Level Personnel, through combinations of descriptors and keywords adhering to the theme. In response, 27 articles were found using the following inclusion criteria: articles in English, Portuguese or Spanish, in full, published and indexed between 2008 and 2018. **Results**: the following stood out as factors that trigger fear: perceptions related to vaginal delivery, fears related to the choice of cesarean section, and fear of inadequate care by the professionals, among other factors. **Conclusion:** giving pregnant women back the power over their bodies, strength and ability to give birth naturally without fear, is a challenge faced by Nursing care.
**Descriptors:** Fear; Parturition; Women's health; Natural childbirth; Nursing

**Resumo: Objetivo:** identificar, nas evidências científicas, fatores considerados pelas mulheres como desencadeantes do medo do parto. **Método**: revisão integrativa com a questão: Que fatores as mulheres consideram desencadeantes ou influenciadores no medo do parto? Foram realizadas buscas nos Portais da Biblioteca Virtual em Saúde e no Portal de Periódicos da Coordenação de Aperfeiçoamento de Pessoal de Nível Superior, através das combinações de descritores e palavras-chave aderentes ao tema. Como resposta, encontraram-se 27 artigos empregando-se como critérios de inclusão: artigos em inglês, português ou espanhol, na íntegra, publicados e indexados no período de 2008 a 2018. **Resultados**: destacaram-se como fatores desencadeantes do medo: as percepções relacionadas ao parto vaginal, medos relacionados à escolha da cesariana, medo pela assistência inadequada dos profissionais, entre outros fatores. **Conclusão:** devolver à grávida o poder sobre seu corpo, a força e a capacidade de parir naturalmente sem medos, constitui um desafio enfrentado para o cuidado de enfermagem.
**Descritores:** Medo; Parturição; Saúde da mulher; Parto normal; Enfermagem

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**Resumen:** **Objetivo:** identificar, en las evidencias científicas, factores que las mujeres consideran como desencadenantes del miedo al parto. **Método**: revisión integradora con la siguiente pregunta: ¿Cuáles son los factores que las mujeres consideran desencadenantes o influenciadores del miedo al parto? Se realizaron búsquedas en los Portales de la Biblioteca Virtual en Salud y en el Portal de Periódicos de la Coordinación de Perfeccionamiento del Personal de Nivel Superior, a través de las combinaciones de descriptores y palabras clave relevantes al tema. Como respuesta se encontraron 27 artículos con el uso de los siguientes criterios de inclusión: artículos en inglés, portugués o español, con texto completo, publicados e indexados en el período de 2008 a 2018. **Resultados**: se destacaron los siguientes factores como desencadenantes del miedo al parto: las percepciones relacionadas al parto vaginal, miedos relacionados con la elección de la cesárea, y miedo relacionado con la asistencia inadecuada de los profesionales, entre otros. **Conclusión:** devolver a la mujer embarazada el poder de decisión sobre su propio cuerpo, la fuerza y la capacidad de parir naturalmente sin miedos, constituye un desafío al que se debe hacer frente desde la atención de Enfermería.
**Descriptores:** Miedo; Parto; Salud de la mujer; Parto normal; Enfermería

## Introduction

Labor is an event both expected and feared by women and their families, as it is full of meanings constructed by culture, which can trigger different feelings, thus exposing women to an insecurity that will result in different fears.[1] Women consider pregnancy and delivery as significant events in their lives; however, the moment of giving birth is often associated with great fear and the expectations during pregnancy can negatively influence the experiences related to delivery and motherhood.[2]

Brazil is going through an epidemic of cesarean sections, with 1.6 million surgeries performed per year. In the last few decades, the national rate of cesarean sections has been increasing steadily, being the most common mode of birth in the country.[2] Fear of pain and fear of childbirth appear as influencing factors for the option for cesarean section.[3]

The phenomenon of fear of pain during delivery and the whole set of perceptions, sensations, fears, feelings and emotions around it are inscribed in many dimensions of each woman's life. The affective-emotional and cognitive spheres, as well as life history, are related to the dimension of subjectivity. At the physiological level, the somatic sphere; the socio-cultural scope, which concerns belonging to and identifying with the values and practices of a

given social group and the socio-institutional level, is related to references regarding the health system and the assistance to which women have access.[4]

In the early days of Christianity, fear was internalized in people and remains today;[5] however, in the 17th and 18th centuries, fear was understood as a singular emotion, constitutive of the subject's psyche, as part of their emotional aspect.[6] With the loosening of patriarchal authority, insecurity in society originated, generating more conflicts, stress and psychosomatic episodes, which have caused anxiety and fear.[7] The idea of fear caused by culture and social behavior still remains, since the unpredictable, uncontrollable and unknown involve the moment of delivery, therefore allowing the cesarean section to be a safer way as an option. This condition is evidenced by its high rate, mainly in the private network.[3]

The socio-cultural dimension interferes with the type of delivery, with the formation of myths, beliefs and opinions that are reflected in the experience of each pregnancy.[8] However, humanization, de-medicalization, or even holism have shown that it is possible to give women autonomy, control and self-confidence.[9] In labor it is necessary to respect physiology. The body itself must be allowed to act, through a form of care that helps to relieve pain, fear and insecurity, not allowing delivery to be a traumatic event.[10] For that to happen, it is necessary that the obstetric nurse and all the professionals who work in childbirth have sensitivity, freedom, qualification and ethics to understand the woman considering her feelings and her integrality.[11]

Thus, it is observed that, in order to promote the understanding of the pregnancy process and minimize possible fears of labor, there must be an exchange of information about the different experiences between the women and the health professionals. The aim of the present study was to identify, in the scientific evidence, the factors considered by women to trigger fear of childbirth.

## Method

This is an Integrative Review (IR) that covers both experimental and non-experimental studies to fully understand the researched and relevant phenomenon in the field of Nursing.[12] Thus, this IR sought to clarify the following review question: What factors do women consider triggering or influencing fear of childbirth? Data collection took place from the following portals: Regional Portal of the Virtual Health Library (*Biblioteca Virtual em Saúde*, BVS), Portal of Virtual Health Library for Nursing (*Biblioteca Virtual em Saúde Enfermagem*, BVS-Enf)-Brazil, and in the Portal of the Coordination for the Improvement of Higher-Level Personnel (*Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*, CAPES). For this, the following keywords and descriptors were used: "*paridade*", "*medo*", "*saúde da mulher*", "*trabalho de parto*", "*parto normal*", "parity", "fear", "labor, obstetric", "*multiparidade*" and "*saúde feminina*". These were used alone or in combinations, as shown in Chart 1, contemplating the study from the following sources: Science Direct, online Medical Literature Search and Analysis System (MEDLINE), Latin American and Caribbean Literature in Social Sciences (*Literatura Latino-Americana e do Caribe em Ciências Sociais*, LILACS), PubMed, IndexPsi, Bibliographic Database specialized in the area of Nursing (BDenf) and Scientific Electronic Library Online (SciELO). It is noteworthy that the same search strategies were used for all the databases/virtual libraries researched.

**Chart 1 -** Search strategies used in the databases and their results, 2018.

| Search strategy | Portal | Database | Found | Leveraged |
|---|---|---|---|---|
| *Paridade* AND *medo* AND "*saúde da mulher*" AND "*trabalho de parto*" AND "*parto normal*" | BVS | | - | - |
| | BVS ENF | | - | |
| | CAPES | | 3 | - |
| | SciELO | | - | - |
| | SCOPUS | | - | - |
| | Science | | - | - |

| | | | | |
|---|---|---|---|---|
| | Direct | | | |
| *Paridade* AND *medo* AND "*trabalho de parto*" | BVS | MEDLINE<br>LILACS | 14<br>1 | 10 |
| | BVS ENF | | 4 | Repeated from the Regional BVS |
| | CAPES | | 10 | - |
| | SciELO | | - | - |
| | SCOPUS | | - | - |
| | Science Direct | | 1 | - |
| Parity AND fear AND "labor, obstetric" | BVS | MEDLINE<br>CUMED<br>IBECS | 21<br>1<br>1 | 2 |
| | BVS ENF | | 6 | Repeated from the Regional BVS |
| | CAPES | | 21 | - |
| | SciELO | MEDISUR | 1 | - |
| | SCOPUS | | 21 | 1 |
| | Science Direct | | 3 | - |
| (*paridade* OR parity) AND (*medo* OR fear) AND ("*trabalho de parto*" OR "labor, obstetric") | BVS | MEDLINE<br>CUMED<br>IBECS<br>LILACS | 29<br>1<br>1<br>1 | -<br>(repeated) |
| | BVS ENF | | 12 | Repeated from the Regional BVS |
| | CAPES | | 18 | - |
| | SciELO | MEDISUR | 1 | - |
| | SCOPUS | | 21 | Repeated previous |
| | Science Direct | | 5 | - |
| (*paridade* OR multiparidade) AND ("*saúde da mulher*" OR "*saúde feminina*") AND "*trabalho de parto*" | BVS | | - | - |
| | BVS ENF | | 8 | Repeated from the Regional BVS |
| | CAPES | | - | - |
| | SciELO | | 3 | - |
| | SCOPUS | | - | - |
| | Science Direct | | - | - |
| *Medo* AND *mulher* AND *parto* | BVS | | - | |
| | BVS ENF. | MEDLINE | 25 | 20 |
| | | LILACS | 19 | |
| | | BDENF | 14 | |
| | | FIOCRUZ | 2 | |

| | | | | |
|---|---|---|---|---|
| | | ENSP | 1 | |
| | | IBECS | 1 | |
| | | IndexPsi | 1 | |
| | | Comprehensiveness | 1 | |
| | CAPES | | 262 | - |
| | SciELO | | 51 | - |
| | SCOPUS | | - | - |
| | Science Direct | | 9 | 1 |

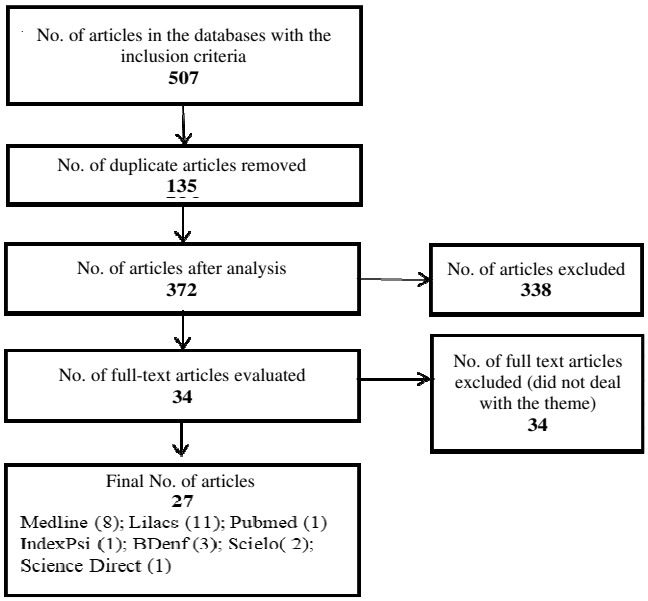
The following criteria for inclusion of articles were established: articles written in English, Portuguese or Spanish; available in full that covered the theme; published and indexed in the period from 2008 to 2018. The 2008 timeframe was determined based on the argument that, in 2005, the Ministry of Health (MoH) prepared the Prenatal and Puerperium Technical Manual: Qualified and Humanized Care,[13] which made it possible to approach the fear of childbirth within the scope of public policies and still considering, by the researchers' decision, a three-year period between the publication of the Manual and the appearance of the first publications directly involving the theme.

The search was carried out from May to July 2018, and a total of 507 articles were found. Subsequently, with careful reading of the abstracts, theses, dissertations, papers published in the annals of events, editorials, incomplete articles, newspaper articles or without abstracts in the databases were excluded, and those that were repeated in more than one database were considered only once.

The stages of the analysis were as follows: identifying the theme to be researched and the issue of review; establishing the inclusion criteria; performing the categorization of the studies; analyzing the studies in detail; interpreting the results found; and preparing the article with the main evidenced results.[14] The search and selection of studies were carried out by the two researchers, simultaneously, seeking consensus through the discussion on the pertinence or not of the inclusion of each selected article. Of the 507 articles initially identified, at the end of the

application process of the inclusion criteria, 27 articles were selected according to Figure 1. [1,4,15-39]

**Figure 1 -** Summary of the search and selection of articles. Rio de Janeiro, 2018.




Regarding the level of evidence, there is hierarchy according to the research design, being level 1 (meta-analysis of multiple controlled and randomized studies), level 2 (individual studies with experimental design), level 3 (quasi-experimental studies), level 4 (descriptive or qualitative approach), level 5 (case reports or experiences) and level 6 (expert opinions).[40] Therefore, the articles were classified as follows: 15 as level 4, 11 as level 1, and 1 as level 5.

## Results and discussion

The 27 publications[1,4,15-39] were described in Charts 2, 3 and 4 whose content presents: authors, year of publication, level of evidence, objective of the study and main results, which answered the review question. It is noticed that, even considering a relatively long period of 10 years, the theme is present and recurrent in the scientific publications.

**Chart 2 -** Synthesis of the articles selected in the Integrative Review, referring to the years 2008-2011. Rio de Janeiro, 2018

| Author / Year / Level of Evidence (LE) | Objective(s) | Results |
|---|---|---|
| Rodrigues AV, Siqueira AAF. [18] 2008 LE = 4 | To develop some reflections on the possible beneficial effects of listening responsively to verbalizing the presence of pain, fears and their correlates in the delivery scene, based on empirical data from research carried out in a maternity hospital located in the city of São Paulo, Brazil. | It showed, among other points, the importance and appreciation of qualified dialog in the parturition process. This process, referred by the parturients, as an experience of a high degree of stress, with experiences of pain, fears and anxieties, but mitigated by the support received. |
| Damasceno AM, Said FA.[26] 2008 LE = 1 | To evaluate an educational practice with the application of the Problem Method, in preparation for the delivery of a group of seven women. | In this group of pregnant women, fear seems to be related to what is unknown to them or to what comes as external appropriation due to their relationships with the environment. |
| Dias MAB, et al.[37] 2008 LE = 4 | To describe in units served by supplementary health, the socioeconomic, demographic, cultural and reproductive characteristics of puerperal women and the determinants of the decision for cesarean delivery, as well as to assess the adequacy of cesarean section indications and the management of labor. | The high proportion of women who reported fear of pain during normal childbirth when choosing a cesarean delivery was surprising, considering the current availability of epidural analgesia and other non-pharmacological methods for pain relief. |
| Laursen M, et al.[34] 2009 LE = 1 | To examine the associations between fear of childbirth and emergency cesarean section and between fear of childbirth and dystocia or labor and fetal distress. | Fear of childbirth during pregnancy was associated with dystocia and emergency cesarean section, but not with fetal distress. |
| Giaxa TEP, Ferreira MLSM.[1] 2011 LE = 1 | To identify the reasons that women have at the end of pregnancy to seek hospital care early. | Women feel fear and insecurity due to fragmented assistance. Not perceiving themselves linked to the prenatal program and at the same time, they do not find the hospital assistance they desire. |
| Barros MLF.[25] | To identify the perception of the | The safety of the woman herself and of |

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| 2011<br>LE = 1 | type of delivery in the scientific literature from the perspective of professionals and women. | the baby is more important than the delivery method; fear and suffering as inherent to delivery; professional attention and the presence of a companion, important for humanization; painful and exhausting previous experience and choice for cesarean section; preference for vaginal delivery because it is safer and more natural; preference for cesarean section associated with fear of not having control over delivery. |
| Hildingsson I, et al.[33]<br>2011<br>LE = 1 | To investigate the prevalence of fear related to childbirth from pregnancy to one year after delivery and to identify factors associated with the cure of fear related to childbirth. | Women who have been cured of fear of childbirth reported a better childbirth experience and prefer a vaginal delivery in a new pregnancy. |
| Pereira RR, et al.[36]<br>2011<br>LE = 5 | To understand through the theory of social representations the socio-cultural dimensions of pain and its impact on the role of women during delivery. | As one of the building elements of female social representations about parturition, pain influences the pregnant woman's behavior from fear and becomes the genesis of other aversive feelings and concerns about childbirth. |
| Pereira RR, et al.[39]<br>2011<br>LE = 4 | To understand, from the female social representations, the role of women in the decision about parturition. | Fear was the most influential factor in the woman's role and in her decision-making power over her choice of delivery. |

**Chart 3 -** Synthesis of the articles selected in the Integrative Review, referring to the years 2012-2014. Rio de Janeiro, 2018

| **Author / Year / Level of Evidence (LE)** | **Objective(s)** | **Results** |
|---|---|---|
| Santos LM; Pereira, SSC.[24]<br>2012<br>LE = 4 | To understand the experiences of puerperal women about the care received during the delivery process in a public maternity hospital in Feira de Santana-Bahia. | It demonstrated that the interviewees experienced the parturition process with loneliness, fear, pain, suffering, abandonment, and had their children, alone. |

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| Adams S, et al.[32]<br>2012<br>LE = 4 | To assess the association between fear of childbirth and duration of labor. | The duration of labor was longer in women with fear of childbirth than in women without such fear. |
| Lagomarsino BS, et al.[22]<br>2013<br>LE = 4 | To know the mediations of culture about women's preferences regarding the delivery method and the influence of family and personal experiences on these preferences and in determining the delivery method. | The medicalized culture of childbirth care can compromise the possibility for women to know, appropriate and dominate the manifestations of the body, contributing to beliefs that vaginal delivery is dangerous, increasing insecurity and fear in relation to any delivery decision. |
| Pimenta LF, Ressel LB, Stumm KE.[23]<br>2013<br>LE = 4 | To understand how culture influences the woman's parturition process. | The participants who received negative comments felt fear, anxiety and insecurity during the delivery experience. |
| Araque LB, López MD[27]<br>2013<br>LE = 4 | This study sought to know the perception of the emotional state of women with pregnancies susceptible to extension. | Emotional well-being is altered by fear of pain during delivery, possible complications, and caring for the newborn, showing a state of nervousness due to imminent delivery. |
| Sydsjö G, et al.[31]<br>2013<br>LE = 4 | To investigate the time for subsequent delivery and delivery outcome in women with secondary FOC, compared to a reference group. | The secondary fear of childbirth prolongs the time for subsequent childbirth and the active phase of labor itself and increases the risk of cesarean delivery. |
| Domingues RMSM, et al.[16]<br>2014<br>LE = 4 | To describe the factors referring to the preference for the type of delivery at the beginning of pregnancy and to reconstruct the decision process for the type of delivery in Brazil. | The main reason for choosing vaginal delivery was the better recovery from this type of delivery and for cesarean section the fear of labor pain. |
| Silva GPS, et al [17]<br>2014<br>LE = 4 | To understand the experience of primiparous women with caesarean section. | The woman is influenced by people close to her when opting for cesarean section and her decision is based on the fear of vaginal delivery, associated with pain and suffering. |
| Anderson CA, Gill M.[35]<br>2014<br>LE = 4 | To explore fears of childbirth in psychological birth trauma (PBT) by younger (13-16) and older (17-19) adolescents. | More than 75% of the adolescents perceived fear. Regardless of age, most feared childbirth. A small group experienced traumatic stress after delivery. The variables of fear in general, parity and absence of it in labor were the greatest. |

**Chart 4 -** Synthesis of the articles selected in the Integrative Review, referring to the years 2015-2018. Rio de Janeiro, 2018

| Author / Year / Level of Evidence (LE) | Objective(s) | Results |
|---|---|---|
| Scarton J, et al. [15] 2015 LE = 4 | To know the experiences of primiparous women in relation to the care practices provided by the Nursing professionals during normal birth. | The fear of not succeeding and the encouragement of the Nursing team; The experience of pain during normal birth; Support versus distancing; Good or bad experience in childbirth? "In the end, everything pays off!" |
| Souza MG, et al.[21] 2015 LE = 1 | To know the concerns of primiparous women about labor and delivery; to identify nurses' actions to ease women's feelings. | They showed their feelings and expectations regarding their relationship with labor and delivery, such as fear, insecurity, and anxiety. However, the presence of the companion proved to be important for inhibiting these feelings. |
| Matinnia N, et al.[28] 2015 LE = 1 | To examine the content of maternal fear and associated demographic factors in a sample of Iranian primiparous women. | Fears related to pregnancy and childbirth were often felt by all the low-risk primiparous women. |
| Schwartz L, et al.[29] 2015 LE = 4 | It investigated sociodemographic, obstetric and psychological factors that affect self-efficacy in pregnant women. | Fear was strongly correlated with the low self-efficacy of childbirth. |
| Tostes NA, Seidl EMF.[4] 2016 LE = 1 | The expectations of primiparous women about childbirth and their perceptions about preparation for childbirth | Expectations related to childbirth, in general negative, perpetuating ideas of a moment of fear, pain and suffering, which can bring risks to the woman and the baby. |
| Arnau Sánchez J, et al.[20] 2016 LE = 1 | To explore the emotions that arise in women during pregnancy, childbirth and the puerperium throughout the care itinerary of primary and hospital care. | Fear: pain in childbirth, pain from contractions and different expectations that are not met and difficulty in the interaction between the woman and the health professionals, provoke a traumatic experience. |
| Feitosa RMM, et al.[19] 2017 LE = 1 | To understand, from the perception of the mothers, the factors that influence the choice of the type of delivery. | The influences of “fear of pain” and the experiences of the individuals and other women in choosing the delivery method are significant. |
| Paul JA, et al.[38] 2017 | Objective of preventing the first cesarean delivery in nulliparous | Maternal anxiety, fear, pain, and unpreparedness also play a role in this |

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|---|---|---|
| LE = 4 | women at term, single and fetal apex. | reluctance. |
| Garthus-Niegel S, et al.[30] 2018 LE = 1 | To examine the etiology of post-traumatic stress symptoms after childbirth within a transactional framework of stress. | The association between previous experience of childbirth, subjectively negative, and fear of childbirth was high and greater than the association between previous obstetric complications and fear of childbirth. |

It should be noted that some of the papers analyzed[1,4] were also a source of reference in the study argumentation. For the construction of the analysis of the results, the ethical dimensions and the central ideas of each of the authors of the analyzed articles were respected.

In order to elucidate important aspects about the fear of childbirth, about its generating factors and its influence on labor, in the choice of the type of delivery, among others, the articles were interpreted and grouped into four thematic groups: Fear-generating factors and the perceptions of vaginal delivery; Fear-generating factors related to the choice of cesarean section; Factors that generate fear due to inadequate care by the health professionals in prenatal care and childbirth; Other fear-generating factors.

## Factors generating fear and the perceptions of vaginal delivery

It was observed that the fear of vaginal delivery is due to the fact that women are afraid of complications, of the risks in the use of invasive procedures or use of forceps, of the most serious sequelae that can happen to her and to the baby. Such risks and complications generate great anxiety, insecurity and uncertainty about childbirth, much more than fear of pain. The women believe that normal birth can have problems, so they prefer the cesarean section,[26] which is understood to be a misconception.

The fear of vaginal delivery was also related to pain, malaise, the fact that it is a sacrifice, suffering and unpleasant. The women imagine unbearable pain and, when faced with it in labor, that emphasizes their fears, sometimes leaving them traumatized about having another child.[18]

The fear for the unknown that is to come and how labor will evolve, causes uncertainty regarding the choice of vaginal delivery. Associated with this fear is the fear of harm that can occur to the baby.[22]

Pain is subjective, perceived differently by each individual, and is influenced by culture. It is a symbolic construction passed down from generation to generation.[41-42] Fear of pain is an idea imposed on the woman by means of family and friends' stories and by the culture she lives in. Usually, they are negative experiences about childbirth, associated with the fear of the unknown that causes it to be exacerbated and remain in the woman's subconscious.

In general, culture is based on technocracy and medicalization, with the support of the hospital environment; the physicians as the responsible individuals for this entire birth process. In this context, women lost control over their bodies and autonomy in terms of different choices from those imposed by society. The emphasis is on fear, apprehension, the feeling of not trusting themselves, being incapable, unable to give birth or losing control at the time of delivery; the fear that something will happen to the baby if they are unable to push or withstand the delivery.[39]

Unnecessary interventions such as the use of exogenous oxytocin, episiotomy, *Kristeller* maneuver, or use of forceps, which should only be used in cases of complications, are used routinely and, as a consequence, the healthy relationship between labor and woman has been decharacterized.[43] The excess of these practices causes insecurity due to the strangeness of the situation for women, compromising self-security and not feeling capable, thus transferring confidence only for the physicians, generating increasingly negative and frustrating feelings about vaginal delivery.

Fear, insecurity or any traumatic experience in the current or previous pregnancy or delivery, will influence personal and conjugal life and the relationship with the baby. Thus, it is increasingly important to pay attention to pregnant women before, during and after pregnancy to minimize and observe possible acquired sequelae.

The lack of knowledge of the body itself and the physiological process of pregnancy cause feelings of doubts and uncertainties, which lead the woman to be insecure. The information received in their social and family context also contributes to the parturient woman not collaborating and not having confidence at the time of delivery. The socio-cultural dimension is capable of interfering in the type of delivery, through the formation of myths, beliefs and opinions that reflect on the experience of each pregnancy.[44] All of this demonstrates the psychological fragility to which women are subjected, due to cultural influence and from the perspective of the medical and hospital technology that is experienced in the world.

There is a need for support and psychological support for pregnant women in order to deconstruct the cultural idea that childbirth is just suffering. Women should be shown the existence of non-invasive technologies of Nursing care, which help at the time of delivery so that anxiety, pain and suffering are minimized and childbirth can be a special moment in the woman's life.[9]

## Fear-generating factors related to the choice of cesarean section

In the choices for a cesarean section, the following are observed: fear of vaginal delivery, fear of sexual life changing after vaginal delivery, and fear of pain. One study shows that 80% of the pregnant women in the public sector are afraid of vaginal delivery, 1.5% of change in their sexual life, and 30% fear of pain.[25]

The choice of the cesarean section for fear of the discomfort of vaginal delivery is not justified, since there is discomfort in both methods during delivery and postpartum. Labor pain,

considered to be non-existent, due to the use of analgesics in cesarean section, does not make the pain disappear in the period from prenatal to post-surgery. In fact, this choice is made by the woman's emotional thinking, based on the existing form, idea or belief and also as a result of the care provided.[25] Part of the pregnant women who chose vaginal delivery changed their mind during pregnancy, opting for cesarean section, as they consider it more appropriate, quiet and safe for the baby's birth, due to the possibility of prior appointment of the delivery date.[4]

It is also noticed that the woman underestimates the complications that cesarean surgery can have and her pain in the postoperative period. In this way, they surrender to the hospitalized and medicalized environment, allowing the action of biomedical power on their bodies and the use of invasive practices, often unnecessary. In general, they just talk to the physician about their preference for cesarean section and they already schedule the surgery.[39]

Other reasons for cesarean section indication were the following: having the tubal ligation surgery;[13,22,37] having a sense of security due to the idea of having less complications;[4,19] not feeling pain due to anesthesia;[19] tranquility because it is a scheduled and planned procedure, which leads to the convenience and preparation of this woman for the day;[2,13-14,19,36] existence of a differentiated medical assistance, mainly in the private network;[36] having had a positive experience with cesarean section previously,[16,34] or the reverse, the negative experience with vaginal delivery;[25,35,39] and the influence of family and friends in the choice.[14,37] In addition to these conditions, medical convenience and the lack of qualified professionals. There are several reasons why women choose not to go through the “suffering and pain” of vaginal delivery and choose a cesarean section. However, it is necessary to reflect on where the desire of women ends and the medical hegemony for the performance of cesarean sections begins.[45]

## Inadequate care by the health professionals in prenatal care and childbirth

It was verified that the function of prenatal care is distorted and incomplete since it is considered as a simple consultation. There is lack of guidelines and explanations, and it has been assessed as inadequate. The procedures are limited to assessing uterine height and listening to the baby's heartbeat.[23]

It is necessary for the health sector to allow itself to be open to social changes and to be able to broadly fulfill its role as an educator and health promoter.[46] Pregnant women are the main focus of this learning process. Some reports state that prenatal care would be very helpful if it provided information, use of lectures, psychological preparation for childbirth, educational guidelines, and support to calm the women.[4]

Information about the different experiences must be exchanged between women and health professionals. This possibility of exchanging experiences and knowledge is considered the best way to promote understanding of the pregnancy process.[47] The lack of adequate professional guidance in prenatal care makes room for greater influences from family and friends. These attitudes generate anxiety and fear about the moment of delivery and the baby's health, leaving pregnant women emotionally and physically vulnerable.[36]

The prenatal period is a time of physical and psychological preparation for childbirth and motherhood and, as such, needs to be a time of intense learning and an opportunity for the health team professionals to develop education as a dimension of the care process.[47] In prenatal care, the professional must act as a health educator, seeking to encourage women's autonomy. To this end, changes are needed in the view of the professionals who need to be trained as educators to assist in the development of women's autonomy and in the care program to ensure safe motherhood.[19]

The lack of dialog between the professional and the pregnant woman in the prenatal period shows that the focus of the consultation is on fetal evaluation. The pregnant woman cannot clarify her doubts, fears and beliefs passed on by family members, friends and the media.

In this way, women remain subjected to cultural valuesand medical hegemony, without the right to choose.

Since prenatal care is an adequate space for women to prepare themselves to experience childbirth in a positive, integrating, enriching and happy way, the educational process (health education) is fundamental not only for the acquisition of knowledge about the process of pregnancy and of giving birth, but also for their strengthening as citizens.[48]

At the time of labor, fear of maltreatment, lack of privacy or respect for the body, and low quality of care appeared in the surveys. Some women cited not feeling welcomed by the team, and that there is standardization of assistance to follow hospital rules. They also cited dissatisfaction with the professionals due to limited intercommunication and affection, even causing loneliness. There was also no clarification about what was happening in labor.[4]

The women reported that the team standardized the care provided, performing routines without evaluating the benefits for them, not seeing them individually.[24] Welcoming is fundamental to humanization, since it is based on attitudes from the professionals that the woman, her family and the necessary care will be accepted and may alleviate the fear arising from the entire process. Regarding the professionals, it was expressed that those who used emotional support strategies made them calmer. They therefore considered the assistance of the team to be important during labor.[12]

Listening warmly to the women about pain, their insecurities and their different ways of experiencing and expressing them, is the step to initiate quality and humanized care, which must be carried out and respected by all health professionals.[12] In order to change the way of thinking about prenatal care, at birth or in the puerperium, a change of view is necessary, seeking to respect individuality, the role of women in childbirth, respecting the culture, beliefs and wishes of the pregnant woman. In this way, it is possible to support women and help them achieve empowerment over their bodies and their will, minimizing fears, anxieties and fears.

## Other fear-generating factors

Some women mentioned the fear of motherhood and of not being able to fulfill their role in caring for the newborn. These fears raise the level of anxiety, the fear of the unknown and test their ability as women, what will it be like when they go home?[27]

The media, Internet, and other communication media show the cesarean section as perfect, without risks, with images of the smiling mother with her child. This has a favorable influence on the choice of the cesarean section and, therefore, has a negative impact on female empowerment for a choice for vaginal delivery, mainly because it emphasizes the suffering of women.[39] This strong influence occurs in Western society and is consolidated by the media, reinforcing the symbol of the pain of childbirth and its fear, emphasizing that the cesarean section is safer.[36] The media organizes daily life and the social imaginary, with television being the mass communication vehicle. Thus, it is an instrument capable of incorporating the signs of society, technically reprocessing them, recycling ideologically and spreading the idea of interest.[48] People recognize each other when they are inserted in the environment in which they live, that is, in their culture. In this way, the woman recognizes herself when she enters society by the option of cesarean section, mainly because the media convey the concept of cesarean section as positive and normal delivery as pain and suffering.

Regarding the presence of the companion doing well, helping and reassuring, it was observed in some articles that his absence brought insecurity.[21,25] The primiparous women said that they were calmer and less concerned with support words and gestures such as holding the hand or some type of massage.[21]

Some women cited the benefits of using non-pharmacological strategies to help with labor. What has been noticed is that techniques such as locomotion, sprinkling bath, meditation, companion support and massage reduced fear and anxiety and increased women's satisfaction.[38]

The search for demedicalization encourages spaces that facilitate parturition as a natural moment for women, intuitive and magical. Through humanistic and holistic practices, it is possible to develop physiology and to respect female nature.[9] So what is sought is a different attitude in the relationship between professionals and the woman, with the purpose to explain, demystify beliefs and support her in her decision and at the time of labor. Thus, she can allow herself to make choices about her body, knowing it, respecting its limits and empowering herself in face of the technocratic society.

The present review presented the following as a limitation: the fact that the Boolean operator *AND* was used in the search strategy in all combinations, which prevents the expansion of the location of evidence. This led to the possibility of contemplating only articles with childbirth and fear together. In addition, only the full articles and available free of charge via the Internet were included, considering that some paper may not have been considered.

## Conclusion

From this review, the scientific evidence identifies the factors considered by women as triggering fear in childbirth, such as the culture passed down by family and friends, stories about pain and all the suffering that vaginal birth causes, and that lead them to suffer with anxiety, insecurities and fears, which will aggravate this fear. Many reasons are cited in the different studies analyzed. This shows that they are underestimating their strength and their physiology, since for centuries they have always given birth naturally without the aid of any medicalized procedure.

In the field of Obstetrics, the contribution is to show the challenge of giving back to pregnant women the power over their body and their thoughts, and that they can have a non-traumatic vaginal delivery. It is not feasible to do this for a few hours during labor. It must be stimulated and developed during prenatal care in order to help and alleviate the suffering of pregnant women in relation to their concepts about childbirth and about themselves, in

addition to demystifying the inability to give birth. For the area of scientific research, the contribution is that field studies deepen this theme from the perspective of women, which are fundamental for the scientific advancement of the process of Obstetric Nursing care.

## References

1. Giaxa TEP, Ferreira MLSM. Miedo e inseguridad de la gestante durante el trabajo de parto como motivos para la demanda de internación precoz. Inv Edu Enferm [Internet]. 2011 [acceso 2018 jul 02];29(3):363-70. Disponible en: https://revistas.udea.edu.co/index.php/iee/article/view/6349/9882

2. BRASIL. Ministério da Saúde, Secretaria de Atenção à Saúde. Portaria nº. 306, de 28 de março de 2016. Aprova as diretrizes de atenção à gestante: a operação cesariana. Brasília, DF: Ministério da Saúde, 2016. Disponível em: http://portalarquivos2.saude.gov.br/images/pdf/2016/marco/31/MINUTA-de-Portaria-SAS-Cesariana-03-03-2016.pdf

3. Dib RV, Simas MCF, Silva ACV, Reis CSC, Progianti JM, Vargens OMC. A influência da dor e do medo na escolha da via de parto pelas mulheres. Enferm Obstét [Internet]. 2018 [acesso em 2019 nov 26];5:e131. Disponível em: http://www.enfo.com.br/ojs/index.php/EnfObst/article/view/131

4. Tostes NA, Seidl EMF. Expectativas das gestantes sobre o parto e suas percepções acerca da preparação para o parto. Temas Psicol. 2016;24(2):681-93. doi: http://dx.doi.org/10.9788/TP2016.2-15

5. Costa JF. Sem fraude nem favor: estudos sobre o amor romântico. Rio de Janeiro: Rocco; 1998.

6. Santos LO. O medo contemporâneo: abordando suas diferentes dimensões. Psicol Ciênc Prof [Internet]. 2003 [acesso em 2018 jul 02];23(2):48-55. Disponível em: http://pepsic.bvsalud.org/pdf/pcp/v23n2/v23n2a08.pdf

7. Mezan R. Freud, pensador da cultura. São Paulo: Brasiliense; 1985.

8. Nagahama EEI, Santiago SM. A institucionalização médica do parto no Brasil. Ciênc Saúde Colet. 2005;10(3):651-7. doi: https://doi.org/10.1590/S1413-81232005000300021

9. Progianti JM, Lopes AS, Gomes RCP. A participação da enfermeira no processo de desmedicalização do parto. Rev Enferm UERJ. 2003;11(3):273-7.

10. Mello AL. Fisiologia do parto: como tudo acontece! Grupo Vínculo: apoio voluntário especializado para cuidados com a vida [Internet]. 2016 [acesso em 2018 mar 14]. Disponível em: http://gvinculo.blogspot.com/2016/01/fisiologia-do-parto-como-tudo-acontece.html

11. Duarte SJH, Borges AP, Arruda GL. Ações de enfermagem na educação em saúde no pré-natal: relato

de experiência de um projeto de extensão da Universidade Federal do Mato Grosso. Rev Enferm Cent Oeste Min [Internet]. 2011 [acesso em 2018 jun 24];7(3):277-82. Disponível em: http://seer.ufsj.edu.br/index.php/recom/article/view/13

12. Whittemore R, Knafl K. The Integrative review: update methodology. J Adv Nurs. 2005;52(5):546-53. doi: https://doi.org/10.1111/j.1365-2648.2005.03621.x

13. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Pré-natal e Puerpério: atenção qualificada e humanizada: manual técnico [Internet]. Brasília (DF): Ministério da Saúde; 2005 [acesso em 2019 ago 15]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/manual_pre_natal_puerperio_3ed.pdf

14. Mendes KDS, Silveira RCCP, Galvão CM. Revisão integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. Texto Contexto Enferm [Internet]. 2008 out-dez [acesso em 2019 nov 27];17(4):758-64.. Disponível em: http://www.scielo.br/pdf/tce/v17n4/18.pdf

15. Scarton J, Prates LA, Wilhelm LA, Silva SC, Possati AB, Ilha CB, et al. "No final compensa ver o rostinho dele": vivências de mulheres-primíparas no parto normal. Rev Gaúcha Enferm [Internet]. 2015 [cited 2018 Jul 08];36(Spec No):143-51. Available from: http://www.scielo.br/scielo.php?pid=S1983-14472015000500143&script=sci_abstract&tlng=pt

16. Domingues RMSM, Dias MAB, Nakamura-Pereira M, Torres JA, d'Orsi E, Pereira APE, et al. Processo de decisão pelo tipo de parto no Brasil: da preferência inicial das mulheres à via de parto final. Cad Saúde Pública. 2014;30 Sup:S101-16. doi: http://dx.doi.org/10.1590/0102-311X00105113

17. Silva GPS, Jesus MCP, Merighi MAB, Domingos SRF, Oliveira DM. The experience of women regarding cesarean section from the perspective of social phenomenology. Online Braz J Nurs. 2014 Mar;13(1):5-14. doi: 10.5935/1676-4285.20144214

18. Rodrigues AV, Siqueira AAF. Sobre as dores e temores do parto: dimensões de uma escuta. Rev Bras Saúde Mater Infant. 2008;8(2):179-86. doi: https://doi.org/10.1590/S1519-38292008000200005.

19. Feitosa RMM, Pereira RD, Souza TJCP, Freitas RJM, Cabral SAR, Souza LFF. Fatores que influenciam a escolha do tipo de parto na percepção das puéperas. Rev Pesq Cuid Fundam. 2017;9(3):717-26. doi: https://doi.org/10.1590/S1519-38292008000200005

20. Arnau-Sánchez J, Martínez-Ros MT, Castaño-Molina MA, Nicolás-Vigueras MD, Martínez-Roche ME. Explorando las emociones de la mujer en la atención perinatal. Un estúdio cualitativo. Aquichan. 2016;16(3):370-81. doi: 10.5294/aqui.2016.16.3.8

21. Souza MG, Vieira BDG, Alves VH, Rodrigues DP, Leão DCMR, Sá AMP. A preocupação das mulheres primíparas em relação ao trabalho de parto e parto. Rev Pesq Cuid Fundam. 2015;7(1):1987-2000. doi: 10.9789/2175-5361.2015.v7i1.1987-2000

22. Lagomarsino BS, Van der Sand ICP, Girardon-Perlini NMO, Linck CL, Ressel LB. A cultura mediando preferências pelo tipo de parto: entrelaçamento de fios pessoais, familiares e sociais. REME Rev Min Enferm. 2013;17(3):680-7. doi: http://www.dx.doi.org/10.5935/1415-2762.20130050

23. Pimenta LF, Ressel LB, Stumm KE. The Cultural construction of the birth process. Rev Pesq Cuid Fundam. 2013;5(4):591-8. doi: 10.9789/2175-5361.2013v5n4p591

24. Santos LM, Pereira SSC. Vivências de mulheres sobre a assistência recebida no processo parturitivo. Physis. 2012;22(1):77-97. doi: https://doi.org/10.1590/S0103-73312012000100005

25. Barros MLF. Perception of health professional and women about type of delivery: literature review. Rev Enferm UFPE On Line. 2011;5(2):496-504. doi: https://doi.org/10.5205/reuol.1718-11976-1-LE.05spe201124

26. Damasceno AM, Said FA. O método problematizador no cuidado educativo com mulheres no preparo ao parto. Cogitare Enferm. 2008;13(2):173-83. doi: http://dx.doi.org/10.5380/ce.v13i2.12433

27. López Araque AB, López Medina D, Linares Abad M. Emotional state of primigravid women with pregnancy susceptible to prolongation. Invest Educ Enferm. 2015;33(1):92-101. doi: https://doi.org/10.17533/udea.iee.v33n1a11

28. Matinnia N, Faisal I, Juni MH, Herjar AR. Fears related to pregnancy and childbirth among primigravidae who requested caesarean versus vaginal delivery in Iran. Matern Child Health J. 2014;19(5):1121-30. doi: https://doi.org/10.1007/s10995-014-1610-0

29. Schwartz JTL, Toohill J, Creedy DK, Baird K, Gamble J, Fenwick J. Factors associated with childbirth self-efficacy in Australian childbearing women. BMC Pregnancy Childbirth. 2015;15:29. doi: https://doi.org/10.1186/s12884-015-0465-8

30. Garthus-Niegel S, Soest TV, Vollrath ME, Eberhard-Gran M. The impact of subjective birth experiences on post-traumatic stress symptoms: a longitudinal study. Arch Womens Ment Health. 2013 Feb;16(1):1-10. doi: https://doi.org/10.1007/s00737-012-0301-3

31. Sydsjö G, Angerbjorn L, Palmquist S, Bladh M, Sydsjö A, Josefsson A. Secondary fear of childbirth prolongs the time to subsequent delivery. Acta Obstet Gynecol Scand. 2013 Feb;(92):2:210-4. doi: https://doi.org/10.1111/aogs.12034

32. Adams SS, Eberhard-Gran M, Eskild A. Fear of childbirth and duration of labour: a study of 2206 women with intended vaginal delivery. BJOG. 2012 Sept;119(10):1238-46. doi: https://doi.org/10.1111/j.1471-0528.2012.03433.x

33. Hildingsson I, Nilsson C, Karlström A, Lundgren I. A longitudinal survey of childbirth-related fear and associated factors. J Obstet Gynecol Neonatal Nurs. 2011 Sept;40(5):532-43. doi: https://doi.org/10.1111/j.1552-6909.2011.01274.x

34. Laursen M, Johansen C, Hedegaard M. Fear of childbirth and risk for birth complications in nulliparous women in the Danish National Birth Cohort. BJOG. 2009 Aug;116(10):1350-5. doi: https://doi.org/10.1111/j.1471-0528.2009.02250.x

35. Anderson CA, Gill M. Childbirth related fears and psychological birth trauma in younger and older age adolescents. Appl Nurs Res. 2014 Nov;27(4):242-8. doi: https://doi.org/10.1016/j.apnr.2014.02.008

36. Pereira RR, Franco SC, Baldin N. A dor e o protagonismo da mulher na parturição. Rev Bras Anestesiol. 2011;61(3):376-88. doi: http://dx.doi.org/10.1590/S0034-70942011000300014

37. Dias MAB, Domingues RMSM, Pereira APE, Fonseca SC, Gama SGN, Theme Filha MM, et al. Trajetória das mulheres na definição pelo parto cesáreo: estudo de caso em duas unidades do sistema de saúde suplementar do estado do Rio de Janeiro. Ciênc Saúde Colet. 2008;13(5):1521-34. doi: https://doi.org/10.1590/S1413-81232008000500017

38. Paul JA, Yount SM, Breman RB, LeClair M, Keiran DM, Landry N, et al. use of an early labor lounge to promote admission in active labor. J Midwifery Womens Health. 2017 Mar;62(2):204-9. doi: https://doi.org/10.1111/jmwh.12591

39. Pereira RR, Franco SC, Baldin N. Representações sociais e decisões das gestantes sobre a parturição: protagonismo das mulheres. Saúde Soc. 2011;20(3):579-89. doi: http://dx.doi.org/10.1590/S0104-12902011000300005

40. Souza MT, Silva MD, Carvalho R. Revisão integrativa: o que é e como fazer. Einstein. 2010;8(1):102-6. doi: https://doi.org/10.1590/s1679-45082010rw1134

41. Teixeira NZF, Pereira WR. Parto Hospitalar: experiências de mulheres da periferia de Cuiabá-MT. Rev Bras Enferm. 2006;59(6):740-4. doi: https://doi.org/10.1590/S0034-71672006000600004

42. Tornquist CS. Paradoxos da humanização em uma maternidade no Brasil. Cad Saúde Pública. 2003;2(19 Suppl 2):S419-27. doi: https://doi.org/10.1590/S0102-311X2003000800023

43. Prata JA, Progianti JM. A influência da prática das enfermeiras obstétricas na construção de uma nova demanda social. Rev Enferm UERJ [Internet]. 2013 [cited 2018 Jul 02];21(1):23-8. Available from: https://www.e-publicacoes.uerj.br/index.php/enfermagemuerj/article/view/6341/5894

44. Albuquerque LC, Pereira EEP, Rios CTF, Corrêa RGCF, Frias LMPS. Conhecimento de mulheres sobre o motivo para a realização do parto cesáreo. Rev Hosp Univ UFMA [Internet]. 2007 [acesso em 2018 jul 02];8(2):9-16. Disponível em: http://www2.ebserh.gov.br/documents/16424/491465/Revista_HU_Volume_8_2_AGO_DEZ_2007.pdf/5e7f3562-e037-4d1d-8d97-f4eadd457a07

45. Sgarbi AKG, Espindola PPT, Julio ICF. Estudos comparativos sobre fatores que influenciam a escolha de fazer o tipo de parto pelas gestantes. Interbio [Internet]. 2013 [acesso em 2018 jul 08];7(1):72-

81. Disponível em: https://www.unigran.br/dourados/interbio/paginas/ed_anteriores/index.php?id=artigo&codigo=%2089&cam=vol7_num1

46. Ministério da Saúde (BR), Secretaria de Políticas de Saúde. Assistência ao pré-natal: manual técnico. 3ª ed. Brasília (DF): Ministério da Saúde; 2000. 66 p.

47. Rios CTF, Vieira NFC. Ações educativas no pré-natal: reflexão sobre consulta de enfermagem como um espaço para educação em saúde. Ciênc Saúde Colet. 2007;12(2):477-86. doi: https://doi.org/10.1590/S1413-81232007000200024

48. Muniz Sodré LES, Kosovski E, coordenadores. Mídia e violência urbana. Rio de janeiro: FAPERJ; 1994. 203 p.

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Conception and planning of the research project; data analysis and interpretation, writing, and critical review of the text.

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