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Research Article / Araştırma Makalesi

Effect of Supportive Midwifery Care in Primiparous on Post-Traumatic Stress Disorder and Fear of Childbirth in Labour*

Travayda Primiparlara Verilen Ebelik Desteğinin Doğum Sonu Posttravmatik Stres Bozukluğu ve Doğum Korkusuna Etkisi*

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ABSTRACT

Introduction: This study was conducted to determine the effect of supportive midwifery care in primiparous on posttraumatic stress disorder and fear of childbirth in labour.
Methods: The study was conducted in the delivery room of a maternity hospital in eastern Turkey. The data were collected between January and November 2018. This study is a quasi-experimental study, in which pregnant women were sampled from the relevant population using the non-probability random sampling method. The sample consisted of 164 women, including 82 in the experimental group and 82 in the control group. The women in both groups were asked to complete a personal information form and the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) Version A. Those in the experimental group received midwifery support during labour. The women in both groups were then given the Wijma Delivery Expectancy/Experience Questionnaire Version B and the Impact of Event Scale-Revised 6–8 hours after childbirth.
Results: The mean prenatal W-DEQ version A score was 47.15±19.68 in the experimental group and 63.23±23.10 in the control group. There was a significant difference in mean scores between the groups ($p<0.001$). The experimental group had a mean postpartum W-DEQ B version score of 37.20±23.50, whereas and the control group had 62.38±27.04 indicating a statistically significant difference between the groups ($p<0.001$). The experimental group had a mean score of 12.09±12.67 on the postpartum event scale, while the control group had a mean score of 18.30±11.96 the difference was statistically significant ($p=0.001$).
Conclusion: Supportive midwifery care during delivery found to lower anxiety of childbirth and the symptoms of posttraumatic stress disorder.

Keywords: Fear of childbirth, Post-traumatic stress disorder, Midwifery, Midwifery support

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ÖZET

Giriş: Bu çalışma, travayda primiparlara verilen ebelik desteğinin doğum sonu posttravmatik stres bozukluğu ve doğum korkusuna etkisini belirlemek amacıyla yapıldı.
Yöntem: Bu çalışma Türkiye'nin doğusunda bir doğum hastanesinin doğumhanesinde gerçekleştirildi. Veriler, Ocak-Kasım 2018 tarihleri arasında toplandı. Bu çalışma yarı deneysel bir çalışma olup gebeler ilgili evrenden olasılıksız rastlantısal örnekleme yöntemi ile örnekleme alındı. Örneklemi, deney grubunda 82, kontrol grubunda 82 olmak üzere 164 gebe oluşturdu. Her iki gruptaki gebelere, kişisel bilgi formu ve Wijma Doğum Beklentisi/Deneyimi Ölçeği A Versiyonu uygulandı. Deney grubuna travay boyunca ebelik desteği verildi. Her iki grupta yer alan gebelere doğumdan 6-8 saat sonra Wijma Doğum Beklentisi/Deneyimi Ölçeği B Versiyonu ve Olayların Etkisi Ölçeği uygulandı.
Bulgular: Doğum öncesi W-DEQ A versiyonu puan ortalaması deney grubunda 47.15±19.68, kontrol grubunda 63.23±23.10 olup, gruplar arasında puan ortalamaları yönünden fark bulundu ($p<0.001$). Doğum sonu W-DEQ B versiyonu puan ortalaması deney grubunda 37.20±23.50, kontrol grubunda 62.38±27.04 olup gruplar arasında puan ortalamaları yönünden istatistiksel olarak önemli fark olduğu belirlendi ($p<0.001$). Doğum sonu olayların etkisi ölçeği puan ortalaması deney grubunda 12.09±12.67, kontrol grubunda 18.30±11.96 olup puan ortalamaları yönünden istatistiksel olarak önemli fark olduğu belirlendi ($p=0.001$).
Sonuç: Travayda verilen ebelik desteğinin, doğum korkusunu ve posttravmatik stres bozukluğunu azalttığı belirlendi.

Anahtar Kelimeler: Doğum korkusu, Travma sonrası stres bozukluğu, Ebelik, Ebelik desteği

1. Introduction

Labour is an important period in women's lives, but it is also a great source of stress for them (Hildingsson & Rubertsson, 2021). Fear of childbirth can range from mild anxiety and fear to severe fear (Dencker et al., 2019; Nilson et al., 2018). Women who are terrified of childbirth lack confidence in labour, are affected by negative birth stories, are afraid of labour pain, lose control during labour, and are afraid of physical injuries during childbirth (Sheen & Slade, 2018; Wigert et al., 2020). Women who give birth again after a negative delivery experience are often afraid of having another unpleasant birth experience. Even though it is natural for them to have concerns or fears about the impending birth, some women have a severe fear response to childbirth. The prevalence of severe fear of childbirth among pregnant women ranges from 3.6% to 22.9% (Nilson et al., 2018). For this reason, studies on this subject have found that 3%–7% of people are clinically diagnosed with fear of birth and have extreme fear, that prevents them from performing their daily life activities (Lukasse et al., 2014; Toohill et al., 2014). According to one research conducted in six European countries, the prevalence of severe fear of childbirth among women was 11.0%, which is higher in primipara (11.4%) than multipara mothers (11.0%) (Lukasse et al., 2014).

Fear of childbirth during pregnancy can lead to a negative birth experience and some mental health issues (Dencker et al., 2019), as well as posttraumatic stress disorder (PTSD) symptoms in the postpartum period (Çapik & Durmaz, 2018). PTSD symptoms are an anxiety condition that can develop after being exposed to a traumatic experience. The typical symptoms include recurring nightmares about the traumatic event, difficulties sleeping, and feeling of isolated, estrangement, and alienation (Dikmen Yıldız, 2018). In a study, it has reported that the fear of childbirth accounts for 3% of the total variation in posttraumatic stress (Çapik & Durmaz, 2018). However, the experience of delivery is not the sole factor that predicts postpartum PTSD symptoms. Previous experiences and a lack of perceived supportive midwifery care during birth may also contribute PTSD symptoms (Peeler et al., 2018; Taheri et al., 2018).

Midwives have important responsibilities in preparing pregnant women for labour by reducing their fears and anxiety, allowing them to have a positive delivery experience (Uçar & Gölbaşı, 2019). Every woman needs someone to assist her in childbirth. Midwifery care can alleviate childbirth-related fear, anxiety, and stress (Hindingsson et al., 2018). Midwives play a crucial role in the delivery team since they accompany women during the whole labour. Supportive care is a thorough approach that begins when the pregnant woman enters the delivery room and continues throughout the entire delivery process. (Lunda et al., 2018). In particular, breathing techniques, sacral massage, listening to music, and distraction can all be useful in reducing labour pain (Hindingsson et al., 2018, Thomson et al., 2019). Furthermore, information is an important component of supportive midwifery interventions (Hindingsson et al., 2018). By providing supportive care throughout labour, midwife can help women have a comfortable and healthy birth with less intervention, as well as contribute to the development of mother and infant health (Karaçam & Akyüz, 2011). Supportive midwifery care is underestimated and neglected by Turkish healthcare professionals. Thus, the purpose of this study was to determine how midwifery care for primiparous women affected PTSD symptoms and fear of childbirth following childbirth.

2. Methods

2.1. Study Design and Participants

This study is a semi-experimental study that compares primiparous who received midwifery support (experimental group) and those who received routine interventions (control group) during labour. The participants were pregnant women who had been referred to the delivery room of a maternity hospital in the Eastern Anatolian region of Turkey. This hospital handles the great majority of vaginal births in the province (about 2,000 deliveries annually). The hospital has a prenatal education class given by midwives, who inform pregnant women about childbirth (e.g., birth process, breathing exercises) throughout the prenatal period. However, the participation of pregnant in these training sessions is limited. Aside from routine childbirth interventions (e.g., fetal monitoring, vaginal examination), supportive care by midwives (e.g., massage, breathing exercises, imagination) provided to pregnant women in labour is limited. The quality and type of care depend on healthcare professionals. Deliveries are performed by midwives and obstetricians.

A power analysis was performed to calculate the sample size. The primary outcome was the total fear of childbirth scores following childbirth. The sample size was calculated as 164 (82 in the experimental group and 82 in the control group), assuming 5% margin of error and a drop in the mean score of childbirth fear from 46.8 at the start (Gökçe İsbir et al., 2016) to 35.8 after the intervention. The pregnant women were sampled using the improbable random sampling method. Data from the experimental

and control groups were collected at different times to avoid them from affecting one another.

Inclusion criteria for the study: Having a cervical opening of 1–5 cm in the hospital application, being in term and having a single pregnancy.

The exclusion criteria from the study: Having a communication problem, having a risky pregnancy that will prevent vaginal birth (e.g., preeclampsia, diabetes, placenta previa), having known major health issues (e.g., anomaly) in the fetus, pregnant who developed medical indications for caesarean delivery after being included.

In this study, 112 pregnant women were recruited for the experimental group, but 30 of them developed medical indications for caesarean delivery; 109 pregnant women were recruited for the control group, however 27 of them developed medical indications for caesarean delivery. Thus, the study concluded with 82 experimental and 82 control groups. There were no pregnant participants who wanted to leave the study. The sample size was completed by applying all stages to each pregnant woman in the experimental and control groups.

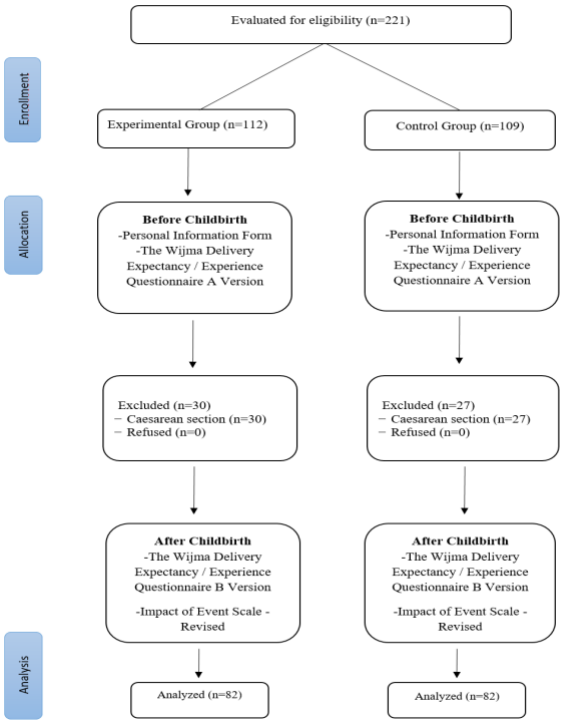

Figure 1. Allocation of participants according to the CONSORT 2010 flow diagram

2.2. Data Collection Instruments

The personal information form,the Wijma Delivery Expectancy/Experience Questionnaire Version A (WDEQ-A), Wijma Delivery Expectancy/Experience Questionnaire Version B (WDEQ-B) and the Impact of Event Scale-Revised (IES-R) were administered.

Personal information form: The questionnaire, which was prepared by the researcher in accordance with the literature, consists of questions regarding pregnant women's sociodemographic characteristics (such as age, education level, income level, employment status, family type and birthing education).

Wijma Delivery Expectancy/Experience Questionnaire: A version fear of childbirth was measured using the WDEQ developed by Wijma, Wijma and Zar (1998). The Turkish validity and reliability study was conducted by Korukçu et al. (2012). W-DEQ version A is a six-point Likert scale with 33 items, the minimum and maximum scores being 0 and 165, respectively. A high item total score indicates a high fear of childbirth. Fear of birth is classified into four levels with the scores obtained from the scale.

- W-DEQ point ≤ 37 mildly,
- W-DEQ point = 38-65 medium-level,
- W-DEQ point = 66-84 severe level,
- W-DEQ point ≥ 85 it shows fear at a clinical level (Andaroon et al., 2020).

The negatively charged questions on the scale (2, 3, 6, 7, 8, 11, 12, 15, 19, 20, 24, 25, 27, 31) are calculated by rotating them in the opposite direction. The scale of Cronbach Alpha value was 0.88 for primiparous and 0.90 for multiparous pregnant (Korukçu et al., 2012). In this study, Cronbach's alpha value of the scale was 0.88.

Wijma Delivery Expectancy/Experience Questionnaire B Version: Fear of childbirth was measured using the WDEQ developed by Wijma et al. (1998). The Turkish validity and reliability study was conducted by Uçar (2013). The scale is used to determine the level of birth-related fear experienced during and after labour. W-DEQ B version is a six-point Likert scale consisting of 33 items. High scores from the scale indicate that pregnant women have a high fear of childbirth. The scale's results are used to classify fear of birth into four stages.

- W-DEQ point ≤ 37 mildly,
- W-DEQ point = 38-65 medium-level,
- W-DEQ point = 66-84 severe level,
- W-DEQ point ≥ 85 ıt shows fear at a clinical level (Andaroon et al., 2020).

The negative questions in the scale (2, 3, 6, 7, 8, 11, 12, 15, 19, 20, 24, 25, 27, 31) are calculated by reversing them in order to ensure consistency in measurement. W-DEQ B version is a six-point Likert

scale with 33 items. Cronbach's alpha value for the scale was 0.88 (Uçar & Beji, 2013). In this study, Cronbach's alpha value of the scale was 0.90.

Impact of Event Scale-Revised: Çorapçıoğlu, Yargı, and Geyran (2006) conducted a Turkish validity and reliability research for this scale, which is used to assess psychological stress during traumatic experiences. Impact of Event Scale-Revised was prepared by Weiss and Marmar in 1997, based on the posttraumatic stress disorder (PTSD) criteria of the American Psychiatric Association (1994). The scale consists of 22 questions, and the severity of symptoms in the previous week is scored between 0 and 4. The participants were asked to answer the questions based on their birth experience. The lowest and highest scores of the scale are 0 and 88, with a high score indicating a high stress level (Çorapçıoğlu et al., 2006). In this study, the Cronbach's alpha value of the scale was 0.86.

2.3. Data Collection

Data were collected between January and November 2018 using face-to-face interviews by the researcher in the pregnant women's rooms. The study was explained to the pregnant women, and written permission was obtained from those who wanted to participate in the study.

When evaluating fear of birth, W-DEQ-A (administered before birth) version was used in the pre-test and W-DEQ B (administered after delivery) version was used in the post-test, as reported in the literature (Alehagen et al., 2006; Nieminen et al., 2016). Pregnant women in the experimental and control groups were given a pre-test utilizing the Personal Information Form and W-DEQ A version in the passive labour service of the delivery room. The pregnant in the experimental group were given midwifery support by the researcher during labour. In the experimental and control groups, W-DEQ B version was used as the post-test and IES-R was applied to women who were taken to the puerperal ward after giving birth, 6-8 hours after delivering birth.

2.4. Midwifery Initiatives

The researcher provided midwifery support in labour to pregnant women who applied at the delivery room, met the inclusion criteria, and were assigned to the experimental group using the methods and contents described in the "Drug-free Methods for Coping with Labor Pain" section of the Pregnancy Information Class Education Book published by the Turkish National Public Health Agency (Ministry of Health, 2014). In this study, information, breathing exercises, sacral massage, and imagination/distraction were administered to the pregnant women (Table 1). These methods were applied during the entire labour in the single rooms of the pregnant. As this was a randomized controlled trial, the women in the control group received no intervention.

Table 1. Methods used during midwifery support

Method	Content
Information	Beginning with the latent phase, the pregnant women was given brief and clear explanatory information about childbirth. She was not left alone, and her needs were met under the conditions of the delivery room to create a positive delivery environment.
Imagination /Distraction	Methods including walking in the corridor, walking in the room, praying, talking about the pregnancy, and talking about the baby were used to distract the pregnant women from her labour pain. To encourage pregnant women to utilize their imagination during construction, methods such as noting the duration of each contraction, envisioning the baby progressing through the birth canal, and imagining the opening of her rosebud cervix were used.
Sacral massage	The pregnant women had a sacral massage throughout her labour, beginning with the latent phase. The massage was performed while in an appropriate position using breathing methods. The massage was performed when the pregnant women was sitting the pregnant in bed, standing her up with support from the wall, kneeling her forward, or lying her on her side in bed. The massage to the sacrum was stopped between contractions. When the pregnant woman suffered from low back pain, she was calmed by applying pressure to the sacral area by using the palms or by clenching the hands into fists.
Breathing exercises	The pregnant woman was taught breathing techniques in the latent phase, before her contractions became more frequent. She was encouraged to do breathing exercises during labour pain.

2.5. Ethical Considerations

Ethical approval was given by the Scientific Research and Publication Ethics Committee of Health Sciences (decision no: 2018/23–26), and written permission was obtained from the institution where the research was conducted. Before starting the study, written consent was obtained from all participants. The participants were informed that they could leave the study at any time. All data were coded and used only for research purposes to protect the privacy of the participants.

2.6. Data Analysis

Data were analysed using the Statistical Package Program for Social Sciences 20.0 package program utilising the descriptive statistics, such as number, percentage, mean, and standard deviation. The independent samples t-test and chi-square test were used to compare the demographic data of the groups. The normality distribution of WDEQ and IES-R was tested using the

Kolmogorov-Smirnov test. As the data did not have a normal distribution, the Mann-Whitney U test and the Wilcoxon signed-rank test were used to compare the intergroup and intragroup mean scale scores, respectively.

3. Results

The sample included 164 pregnant women (82 in the experimental group, 82 in the control group). Table 2 presents the characteristics of the participants. No statistically significant difference was found in the experimental and the control groups in terms of age, employment status, and birth preparation education (p>0.05), but a statistically significant differences was found between the groups in terms of education, income levels and family type (p<0.05).

Table 2. Characteristics of the participants

Characteristics	Experimental group (n=82)		Control group (n=82)		*P*-value
	n	%	n	%	
Age (years), mean ± SD	24.44 ± 3.71		24.12 ± 3.33		0.566[a]
Educational level					
Illiterate	-	-	4	4.9	
Primary school	12	14.6	12	14.6	0.006[b]
Secondary school	16	19.6	29	35.4	
High school	27	32.9	26	31.7	
University	27	32.9	11	13.4	
Income level					
Good	17	20.7	19	23.2	0.031[b]
Moderate	52	63.4	60	73.2	
Low	13	15.9	3	3.7	
Employment status					
Working	10	12.2	16	19.5	0.200[b]
Not working	72	87.8	66	80.5	
Family type					
Nuclear family	65	79.3	52	63.4	0.025[b]
Extended family	17	20.7	30	36.6	
Having childbirth education					
Yes	28	34.1	20	24.4	0.170[b]
No	54	65.9	62	74.6	

[a]independent t-test. [b]Chi-squared test. SD: Standard Deviation.

Table 3 compares the fear of childbirth of pregnant in the experimental and control groups before and after delivery. Accordingly, prenatal birth fear for mean score of those in the experimental group was 47.15±19.68, which decreased to 37.20±23.50 after delivery (p=0.001). The prenatal and postnatal birth fear for mean scores of those in the control group were 63.23±23.10 and 62.38±27.04, respectively (p=0.390).

Table 3. Comparison of birth fear for experimental and control groups before and after delivery

	Experimental group (n=82)	Control group (n=82)
	Mean ± SD	Mean ± SD
Fear of birth (WDEQ-A version scores)	47.15 ± 19.68	63.23 ± 23.10
Fear of birth (WDEQ-B version scores)	37.20 ± 23.50	62.38 ± 27.04
p-value[a]	0.001	0.390

[a]: p < 0.05 indicates significant difference, according to the Wilcoxon signed-rank test. WDEQ-A: The Wijma Delivery Expectancy/Experience Questionnaire A version. WDEQ-B: The Wijma Delivery Expectancy/Experience Questionnaire B version. SD: Standard deviation.

Table 4 shows the prenatal WDEQ-A and postnatal WDEQ-B mean scores of pregnant women in the experimental and control groups, as well as the difference between these scores, and their IES-R mean scores. A statistically significant differences was found between the groups' prenatal and postnatal fear of childbirth (p<0.001). The experimental group's WDEQ mean score decreased by 9.95±24.32 after delivery compared to the prenatal period, whereas the control group's reduction was only −0.85±17.89 (p=0.010). The experimental group experienced considerably decreased postpartum PTSD symptoms compared to the control group (p<0.001).

Table 4. Comparison of PTSD symptoms after delivery and fear of birth before and after delivery between two groups

	Experimental group (n=82)	Control group (n=82)	*P*-value[a]
	Mean ± SD	Mean ± SD	
Fear of birth (WDEQ-A version scores)	47.15 ±19.68	63.23 ± 23.10	< 0.001
Fear of birth (WDEQ-B version scores)	37.20 ± 23.50	62.38 ± 27.04	< 0.001
Difference	-9.95 ± 24.32	-0.85 ± 17.89	0.010
PTSD symptoms (IES-R scores)	12.09 ± 12.67	18.30 ± 11.96	< 0.001

[a]: p < 0.05 indicates significant difference, according to the Mann-Whitney-U test. IES-R: Impact of Event Scale–Revised. SD: Standard Deviation

4. Discussion

Labour is an uncontrollable procedure with uncertain consequences, particularly for those giving birth for the first time (Miller & Danoy-Monet, 2021). Therefore, every woman needs someone to support her during labour (O'Connell, 2021). Midwifery support during labour can help to minimize fear, anxiety, and stress associated with childbirth (Hildingsson et al., 2018; Striebich et al., 2018). This study examined how the effects of supportive midwifery care for primiparous on PTSD symptoms and fear of childbirth.

In our study, it was determined that the experimental and control groups were similar in terms of age, employment status and birth preparation education among the control variables. However, it was determined that the education level, income levels and family type of the pregnant women in the experimental group were higher than the control group and there was a statistically significant difference between the groups (p<0.05; Table 2). It is thought that this difference between the groups is due to reasons such as the small number of primiparas included in the sample.

In our study, it was observed that the rate of those who had prenatal fear of birth decreased after birth in the experimental group that

received midwifery support throughout labour, while the difference between prenatal and postnatal fear of birth levels was determined to be statistically significant ($p<0.001$; Table 3). Studies have shown that giving support during labour and upon birth has a positive effect on fear of childbirth (O'Connell, 2021, Karabulut, 2016; Alizadeh-Dibazari, 2023). Sydsjö et al. (2015) reported that pregnant women with severe fear of childbirth had a positive birth experience as a result of continuous midwifery support, and that all women in the study stated that they would recommend midwifery support to their friends (Sydsjö et al., 2015). According to Çankaya and Can's (2021) study, providing midwifery support to women who are afraid of delivery decreases their fear (Çankaya & Can, 2021). These findings show that the support given by midwives before birth reduces the fear of birth.

This study found that the levels of prenatal and postnatal fear of childbirth in the control group, which received routine delivery interventions during labour were similar ($p=0.390$; Table 3). According to studies have reported that pregnant should be educated before giving birth and that those who could not receive such an education should be provided with relevant training and assistance during labour to lessen their fear of childbirth (Ministry of Health, 2014; Alizadeh-Dibazari, 2023; Firouzbakht, 2015). The pregnant women in the control group had routine delivery interventions, with only 24.4% of them received birth preparation training before delivery. Based on these findings, not only prenatal birth preparation education but also midwifery support during birth is important. We can state that the birth fears of pregnant women who received routine birth interventions by midwives during labour have not changed.

This study found that the pregnant women in the experimental group who received midwifery support during labour reported a reduced post-intervention fear of childbirth than those in the control group, with the difference statistically significant ($p<0.001$; Table 4). In a study, the majority of pregnant women who received consultation during labour, especially from midwives, were satisfied with the support and had less fear of childbirth decreased (Perriman et al., 2018). Larsson, Hildingsson, Ternström, Rubertsson, and Karlström, (2019) found that the counselling given by midwives in childbirth positively affected pregnant women's thoughts about childbirth (Larsson et al., 2019). According to Çankaya and Can (2021), providing labour support can lessen fear of childbirth and negative thoughts about labour. These results are consistent with those obtained from this study (Çankaya & Can, 2021).

In this study, the experimental group experienced considerably less postpartum PTSD than the control group (Table 4). This finding can be attributable to variety of sources. First, studies have shown that providing healthcare services during labour reduce postpartum stress symptoms (Çankaya & Can, 2021). Second, pregnant women who are constantly supported during labour perceive a more positive delivery experience (Larsson et al., 2019); therefore, a lack of supportive care can lead to PTSD symptoms (Van Dinter-Douma, 2020). In this study, support from the midwives reduced the fear of childbirth, which may also have reduced PTSD symptoms after childbirth. Fear of childbirth is an important factor in the development of postnatal PTSD symptoms (Ayer et al., 2016). These variables may cause PTSD symptoms to decrease fallowing delivery.

Furthermore, in this study, the prenatal WDEQ-A mean score was significantly higher in the control group than in the experimental group. Many variables can affect fear of childbirth (Table 3), aside from women's personality traits, sociodemographic characteristics, and psychosocial conditions, external factors (e.g., society, culture, and obstetric history) can also play a significant impact on their level of fear of childbirth. Therefore, fear of childbirth is a complex issue that cannot be easily quantified (Geissbuehler & Eberhard, 2002). This condition is considered to be the cause of the group differences.

4.1. Limitations

This study has some limitations. First of all, since the study was conducted in a hospital environment in a province in eastern Türkiye, it cannot be generalized to all pregnant women. Therefore, the results cannot be generalized to all women in the country. However, it can be used for comparison with results from other studies. Second, no randomization was applied in the sample selection due to concerns about the participants' exclusion and withdrawal rates.

5. Conclusion

The supportive midwifery care given to primiparous women reduced their fear of childbirth and PTSD symptoms following childbirth. In this regard, midwives should be encouraged to ensure active participation by creating an ideal birth environment, and one-on-one midwifery support (physical, spiritual, etc.) should be increased for pregnant women. In addition, the quality of midwifery care should be increased, which will help to improve therefore the psychosocial health of women in the postpartum period, and minimize their fear of childbirth. In order to obtain detailed and

comprehensive information, it is recommended to conduct long-term studies covering a larger number of cases.

Article Informations

Evaluation: Two External Reviewers / Double Blind

Ethical Consiredation: Ethical approval was given by the Scientific Research and Publication Ethics Committee of Health Sciences (decision no: 2018/23–26), and written permission was obtained from the institution where the research was conducted. Before starting the study, written consent was obtained from all participants. The participants were informed that they could leave the study at any time. All data were coded and used only for research purposes to protect the privacy of the participants.

*This study was produced from the master's thesis titled "The Effect of Midwifery Support Given to Primiparous in Labor on Postpartum Posttraumatic Stress Disorder and Birth Fear" (Publication Date: 2019). This research was presented as an oral presentation at 5th national 4th International Congress on Midwifery, November 06 - 09, 2019, Ankara, Türkiye.

It is stated that the scientific and ethical principles were adhered to during the preparation of this study, and that all the studies utilised are duly referenced in the bibliography.

Similarity Screening: Done – iThenticate

Ethical Statement: health@artuklu.edu.tr

Authorship Contribution:

Research Design (CRediT 1):	ZB (%40) - TU (%60)
Data Collection (CRediT 2)	ZB (%60) - TU (%40)
Research - Data Analysis - Verification (CRediT 3-4-6-11)	ZB (%25) - TU (%75)
Writing the Article (CRediT 12-13)	ZB (%60) - TU (%40)
Development and Revision of the Text (CRediT 14)	ZB (%50) - TU (%50)

Conflict of Interest: No conflict of interest declared.

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