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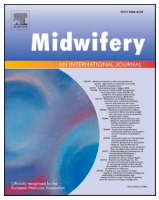

Factors helping pregnant multiparas cope with fear of birth: A qualitative study

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ABSTRACT

Objective: This study describes factors helping pregnant multiparas cope with their fear of birth and aims to contribute insight into measures that could be taken to support and develop care for multiparas with fear of birth.
Methods: Purposive sampling was used for collecting data from closed discussion forums. An electronic questionnaire included structured background questions and qualitative open-ended questions related to the factors multiparas had found helped them cope with their fear of birth. After excluding respondents in early pregnancy ($n = 20$), the data consisted of answers from 78 pregnant multiparas from Finland. The data were analysed using inductive content analysis.
Results: The factors helping pregnant multiparas to cope with their fear of birth included obtaining information, planning ahead, receiving empathic support, dealing with emotions in different ways, and focusing on the positive.
Conclusions: The support multiparas receive for their fear of birth from healthcare providers is insufficient and the quality and content of care varies widely. As a result, multiparas have been left to personally take responsibility for coping with their fear.
Implications for practice: The care for treating fear of birth in multiparas needs to be improved. This requires a critical evaluation of the maternity system, policies, and competence of healthcare professionals who work with pregnant people.

Introduction

Statement of significance
Issue: Fear of birth has increased in the recent years with possible serious consequences on the mother's and family's overall well-being.
What is already known: Clinical trials targeting especially primiparas with FOB have been conducted and found that FOB can be treated effectively with different types of interventions.
What this paper adds: An up-to-date understanding of the single factors that might help pregnant multiparas to cope with their FOB. Findings can be used to improve care for multiparas with FOB.

Almost every pregnant person is nervous about their upcoming birth at some point during their pregnancy. However, some experience fear of birth (FOB) which ranges from minor worries and anxieties to a severe fear of birth, also called tokophobia (O'Connell et al., 2021). In multiparas, a previous negative experience of birth is the main cause for FOB. Multiparas might be afraid of the reoccurrence of a traumatic experience or complicated birth. (Dencker et al., 2019) Fear can overshadow the entire pregnancy by causing distress and affect the mother's mental well-being, affect the method of birth by leading to an avoidance of vaginal birth or lead to postpartum depression and problems in bonding with the baby (Dencker et al., 2019; Reshef et al., 2023).

In recent years fear of birth has increased worldwide (O'Connell et al., 2017). The rate of FOB diagnoses was 1,8% in 2004 and 10,3% in 2018 for Finnish multiparas (Vaajala et al., 2023).

In Finland, antenatal and intrapartum care reaches almost 100 percent of pregnant people and is financed by public funds. Public health nurses are the primary care providers during pregnancy in primary care although they are not trained in intrapartum care. This is unusual compared to other countries practices, where antenatal care is provided

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by midwives (e.g. Henriksen et al., 2020; Hildingsson, Karlström, et al., 2019). Midwifery-led-care for the antenatal period is also recommended by the WHO (WHO, 2016). However, in Finland antenatal midwifery services and routine follow-up appointments for pregnancy can be bought from the private healthcare sector or from self-employed midwives.

In Finland, all pregnant people who need special support, such as those with FOB, are detected in primary care and referred to specialised health care. Pregnant people with FOB are offered counselling by midwives and obstetricians at outpatient fear clinics which are a part of specialised health care (Rouhe and Saisto, 2013). Usually, these appointments take place in the third trimester of pregnancy and only single visits are offered. In Sweden and Norway, where treatment for FOB is provided similarly, counselling has been shown to have only minor effects in reducing FOB (Henriksen et al., 2020; Larsson et al., 2015). There are no studies from Finland on the effects of counselling on FOB.

Several large-scale clinical trials concerning FOB have been conducted during the past decade. However, in most of this research standardised questionnaires and psychometric scales have been used for data collection and the emphasis has been on treating primiparas with FOB. (O'Connell et al., 2021) Also, qualitative studies on FOB have been conducted, but pregnant multiparas' point-of-view has been more random, and study findings are possibly out-dated (Eriksson et al., 2006; Haapio et al., 2013; Melender, 2002).

Nonetheless, FOB has increased in recent years and changes in society and healthcare might impact fear and the help that pregnant people need. Hence, an updated study is needed to better understand the fear of multiparas. Thus, the purpose of this study was to describe factors helping pregnant multiparas cope with their fear of birth. The findings of this study could help in developing treatment and overall care during pregnancy and birth for multiparas with FOB.

Methods

This is a qualitative study with a descriptive design. Critical realism served as the guiding theory (Bergin et al., 2008). Purposive sampling was used in the data collection. The invitation to participate in the study, after obtaining permission from the administrators, was posted by the first author (LS) to three Facebook groups and one discussion forum. The groups and discussion forum were selected on the basis that their members were known to be pregnant people. The invitations described the purpose of the study, the voluntary nature of participation, the confidentiality of reporting, and inclusion criteria: pregnant at the time of the study, multiparous, Finnish-speaking, over 18 years of age, and a personal experience of FOB (meaning it was not necessary to have a formal diagnosis of FOB). At the end of the invitation there was a link from which the participants could get hold of the online questionnaire. Participants submitted their answers by pressing the submit-button at the end of the questionnaire.

The questionnaire used in the data collection was developed by the research team by going through previous research questionnaires related to FOB. The questionnaire was pilot tested on five women (data not included in the analysis) and minor revisions were made based on the feedback. The questionnaire included background variables (Tables 1 and 2) and open-ended questions relating to factors helping cope with FOB (e.g., "Please describe what kind of personal means you have employed to alleviate your fear of birth" and "Please describe what has helped you with your fear of birth"). Responses were collected from February to June 2020. The study was conducted in Finland.

In total, 98 pregnant multiparas with FOB participated voluntarily in the study. 20 participants were excluded from the analysis, because they were so early in pregnancy (under 16 gestational weeks) that they did not have enough experience of support from maternity care in this pregnancy. Thus, the data for this study consists of 78 pregnant multiparas' answers. Weeks of pregnancy ranged from 16 to 40 weeks, with a mean of 30 weeks. On a scale of mild, moderate, and high almost 70 % assessed that their fear was high. (Table 1) Two fifths considered support received from the public health nurse insufficient. Also, two fifths of those who had visited the fear clinic considered the visit useless. Support from the spouse was important to the multiparas; close to two thirds of participants perceived their spouse's role as considerable. (Table 2)

Table 1
Participants' ($n = 78$) background variables and obstetric information

Variable	n	%
Age		
20–27	21	27,0
28–34	42	53,8
35–40	15	19,2
Level of education		
No vocational education	7	9,0
Vocational school	35	44,9
Polytechnic education	15	19,2
University education	21	26,9
Employment situation		
Employed (full-time or half-time)	28	35,9
On sick leave	2	2,6
On maternity leave	29	37,2
Student	12	15,4
Other	7	8,9
Family situation		
Married	39	50,0
Cohabiting	38	48,7
Single	1	1,3
Psychological health (self-rated)		
Poor	2	2,6
Satisfactory	12	15,4
Good	64	82,0
Diagnosed mental health issue		
Yes	20	25,6
No	58	74,4
Weeks of pregnancy at time of inquiry		
16–21 weeks	11	14,1
22–30 weeks	31	39,7
31–40 weeks	36	46,2
Number of previous births		
1	58	74,4
2	12	15,4
3–5	8	10,2
Time since last birth		
< 1 year	3	3,8
1 –3 years	41	52,6
3 – 5 years	16	20,5
> 5 years	18	23,1
Fear of birth		
Mild	3	3,9
Moderate	21	26,9
High	54	69,2

Table 2
Treatment and support for FOB that the participants ($n = 78$) received

Variable	n	%
Support received from public health nurse		
Insufficient	33	42,3
Sufficient	45	57,7
Visit to fear clinic		
No	32	41,0
Yes	46	59,0
Usefulness of appointment at a fear clinic (if applies)		
Useless	16	44,4
Helpful	20	55,6
Role of support from spouse		
Minor	11	14,1
Moderate	17	21,8
Considerable	50	64,1

Data analysis

Inductive content analysis was selected as it has been found to be

extremely well-suited to analysing data on multifaceted, sensitive phenomena, such as FOB. The content analysis phases of preparation, organisation and reporting were followed (Elo and Kyngäs, 2008). In the preparation phase the units of analysis selected were the answers to the open-ended questions that focused on factors that helped coping with FOB. These answers were then read through to get a sense of the data to be coded. The organisation phase followed the process of open coding, categorization, and abstraction. The answers were manually coded into initial categories, which were sorted through grouping into subcategories and further into categories. Categories were named using content-characteristic words. As a result, this process formed a concise description of the factors that help pregnant multiparas cope with their fear of birth. An example of the analysis process is shown in Table 3.

To identify and minimise the effect of researcher bias, self-reflexivity was carried throughout the research process (Alvesson and Sköldberg, 2018). The first author (LS), who performed the analysis, with the other authors providing comments at each stage, is a midwife, who has experience in treating people with FOB. To recognise this position as an insider, which inevitably influenced the interpretation of the multiparas' answers, a research diary was maintained to journal the researcher's thoughts and feelings. The diary notes informed the analysis through reflection and discussion with the research team.

Ethical considerations

The study was carried out according to the ethical principles of the Helsinki Declaration (WMA – The World Medical Association, 2013). Participation in the study was voluntary. Answering the questionnaire and sending it by pressing the answer button served as informed consent to participate (Holloway, 2017). The autonomy, privacy and data protection of the research participants were considered at all stages of the research (TENK, 2019). Ethical approval from the Ethics committee was not required for this research according to the Finnish National Board on Research Integrity (TENK, 2019) and Finnish law (1999/488). The academic ethics committee of Tampere region provided a letter confirming that they do not normally provide ethical approval for studies such as in question. The research plan was approved by Tampere University.

Results

Factors that helped pregnant multiparas cope with fear of birth were **obtaining information, planning ahead, receiving empathic support, dealing with emotions in different ways, and focusing on the positive**. (Table 4)

Obtaining information

One factor that helped multiparas cope with fear was **obtaining information**, including ***obtaining information about birth-related interventions, learning about vaginal birth, and obtaining information from imaging examinations.*** It also included ***exploring pain relief options, understanding one's needs, and clarifying previous events.***

Table 3
Description of the analysis

Example of original quotes	Reduced quote	Sub-category
"The previous childbirth went pretty ok, so thinking about the good things related to that."	Remembering good things from a previous birth	Reminiscing on good experiences from previous childbirths
"In my case, recovery from caesareans has always been quick."	Experience of rapid recovery after c-section	
"One of my miscarriages also turned out to be a corrective childbirth experience: I got to feel how normal labour pain feels and how well I can cope with it."	Undergoing a miscarriage as a healing birthing experience	
	Experiencing normal labour pains during miscarriage	
	Coping well with pain during miscarriage	

Table 4
Factors helping pregnant multiparas ($n = 78$) cope with fear of birth

Upper category	Sub-category
Obtaining information	Obtaining information about birth-related interventions
	Learning about vaginal birth
	Obtaining information from imaging examinations
	Exploring pain relief options
	Understanding one's needs
	Clarifying previous events
Planning ahead	Preparing for possible complications during pregnancy
	Preparing to cope with pain
	Preparing for possible complications during childbirth
	Planning the place of birth
	Preparing for postpartum recovery
Receiving empathic support	Getting tangible support from a loved one
	Getting complex peer support
	Respect for the multipara's choices
	Recognition of fear
Dealing with emotions in different ways	Accepting emotions
	Relaxing the mind
	Facing fears
	Avoiding unpleasant emotions
	Reasoning
Focusing on the positive	Creating hope for a successful birth
	Reminiscing on good experiences from previous childbirths
	Being aware of the temporary nature of pregnancy
	Thinking about the baby

Obtaining information about birth-related interventions included getting familiar with the caesarian section (CS) as a method of birth and understanding the facts and risks related to it. Different options for inducing birth and the best time for induction were also discussed at the maternity hospital.

Learning about vaginal birth included studying the physiology and course of birth, listening to audiobooks related to birth, and obtaining information and guidance from the midwife at the outpatient clinic about the normal course of birth. Furthermore, it included learning independently about possible complications, risks and the possible situations that may arise during birth. In addition, it included hearing about vaginal births from doctors based on their own professional experiences.

"I've tried to find out about things and familiarize myself with the complications that occur during childbirth, etc. better." (Respondent pregnant with third child at 27 weeks)

Obtaining information from imaging examinations included obtaining information on the baby's size with ultrasound imaging. It also included knowing the baby's position and possible breech presentation well in advance before birth as well as obtaining the results of the magnetic resonance imaging of the pelvic dimensions. In addition, it included having an additional accurate ultrasound examination done by a doctor at a private clinic, because the multiparas' worries in primary care had not been taken seriously.

Exploring pain relief options included gathering information about pain relief methods to use at home before leaving to the hospital and reading about different relaxation exercises. In addition, it included reading about medical pain relief methods and discussing the topic of pain relief with a familiar private midwife who was hired during pregnancy.

Understanding one's needs included searching, considering, and understanding what one wanted from a good birthing experience. This also included determining one's preferred mode of childbirth.

Clarifying previous events included discussing previous birth experiences with a midwife, public health nurse, psychiatric nurse or doctor. In addition, it included processing events independently. Clarifying the events that had occurred during the previous birth, and understanding what had happened and why, helped multiparas deal with fear. It also included talking about the complications that had occurred in the previous pregnancy and the factors that influenced these with healthcare professionals.

"I have also looked into the complications of my first pregnancy, and the factors affecting them."(Respondent pregnant with third child at 16 weeks)

Planning ahead

Another factor that multiparas felt helped them cope was **planning ahead.** It included ***preparing for possible complications during pregnancy, to cope with pain, and possible complications during childbirth.*** Furthermore, it included ***planning the place of birth*** and ***preparing for postpartum recovery.***

Preparing for possible complications during pregnancy included making a plan on tests and follow-ups for pregnancy and even before trying to get pregnant. This meant planning additional ultrasounds, and visits to the maternity hospital to talk to the obstetrician. Furthermore, it included switching to private care because the multiparas felt that private clinics offered more frequent follow-up appointments and that their personnel had a lower threshold for writing referrals to a hospital compared to public antenatal clinics.

Preparing to cope with pain included considering alternatives for pain medication. Respondents had written down their wishes for pain relief to give to their midwife when arriving at the hospital to give birth. Furthermore, this category included different intrapartum relaxation methods, such as mental exercises on controlling pain, which the multiparas had learned at private hypnobirthing classes. For some, it also involved planning the use of relaxation methods such as taking a bath or a shower, or a TENS device during childbirth. Some had also rented a TENS machine for the upcoming labour.

Preparing for possible complications during childbirth included preparing for problems related to a long distance to the hospital, problems associated with previous precipitous births, and for the possibility to get pain relief for the first time by inducing the birth. Furthermore, it included getting a request for CS approved in the early stages of pregnancy or even before getting pregnant, and preferably in writing. This way the multiparas did not have to fear for the baby's life or health, and avoided a new traumatic birthing experience or being left alone in the birthing room like during a previous labour.

"In fact, I will refuse any medication and even die there in the hospital unless I get a caesarean section. That's actually the only thing I'm sure of. I am not going to give birth vaginally."(Respondent pregnant with second child at 30 weeks)

Planning the place of birth included planning to give birth in a familiar hospital, and visiting the hospital facilities beforehand. It also included planning a homebirth or giving birth in a different hospital than during the previous birth.

Preparing for postpartum recovery included making detailed plans to request certain blood tests and iron infusions, in case that the multipara would experience severe dizziness after birth as it had previously happened. For those who were expecting a caesarean birth, preparing for the postpartum period also involved planning the everyday life with the baby in advance, so that it would run as smoothly as possible. Recovery was also promoted by practical actions, such as hiring a cleaner for the postpartum period to avoid having to take care of the home after surgery.

Receiving empathic support

The multiparas reported experiences of **receiving empathic support,** including ***getting tangible support from a loved one, getting complex peer support, respect for the multipara's choices, and recognition of fear,*** as a factor that promoted their coping with fear.

Getting tangible support from a loved one included receiving various forms of support from the spouse. A supportive spouse took responsibility for everyday routines during a difficult pregnancy, but also promised to be actively involved after birth in taking care of the baby in everyday life, for example by feeding and bathing the baby. Multiparas also reported that their fear was alleviated by the knowledge that their spouse was going to support them during the upcoming birth, having the spouse at their side, encouraging them and coping with the situation together.

Getting complex peer support included peer support from other pregnant multiparas in closed online groups who were set to give birth in the same month. In addition, it included sharing experiences with friends who had given birth, talking to friends who also struggled with FOB, and siblings, mothers, and grandmothers sharing their own experiences of birth and fear. Furthermore, it included receiving peer support from people who had experienced stillbirth or traumatic childbirth.

Respect for the multipara's choices included not being pressured or forced to give birth vaginally. This also included discussing the upcoming CS in a positive and non-judgemental manner at the antenatal clinic and a doctor who accepted the multipara's choice to have a CS without reservations. Furthermore, it included spousal support as well as the approval from a psychologist and relatives for the decision to have a CS. Meanwhile, for multiparas who wished to give birth vaginally, gaining respect included the doctor not pressuring them to have a CS, but remaining discrete in only mentioning the possibility of a CS.

"None of those close to me have judged me for having a c-section." (Respondent pregnant with second child at 39 weeks)

Recognition of fear included the spouse's understanding of all the different stages of dealing with fear. In addition, it included a psychologist's understanding of the traumatic birth that the multiparas had gone through and not ignoring this. It also included extra visits to the antenatal clinic to avoid excessive anxiety and prevent the fear from getting worse, and receiving several referrals to the fear clinic both in early pregnancy but also later in pregnancy. Furthermore, it included getting an official diagnosis for fear from a doctor at the maternity hospital. However, not all the multiparas had received help from public healthcare, which had led them to switch to a private antenatal clinic in an effort to receive empathic treatment and recognition of the trauma caused by previous childbirth.

"At a private clinic, I am treated empathetically – I am not humiliated, and caregivers do not contradict my trauma caused by my previous birth or tell me that my experiences are wrong because we are both still alive." (Respondent pregnant with second child at 16 weeks)

Dealing with emotions in different ways

The multiparas reported **dealing with their emotions in different ways,** including ***accepting emotions, relaxing the mind, facing fears, avoiding unpleasant emotions,*** and ***reasoning***, as a factor that helped them cope with fear.

Accepting emotions included examining what one was feeling, structuring the emotions, processing them in writing, and finally trying to name them. It also included expressing emotions. Multiparas reported that they allowed themselves to cry and rage when they felt like it, and this had helped them cope with their fear.

"I have not denied myself of feeling any emotions but I have tried to name them." (Respondent pregnant with second child at 37 weeks)

Relaxing the mind included doing yoga, especially yin yoga, as well as meditation and self-compassion exercises. It also included doing breathing and relaxation exercises which multiparas had learned in

private childbirth classes.

Facing fears included processing one's fears, and considering and dealing with the causes of fear together with healthcare professionals. In addition, it included telling one's spouse about emotions related to fear. For some multiparas, it involved attending EDMR therapy sessions and a trauma workshop that allowed them to process previous childbirth-related trauma.

Avoiding unpleasant emotions included pushing the future birth out of one's mind or denying it altogether. It also included staying active by focusing on other things, such as painting or renovating, so that there would be no time to think about the upcoming childbirth. For some, this had also included intentionally missing antenatal clinic and doctor's appointments.

"I prefer to stay active even though I'm tired. - - I don't have time to think about it (upcoming birth) while I'm painting the walls." (Respondent pregnant with third child at 39 weeks)

Reasoning included hearing about others' experiences of difficult births which had brought perspective to the multiparas' own thinking and made them rationalise their fears as unfounded as they had not experienced such traumatic events. Some of the multiparas were healthcare professionals which helped them adopt a professional attitude towards birth and fear. It also included coming to terms with one's own, and the child's, mortality.

Focusing on the positive

A factor that multiparas found to alleviate their fears was **focusing on the positive.** This included ***creating hope for a successful birth, reminiscing on good experiences from previous childbirths, being aware of the temporary nature of pregnancy,*** and ***thinking about the baby.***

Creating hope for a successful birth included believing that this birth will progress faster and that it will be easier than the previous one. In addition, it included a belief in getting to the hospital faster this time, which would also result in getting pain relief earlier than previously. Furthermore, it included relying on words of comfort from others related to easier childbirth, such as an encouraging spouse building the multipara's confidence in that the birth would go better than the last time.

"The fact that the second birth is often faster than the first and you already know at least a little about what to expect." (Respondent pregnant with second child at 35 weeks)

Reminiscing on good experiences from previous childbirths included thinking about the good things about previous births, such as births that had progressed like in textbooks, but also previous miscarriages that had turned out to be good and healing birthing experiences. In the latter example, the participant had experienced normal labour pain for the first time during the miscarriage and had coped well with the pain, which was perceived as a helping factor. In addition to vaginal births, some respondents had good previous experiences of CS.

Being aware of the temporary nature of pregnancy included knowing the exact date when the birth would be induced or when the CS would be performed. Some multiparas focused on their due date and told themselves that it would put an end to their fear and anxiety, which in turn helped them cope. Some were also helped by the knowledge that this was going to be their final pregnancy and childbirth.

Thinking about the baby included awareness of the pregnancy leading to having a baby and the comfort of thinking about a healthy baby. Feeling love for the unborn child also helped the multiparas with their fear.

"Also, knowing that giving birth leads to having a baby helps."(Respondent pregnant with second child at 30 weeks)

Discussion

The findings of this study indicate that multiparas have several different types of factors that help them cope with FOB. Healthcare professionals in maternity care are in a pivotal role in supporting multiparas. However, in all cases support from professionals is not sufficient or it is of the wrong kind for the individual. Hence, some multiparas take matters in their own hands to ease their distress or seek help from the private sector, friends, and family.

Previous studies have found that obtaining knowledge plays an important role for primiparas with FOB (Eriksson et al., 2006; Larsson et al., 2019; Melender, 2002). The findings of this study also confirm the importance of information for multiparas. It cannot be assumed that multiparas have appropriate information about giving birth even though they have a previous experience of giving birth. It may even be that they have incorrect information coloured by a previous unprocessed and negative birthing experience. In this study, the participants noted that they could not entirely rely on getting the information they needed from the antenatal clinics. Public health nurses may find it challenging to provide information concerning birth, as they are not trained in intrapartum care. This results in pregnant multiparas with FOB having to rely on appointments at a fear clinic where they can meet a midwife. However, a single appointment at a fear clinic is seldom enough because the multiparas' needs vary during pregnancy.

When the provision of information was inadequate, the multiparas were left to seek information on their own. This is problematic in many ways. Firstly, the accuracy of the information cannot be verified. Secondly, it is necessary to offer pregnant people an opportunity to speak about information with a healthcare professional to put it into context. Lastly, the wrong type of information might increase fear instead of helping to cope with it. The provision of information about birth should be a fundamental part of maternity care. Thus, multiparas need to be provided with correct information concerning birth, different possibilities, risks and benefits, all throughout their pregnancy and according to their individual needs, and preferably by known midwives as noted in previous studies (Hildingsson, et al., 2019a, 2019b).

The findings of this study highlight the significance of previous poor birthing experiences, and how these affect the ongoing pregnancy, the objects of fear, and the factors that multiparas use to cope with their fears. Multiparas were ready to go to extreme lengths in trying to control anything they could, including collecting information about birth and making meticulous plans, to avoid the reoccurrence of the previous negative events. This is logical because FOB among multiparas is often based on previous poor birth experiences and a worry that these may recur (Størksen et al., 2013). But not only poor birthing experiences affected the multiparas, but also more generally poor experiences with healthcare professionals which included not taking the multiparas' expectations seriously or their previous experiences of being neglected, being perceived as excessively demanding. This resulted in switching to a private antenatal clinic or not going to antenatal appointments at all. Previous studies have not identified these methods of coping with fear. However, in a Swedish study, fearful pregnant women had similar negative experiences of the attitudes of healthcare professionals (Eriksson et al., 2006). It is of utmost importance that healthcare professionals who meet pregnant people convey an empathic approach to their experiences and feelings. Healthcare professionals need to be offered further education and training on how to encounter and support pregnant people with FOB. It is also important to study professionals' experiences of caring for people with FOB to better understand professionals' points of view and possible barriers to good care.

An interesting finding was that some multiparas tried to distract themselves from their fear. Some were in complete denial of the upcoming birth and their related fear. Others focused on positive things. The study by Eriksson et al. (2006), showed both an evading approach to coping with the fear of birth and women processing their fears by applying positive thinking. In this study, however, attempts to have an optimistic outlook even when this may not have been fully realistic were not only found among the pregnant people themselves but also in their friends, family, and healthcare professionals. Denying fear might be a symptom of traumatic stress (Söderquist et al., 2004). Alternatively, it

might be a way to cope with fear when the care that is offered is not appropriate. Pregnant people who distance themselves from their thoughts associated with fear are probably difficult to detect in healthcare. Consequently, they are left without support. It is essential to adopt a routine screening tool for FOB in antenatal care to help find all the pregnant people who need additional support during pregnancy. The Fear of Birth Scale (FOBS) (Haines et al., 2011) is a relatively easy and short tool to assess fear and could be easily applied. In addition, if fear is detected, it is important to offer appropriate treatment preferably at an early stage of pregnancy, throughout pregnancy, and possibly even before trying to get pregnant.

To conclude, in addition to multiparas finding their own ways of coping or getting help from healthcare professionals, the findings of this study show that spouses played an important role in participants' coping with fear. A previous study found that inadequate spousal support increases the risk of fear (Marcelina et al., 2019). Thus, it is highly important to pay attention also to the coping of the spouses to avoid spousal fatigue caused by bearing the burden of their loved one's fear. In addition, it is important to ask about social support networks in early pregnancy and provide pregnant people expecting a child on their own with extra support if they do not have close relatives or friends to rely on.

Strengths and limitations

Trustworthiness in a qualitative study is based on credibility, dependability, conformability, and transferability (Lincoln and Guba, 1985). Credibility was demonstrated by the heterogeneity of the groups regarding sociodemographic variables, and by not dismissing anybody from the study due to a lack of a formal diagnosis of FOB. However, the closed discussion groups from which participants were recruited represent a certain kind of a sample because some groups have a specific view on pregnancy and birth, e.g., organic birth or CS on demand. Also, the participants of this study were in different stages of pregnancy which might influence the factors helping them cope with fear. Dependability was strengthened by describing the research process clearly. An example (Table 3) is provided so that the reader can assess the progress of the analysis process. Conformability refers to objectivity, which was enhanced by presenting illustrative and clarifying original quotes to show a connection between data and findings. To enable readers to assess the transferability of the findings, clear descriptions of the selection and characteristics of the participants were presented. Written answers to the open-ended questions varied in length but were generally quite compact. Thus, regarding sample size and saturation, a fairly large number of participants were recruited for data saturation to be reached and to ensure that the phenomenon would be described in versatile ways. Lastly, the utilization of SRQR standards (O'Brien et al., 2014) in reporting improves the transparency of this study.

Conclusions

This study shows that obtaining information, making plans, and in general, playing an active role in one's care is essential for multiparas with FOB. Also, being able to rely on the support of others in dealing with feelings helped with coping. Unfortunately, many of the participants in this study found the support of healthcare providers insufficient.

It would be highly valuable to prepare a national guideline on FOB, to ensure that the treatment of pregnant people with FOB is evidence-based and equal. The guideline would involve the use of a screening tool for FOB, include different types of interventions based on the best available evidence, and it would also take a stand on healthcare professionals' care responsibilities.

Preparing such a guideline would require a critical examination of the maternity health system, related policies and the competence and roles of the healthcare professionals who work with pregnant people. Collaboration between primary and specialized care should particularly be explored. Moreover, the role of midwives in maternity care will have to be addressed. Further research is also needed. It is important to develop, evaluate and implement interventions tailored for multiparas with FOB.

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None to declare.

Ethical Approval

An Ethical Statement was not applicable in this study. Ethical approval from the Ethics committee was not required for this research according to the Finnish National Board on Research Integrity (TENK 2019) and Finnish law (1999/488). The academic ethics committee of Tampere region provided a letter saying that they do not normally provide ethical approval for studies such as in question. The research plan was approved by Tampere University.

CRediT authorship contribution statement

Laura Sandström: Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing, Visualization. **Marja Kaunonen:** Validation, Writing – review & editing, Supervision. **Reija Klemetti:** Writing – review & editing. **Eija Raussi-Lehto:** Validation, Writing – review & editing. **Anna Liisa Aho:** Conceptualization, Methodology, Validation, Investigation, Writing – review & editing, Visualization, Supervision.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2023.103803.

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