JBACHS
Journal of Basic and Clinical Health Sciences

J Basic Clin Health Sci 2020; 4:160-167
https://doi.org/10.30621/jbachs.2020.990

Original investigation

Maternal Perspective for Support and Control in Birth

Gülden Aynaci[1]

[1]Trakya University Health Science School, Obstetrics and Gynecology, Edirne, Turkey

Address for Correspondence: Gülden Aynaci, **E-mail:** guldenaynaci@hotmail.com
Received: 21.0.2020; **Accepted:** 09.04.2020; **Available Online Date:** 15.05.2020

Cite this article as: Aynaci G. Maternal Perspective for Support and Control in Birth. J Basic Clin Health Sci 2020; 4:160-167.

ABSTRACT

Purpose: The feeling that women have control over their bodies during birth is important. During and after birth, providing good communication with the health care team helps ensure that postpartum periods are of good quality for mothers. We evaluated the parameters affecting pregnants during the delivery process.

Methods: Our study was conducted between September 2019- January 2020 with the 230 patients who gave birth in Trakya Medical Faculty Hospital. Data from 2 scales were used; 'Support and Control in Birth Scale (SCIB)' and 'Discomfort Intolerance Scale (DIS)'. Additional clinical information were recorded.

Results: SCIB scores increased with an increase in the education level. Patients with higher DIS scores were more intolerant of discomfort. However, they also had high SCIB scores. Patients who had high SCIB scores didn't lose control during labor. SCIB scores were found to be lower in patients who had additional interventions such as foley catheter, experiencing a painful vaginal examination. The scores of those who had normal vaginal delivery were higher than those who had cesarean section. There was a significant relationship between DIS, SCIB and labor duration.

Conclusion: The sensitivity and tolerance factors of pregnants should be examined at structural level. During and after childbirth, suitable environments for the mother should be created and adaptation to the new situation should be ensured. The higher control detected during labor results with less severe pain, more intense positive emotions and less intense negative emotions. With more supportive care services; perceived control increases in patients and they experience a more comfortable delivery process.

Keywords: Pregnancy care, perinatology, Support and Control in Birth Scale, Discomfort intolerance Scale, postpartum care

INTRODUCTION

The cultural background influences women's responses to physiological and emotional changes at birth. Health professionals must be able to evaluate these responses correctly (1). Health care provider must evaluate the maternal support and control perceptions in the delivery process. Achievement of those goals is valuable for improving quality in obstetric care.

Dissatisfaction with the birth process may impair the psychological health of the mother, which may prevent women from appropriately adopting their maternal roles (1). Many factors affect women's satisfaction with the experience of childbirth. The higher satisfaction level of pregnant women makes them think more calmly during the delivery process; that also increases the capacity of health care workers to fulfill the instructions of pregnant women. The feeling that women have control over their bodies during birth is important (2). During and after birth, providing good communication with the health care team helps ensure that pregnancy and postpartum periods are of good quality for both mothers and babies.

Knowledge and skills gained during pregnancy and the postpartum period and breastfeeding training contribute to the healthy newborn period for the baby and increase the maternal well-being. Quality of intrapartum and postpartum care increases the satisfaction of women starting from birth. Two factors particularly affect this satisfaction (3). The first factor is providing sufficient and qualified access to intrapartum support for pregnant women and the second one; the woman's ability to have sufficient control over the body during childbirth.

An important parameter affecting the satisfaction of pregnant women is the control perceived by women. Pregnant women develop feelings that they can not control. The feeling of low control perceived by the during labor may reveal symtomos as severe as post traumatic stress syndrome. The other factors that affect perceived control include self-sufficiency at birth, positive emotional states, and reduced stress symptoms associated with labor (4). Birth is a phenomenon that is affected by the personal characteristics of pregnant women, cultural variables, and the approaches of health professionals. Cultural attitudes towards birth management, what is expected of women during childbirth, and the support of individuals who play a role in birth are important since all these components affect the positive emotions perceived by pregnant women during delivery.

Birth is one of the most important experiences in a woman's life. Women's satisfaction with the birth experience is essential for both mother and baby health. In this study, we evaluated the parameters affecting pregnant women during the delivery process. We aimed to contribute to the improvement of the quality of care given by health professionals before, during, and after the delivery.

METHODS

Setting and Sample

Our study was conducted between September 2019- January 2020 with face to face interviews with the patients who gave birth in the perinatology department of Trakya University Medical Faculty Hospital.

Study Design

Postpartum women between at least 24 hours postpartum period and 72 hours postpartum period were included in the study.

Measurements

In our study; Data from 2 scales were used; 'Support and Control in Birth Scale (SCIB) (5) and 'Discomfort Intolerance Scale (DIS) (6) were used. In order to characterize the participants, the first part of the questionnaire included a series of specific questions. Additional clinical information, sociodemographic characteristics, some information about the pregnancy and delivery process were recorded.

1. Support and Control in Birth Scale (SCIB)

In this study, the validity and reliability of SCIB, which was proven to be a valuable tool for measuring perceived control and support at birth during the postpartum period was used to examine the experiences and perceptions of women in the postpartum period. The scale evaluates women in 3 dimensions. These three dimensions are as follows; support, internal control, and external control (5, 7). The scale (5, 7). A five-stage Likert-type scale is used for answers between "I completely agree" and "I totally disagree. "The possible scores on this scale range between 33 to 165. Higher scores indicate a higher degree of perceived support and control at birth.

The SCIB consists of two main parameters. First, it evaluates the interactions of women in the postpartum period with the environment and the support they receive from health care providers. The second consists of questions targeting to examine whether the women were in control during their labor or not. Perceived support and perceived sense of control play an essential role in women's birth experiences. SCIB is used to evaluate these two related parameters. The scale consists of 3 subscales that measure women's perceptions of support at birth, external control, and internal control. The scale is applied by using a 33-item questionnaire. The validity and reliability study of the scale in Turkish was conducted and proved to be feasible (5,7).

More specifically, items 1-12 include the support subscale. The support subscale is evaluated with 12 questions examining attitudes, patience, empathy, and help. For example, there are 12 questions such as "The staff helped me try different positions" and "the staff noticed the pain I experienced'.' The items 13.-23. includes the external control subscale. The information is about decisions and procedures. As sample questions; "I chose whether or not I could be informed" or "Health workers in the delivery room have taken control of the labor process".

Finally, the internal control subscale consists of the items between 24–33 In this section, ten questions focusing on pain, emotion, and behavior control are present. Some of them are as follows; "I have overcome pain", "I was able to control my reactions to pain" and "I behaved in a way that I did not suit myself".

Participants' scores obtained from the scale, sociodemographic characteristics, clinical characteristics of their pregnancies, and the scores obtained from the DIS scale were analyzed.

2. Discomfort Intolerance Scale (DIS)

DIS is a valid and reliable 7-point Likert type and self-assessment scale that assesses the degree of pain threshold and resistance to physical discomfort. The answers options range from 0 (not suitable for me at all) to 6 (totally suitable for me)(6). It consists of 7 questions. The questions include; "As soon as I feel physically uncomfortable, I immediately start to do something to relieve the discomfort", "I am more sensitive to the feeling of bodily unrest than most people". In our study, the participants' ability to withstand disturbing bodily sensations and their tendency to avoid disturbing situations were evaluated.

Data analysis

SPSS 20.0 Package Program was used in all statistical analyses of the collected data. Data were compiled with appropriate descriptive statistics. Descriptive statistics for numerical variables were given as mean and standard deviation. Descriptive statistics for categorical variables were given as percentages and frequency. Shapiro-Wilk test was used to check the normal distribution of the data. Data were analyzed with Pearson or Spearman, according to suitability. Student t and Mann Whitney U test were used for pair comparisons of the groups. Chi-square test was used for the relationships between categorical variables. One-way analysis of variance was used in comparisons for more than two groups.

After a one-way analysis of variance, multiple comparisons were evaluated by the Tukey test. In the comparison of more than two groups, Kruskal Wallis multiple comparison test (Siegel-Castellan test) was used when appropriate. In all statistical analyses, the significance level was determined as 5%.

Ethical Consideration

Approval for this study was obtained from Trakya University Medical Faculty Scientific Research Ethical Committee on and informed consents were obtained from all pregnant volunteers (Decision No: 22121724-050.04.04).

RESULTS

The study included 230 volunteer women in the postpartum period who were admitted to the obstetrics clinic of Trakya University Medical Faculty Hospital and gave birth to healthy children. The women aged between 18 and 43 years old with no psychological illness, smoking or alcohol history, and were between 24 hours-72 hours of the postpartum period were included in the study. Patients with chronic hypertension, pregnancy-related hypertension, preeclampsia, eclampsia, rheumatologic disease, oncologic disease, existing or previous cardiopulmonary disease were excluded from the study. Existing acute respiratory disease (e.g., bronchitis), history of epilepsy, cardiac dysfunction, or other serious medical illnesses (e.g. emphysema), and limited mental competence, or the absence of written, informed consent were among the exclusion criteria for our study.

This study aims to evaluate the perceptions of the patients and the parameters affecting them during delivery and to increase the quality of obstetric care. We examined the maternal well-being and the quality of the experienced birth processes. In this way, we targeted to contribute to the increasing care that is provided by the health personnel in obstetric health services and expand awareness on emotions such as stress and anxiety that may occur during delivery.Also, we wanted our work to contribute to the improvement of the quality measures identified against physical problems that may arise in pregnant women.

For this reason, we used the 'Support and Control in Birth Scale (SCIB) that are used in different cultures and its influencing parameters in Turkish pregnant women in our hospital. Our study examines the necessity of quality of care and interventions in improving both maternal and fetal health. Among the primary health care services, the necessity of the evaluation of the quality of maternal well-being, and increasing the evidence-based patient care interventions were evaluated.

The mean age of the women in our study was 26.84 (SD: 4.70). Pregnant women between 33-40 weeks of gestation, who had a normal delivery or who underwent emergency cesarean section were included in the study. Those with elective cesarean section were excluded from the study because they could not score on the birth experience scale. The relationship between sociodemographic and clinical characteristics, SCIB, and DIS scores were evaluated in postpartum women. Participants were asked the last school they had graduated. A hundred and fifty-one patients were primary and secondary education graduates, 56 had high school graduation, and 23 were university graduated and over. SCIB scores increased with an increase in the education level. Patients with higher DIS scores were more intolerant of discomfort. However, they also had high SCIB scores. Patients who had high SCIB scores did not lose control during labor which is a though period of their life-times (Table 1).

According to family income level, 36 participants had a good income, 157 participants had average, and 37 participants had low income. SCIB scores of those with average income were higher than those with low income ($p < 0.001$). There was no statistically significant relationship between income level change and DIS. However, as income level increases, DIS scores were increasing as well, which indicates less intolerance to discomfort. When the participants are evaluated according to their occupations, there was no significant relationship between SCIB and DIS scores (Table 1).

During the labor, SCIB and DIS scores were evaluated according to the interventions the women underwent. The participants were mostly disturbed by the enema ($p= 0.003$). SCIB scores were found to be lower in patients who had additional interventions such as foley catheter for urine drainage, continuous electro-fetal monitoring, having an episiotomy, or experiencing a painful vaginal examination, but there was no clinically significant difference. Those who had high DIS scores indicating less intolerance to discomfort, it was observed that they were exposed to additional interventions such as fundal pressure and intravenous induction during labor (Table 1).

Age changes and SCIB and DIS scores of the participants were analyzed. As the age increased, SCIB support, SCIB internal control, SCIB total, and DIS scores were better. There was no significant relationship between age and external subscale (Table 2).

When evaluated according to the type of birth, SCIB and DIS scores of those who had normal vaginal delivery were higher than those who had cesarean section ($p= 0.007$; $p< 0.001$) (Table 3).

The women were asked about their last birth and the number of healthy pregnancies. SCIB, SCIB subscores, and DIS scores were better in patients with three or more healthy pregnancies than those who had their first or second pregnancy ($p = <0.001$) (Table 3).

When examined according to the number of births, SCIB scores of those who delivered three or more had a tendency to a lower score. The best scores were observed in women who delivered twice ($p = 0.003$). There was no significant relationship between the number of births and DIS ($p = 0.893$) (Table 3).

SCIB scores of those who had breastfed their babies for more than one year in their previous pregnancies were higher than those who had given breastmilk less than one year ($p <0.001$). It was observed that patients who breastfed for a long time had higher tolerance intolerance to discomfort (Table 3).

Table 1. Sociodemografic parameters of the participants

Parameters	n (%)	SCIB+	p	DIS++	p
Which school did you graduate last?					
Primary School	151	110.31 (± 30.74)	< 0.001*	20.05 (± 9.47)	< 0.001*
Middle School	56	114.73 (± 19.34)		24.64 (± 8.90)	
High School	23	132.34 (± 21.75)		23.04 (± 7.66)	
What is the income status of the pregnants' family?					
Bad	37	100.59 (± 25.80)	< 0.001*	20.16 (± 8.71)	0.923
Good	157	118.45 (± 23.12)		21.63 (± 9.32)	
Well	36	105.75 (± 42.43)		25.59 (± 10.20)	
What is the pregnants' job?					
0	75	140.73 (± 21.05)	0.097	19.80 (± 8.94)	0.138
1	125	130.72 (± 34.93)		22.26 (± 9.20)	
2	30	139.03 (± 35.10)		22.36 (± 10.64)	
Which of the following interventions were administered to you during childbirth?					
A. Induction (Medication given for pain and contraction)					
No	128	111.27 (± 31.33)	0.503	20.81 (± 9.53)	0.169
Yes	102	116.50 (± 23.62)		22.30 (± 9.09)	
B. Enema (Medication from rectum)					
No	161	110.55 (± 30.97)	0.003*	19.45 (± 8.57)	< 0.001*
Yes	69	120.68 (± 18.84)		26.17 (± 9.45)	
C. Continuous electro-fetal monitoring (Continuous NST)					
No	112	111.45 (± 33.51)	0.312	19.45 (± 7.51)	0.016*
Yes	118	115.62 (± 22.05)		23.38 (± 10.49)	
D. Painful vaginal examination was performed.					
No	122	110.70 (± 33.14)	0.238	20.72 (± 8.66)	0.877
Yes	108	116.86 (± 21.05)		22.31 (± 10.04)	
E. Foley catheter was inserted for urine drainage.					
No	79	106.46 (± 39.73)	0.120	20.51 (± 8.36)	0.476
Yes	151	117.32 (± 18.84)		21.97 (± 9.82)	
F. Fundal pressure (pushed into pelvis during delivery)					
No	160	114.39 (± 27.20)	0.678	21.86 (± 9.61)	0.348
Yes	70	111.77 (± 30.58)		20.57 (± 8.74)	
G. Episiotomy (incision made from below, sutured)					
No	156	111.58 (± 31.60)	0.237	21.88 (± 9.75)	0.366
Yes	74	117.82 (± 18.81)		20.60 (± 8.45)	

+ Support and Control in Birth Scale (SCIB)
++ Discomfort Intolerance Scale (DIS)

Table 2. The correlation between Age and SCIB and DIS

	SCIB+ Support		SCIB+ External Control		SCIB+ Internal Control		SCIB+ Total		DIS++	
Parameters	**rho**	**P**	**rho**	**p**	**rho**	**P**	**rho**	**p**	**rho**	**p**
Pregnant' Age	0.162	0.014*	0.067	0.308	0.156	0.018*	0.162	0.014*	0.100	0.128

+ Support and Control in Birth Scale (SCIB)
++ Discomfort Intolerance Scale (DIS)

Table 3. The correlation between SCIB, DIS and pregnants' clinical parameters.

	SCIB Support		SCIB Control		SCIB Main		SCIB Total		DIS	
	Median	**p**	**Median**	**p**	**Median**	**p**	**Median**	**p**	**Median**	**P**
What kind of your last birth?										
NSVD	64.00	0.101	52.00	0.999	120.00	0.342	139.00	0.007*	24.00	<0.001*
SCAT	61.00		53.00		113.00		125.00		16.00	
How much have you had been a pregnant until now?										
0	61.00	0.003*	54.00	0.035*	105.00	<0.001*	133.00	<0.001*	16.00	0.003*
1	60.00		52.00		118.00		132.00		16.00	
2	63.00		52.00		115.00		137.00		17.50	
3	68.50		58.50		131.00		157.00		30.00	
4	63.00		48.00		111.00		129.00		21.00	
5	74.00		56.00		127.00		143.00		20.00	
How many times did you give birth?										
0	62.00	0.012*	53.00	0.001*	120.00	0.005*	137.50	0.003*	18.00	0.893
1	64.00		52.00		120.00		136.00		19.00	
2	65.00		56.00		124.00		148.00		20.00	
3	63.00		50.00		111.00		129.00		18.00	
4	49.50		34.50		81.50		107.00		21.00	
Giving mother's milk for your last children?										
< 1 year	61.00	<0.001*	52.00	0.061	116.00	0.006*	133.00	0.015*	18.00	0.263
1- 2	63.50		48.00		116.50		142.00		20.00	
> 1 year	67.00		55.00		124.00		143.00		17.00	
Participants' Region in Turkey										
Easteren	62.00	0.004*	53.00	0.094	120.00	0.031*	134.00	0.007*	18.00	0.001*
Central Anatolia	61.00		52.00		115.00		133.00		16.00	
Western	67.00		52.00		124.00		148.00		21.00	
Labour time										
< 8 hours	68.00	<0.001*	52.50	0.080	124.50	<0.001*	148.00	<0.001*	20.50	0.003*
> 8 hours	61.00		52.00		115.50		132.00		17.00	
Which school did you graduate last?										
Primary	62.00	0.008*	53.00	<0.001*	120.00	<0.001*	134.00	<0.001*	16.00	0.005*
Secondary	65.00		48.00		112.00		140.00		26.00	
University and more	71.00		63.00		135.00		164.00		20.00	
What is the income status of the pregnants' family?										
Bad	58.00	<0.001*	48.00	<0.001*	107.00	<0.001*	122.00	<0.001*	18.00	0.923
Good	64.00		55.00		121.00		138.00		18.00	
Well	70.00		52.00		127.00		143.00		21.50	
What is the pregnants' job?										
Housewife	62.00	<0.001*	57.00	<0.001*			134.00	0.097	16.00	0.068
Employer	62.00		50.00				133.00		19.00	
Officer	52.00		52.00				142.00		18.00	

+ Support and Control in Birth Scale (SCIB)
++ Discomfort Intolerance Scale (DIS)

Table 4. The evaluation of SCIB+ and DIS++ correlation

Parameters	**DIS++**		
	Median (Q1-Q3)	**Spearman rho**	**p**
SCIB+ Total	120.00 (101.00-130.00)	0.192	0.003*
SCIB+ Support	63.00 (55.25- 72.00)	0.246	< 0.001*
SCIB+ Control	52.00 (46.00- 60.00)	0.044	0.506

+ Support and Control in Birth Scale (SCIB)
++ Discomfort Intolerance Scale (DIS)

When evaluated according to the demographic regions, the scores of participants from Turkey's western region was found to be better than those from Eastern regions and Central Anatolia. However, this result was not clinically significant (Table 3).

Participants were also asked how long the labor in their previous delivery lasted. Forty-eight women stated that labor lasted 0-8 hours, and 182 women stated that it was 8 hours or more. SCIB Support ($p<0.001$); SCIB Internal Control ($p<0.001$) and SCIB Total scores were higher in women whose labor lasted less than 8 hours compared to the women with longer labor duration. There was a significant relationship between DIS and labor duration ($p= 0.003$) (Table 3).

There is a positive and statistically significant correlation between SCIB Support and DIS variables ($p<0.001$) (Table 4), which means that we can use both of them for the evaluation of pregnant women's perceptions about the labor process.

DISCUSSION

The relationship between culture and pain at birth was investigated in the researches. This situation seems to be important in pain management (8,9).

The ability of the patient to cope with the pain and the process is determined by the ability to make the right decisions, and by understanding the medical condition in the simplest way, it can be explained. In our study, it was seen that SCIB scores increased as the education level increased (Table 1). The pain experienced at birth varies according to individuals and cultures. In one study, Finnish women stated that they have confidence in their bodies about birth and that birth is a health indicator. In another study conducted on Chinese women reported that they were ashamed of screaming during childbirth, and they screamed in late stages of the labor since it is a way of providing energy to the body in later stages of the delivery process (7,10,11). In our study, SCIB and DIS scores of the average socioeconomic and sociocultural groups were better than the low income and low cultural ones.

Birth with its prenatal, and postnatal faeatures is a process that must be managed with kindness and patience with respect for women's privacy. Researches have shown that women who receive continuous supportive care need less obstetric intervention during labor (7). Patients who have received adequate supportive care had higher rates of spontaneous birth, shorter labor duration, and higher birth satisfaction (12). In our study, it was shown that the DIS scores were higher, and the scores obtained from SCIB were better in women with shorter labor duration (Table 2).

It was seen that providing quality support to women in the care service during labor and delivery increased maternal well-being. Women with a high SCIB score had an increased sense of control and competence. Supportive maternal care is possible with physical support, emotional support, information sharing and experience transfer. Quality patient care provides increased adaptation for women preparing for childbirth.This care can be provided by health professionals, including nurses and doctors.

The women who experience a traumatic birth reported that they had low self control on their emotions during labor (2,4). In our study, SCIB and DIS scores were lower in those with cesarean section after labor (Table 3). In our study, the main determinant of not losing control at birth was the level of satisfaction experienced during childbirth. The sensation of control during pregnancy is significantly associated with the satisfaction of women at birth.

Discomfort intolerance (DI) plays a key role in the connection between the perception and interpretation of negative physical sensations (13). Perceptions and interpretations may increase the intensity of sensations in patients with high levels of DI when they encounter involuntary physical sensations. DIS and SCIB studies of different researches are consistent with this idea (13). Individuals with high DI are more likely to interpret sensations such as threatening and overreacting to sensations. In this way, DIS may be positively associated with SCIB. This may increase the intolerance of disturbing physical senses. It is thought that the tendency to overreact to the meaning of senses related to the process anxiety may increase and it is associated with the increase in DIS score.

In our study, DIS and SCIB were found to be moderately related. By applying DIS during pregnancy, women with DI can be identified and programs can be developed to provide additional prenatal support. Pregnant women with increased knowledge and awareness about labor will help achieving a higher quality pregnancy period and delivery process. Thus, the protection and development of maternal and fetal health will be supported.

During biological difficulties, DIS uniquely predicts participants' self-reported anxiety (14). In our study with DIS; and whether the participants showed fear of responding to a biological challenge such as childbirth was examined; SCIB and DIS had an interactive effect in responding to obstetric symptoms during biological difficulty. There was no significant difference in response to obstetric symptoms between those with low SCIB and those with low or high DIS. However, in high SCIB subjects, obstetric symptoms were significantly higher in patients with high DIS than in those with low DIS.

The behavioral component of cognitive behavioral therapy involves exposing individuals with anxiety disorders to stimuli they fear (13). The results of this study also benefit from treatment effects. Although DI is not often discussed in the treatment of anxiety psychopathology in pregnant women, it is likely to be a critical component of treatment for birth anxiety. Successful exposure can greatly improve the ability of patients to tolerate concerns and other negative emotions that arise during treatment interventions. Women who are evaluated with DIS and SCIB during pregnancy and become accustomed to the conditions during labor may have a higher tolerance in labor.

Intolerance to discomfort (DI); shows the level of an individual's ability to withstand physical restlessness or disturbing physical conditions (6). DI characterizes not only the ability to withstand the painful stimulus, but a broader sensory scope that encompasses all disturbing stimuli. In our study, the DIS scores of the patients

who were treated during labor were higher.That is to say, those who are intolerant of the discomfort need further intervention.

Studies have shown that women score lower on SCIB's three subscales in external control scale (5,15). SCIB scores were found to be low in our study.Out of the three subscales of this scale, external control was found to be low.Participants had the lowest perception of external factors such as access to information and decision making during labor and delivery, indicating that they had the lowest perceived control.This showed that women had less share in obtaining information during labor and participating in decision making during childbirth. Women's participation in decision-making on their own bodies makes them feel honorable and respected both during hospitalization and during labor. Effective communication initiated by healthcare providers is a leading factor in gaining external control in women.

Another sub-factor evaluated by SCIB is internal control. Internal control is the ability of women to control their thoughts, feelings, behavior, pain and physical functioning during labor and delivery direct events through their own efforts. In some countries, birth is seen as an experience of transition to adulthood and showcasing femininity. Due to the internal control structure; It is about the beliefs of the participants belonging in different cultures. Therefore, women's endeavors and efforts to facilitate the process vary from society to society (5,15). Internal control scores were better in our study. Among the factors with the lowest perception of internal control items were; "pretending that I am not myself in pain responses", "The pain I had was much more than I could control". Those items indicate low control level during birth; and supports the studies reporting that labor pain is a high adverse affect factor for labor. However, it should be kept in mind that severe pain at birth allows the woman to support uterine contractions. Therefore, intrapartum pain management with non-pharmacological interventions in Turkey, should be provided to pregnant women.

Our study aiming to increase satisfaction during labor, provides valuable information to examine changes in clinical practice and to modify patient care based on sociodemographic characteristics.

CONCLUSION

This study contributes to the literature by providing a different structural examination regarding insufficient tolerance to anxiety sensitivity and intolerance of discomfort during labor and delivery. The results show that the sensitivity and tolerance factors of both pregnant and postpartum women should be examined at structural level. However, anxiety and obstetric tolerance may be associated with higher grade variables. These findings indicate that a current anxiety sensitivity assessment during pregnancy and postpartum period may suggest other studies to evaluate the positive effects on maternal and fetal health.

There is a weak positive correlation between SCI and DIS. However, the relationship was statistically significant. Although the result is statistically significant, further studies are recommended to assess whether it is clinically significant.

During pregnancy, physician, nurse, midwife; should ensure the healthy adaptation of the pregnant woman and her family to pregnancy. Care processes should be applied to pregnant women against situations such as change in family processes, anxiety, lack of information. Pregnancy follow-ups should be performed regularly. During and after childbirth, suitable environments for the mother and the baby should be created and mother's adaptation to the new situation should be ensured.

As a result, the higher control detected during labor results with less severe pain, more intense positive emotions and less intense negative emotions. With more supportive care services in the delivery process; perceived control increases in patients and they experience a more comfortable delivery process.

ACKNOWLEDGEMENTS

Thank you for statical evaluation to Ass. Prof. Dr. Selçuk Korkmaz

Informed Consent: The study included 230 volunteer women in the postpartum period who were admitted to the obstetrics clinic of Trakya University Medical Faculty Hospital and gave birth to healthy children. Written informed consent was obtained from the participants. During our data collection, the participants' privacy was protected.

Compliance with Ethical Standards: Ethical approval for the study was given by the Scientific Research Ethics Committee of Trakya University Faculty of Medicine (Approval No: 22121724-050.04.04).

Peer-review: Externally peer-reviewed.

Author Contributions: Concept - GA; Design - GA; Supervision - GA; Fundings - GA; Materials - GA; Data Collection and/or Processing - GA; Analysis and/or Interpretation - GA; Literature Search - GA; Writing Manuscript - GA; Critical Review - GA

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study has received no financial support.

REFERENCES

1. Bell, A. F., & Andersson, E. (2016). The birth experience and women's postnatal depression: A systematic review. Midwifery, 39, 112-123. [CrossRef]
2. Raphael-Leff, J. (2018). The Psychological Processes of Childbearing, 4th ed. Routledge e-book.
3. Bradley, S., McCourt, C., Rayment, J., & Parmar, D. (2019). Midwives' perspectives on (dis) respectful intrapartum care during facility-based delivery in sub-Saharan Africa: a qualitative systematic review and meta-synthesis. Reproductive health, 16(1), 116. [CrossRef]
4. McGowan, E. C., Du, N., Hawes, K., Tucker, R., O'Donnell, M., & Vohr, B. (2017). Maternal mental health and neonatal intensive care unit discharge readiness in mothers of preterm infants. The Journal of pediatrics, 184, 68-74. [CrossRef]
5. Ford, E., Ayers, S., & Wright, D. B. (2009). Measurement of maternal perceptions of support and control in birth (SCIB). Journal of Women's Health, 18(2), 245-252. [CrossRef]
6. Schmidt, N. B., Richey, J. A., & Fitzpatrick, K. K. (2006). Discomfort intolerance: Development of a construct and measure relevant to panic disorder. Journal of anxiety disorders, 20(3), 263-280. [CrossRef]
7. Inci, F., Gokce Isbir, G., & Tanhan, F. (2015). The Turkish version of perceived support and control in birth scale. Journal of Psychosomatic Obstetrics & Gynecology, 36(3), 103-113. [CrossRef]
8. Ogollah, R., Bishop, A., Lewis, M., Grotle, M., & Foster, N. E. (2019). Responsiveness and Minimal Important Change for Pain and Disability Outcome Measures in Pregnancy-Related Low Back and Pelvic Girdle Pain. Physical Therapy, 99(11), 1551-1561. [CrossRef]
9. Aynaci, G., & Guksu, Z. (2019). The effects of dietary folate and iron supplementation on restless legs and preeclampsia in pregnancy. Progress in Nutrition, 21(2). [CrossRef]
10. Callister, L. C., Khalaf, I., Semenic, S., Kartchner, R., & Vehvilainen-Julkunen, K. (2003). The pain of childbirth: perceptions of culturally diverse women. Pain Management Nursing, 4(4), 145-154. [CrossRef]
11. McLachlan, H., & Waldenström, U. (2005). Childbirth experiences in Australia of women born in Turkey, Vietnam, and Australia. Birth, 32(4), 272-282. [CrossRef]
12. Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2013). Continuous support for women during childbirth. Cochrane Database of Systematic Reviews(7). [CrossRef]
13. Mitchell, M. A., Riccardi, C. J., Keough, M. E., Timpano, K. R., & Schmidt, N. B. (2013). Understanding the associations among anxiety sensitivity, distress tolerance, and discomfort intolerance: A comparison of three models. Journal of anxiety disorders, 27(1), 147-154. [CrossRef]
14. Schmidt, N. B., Buckner, J. D., & Keough, M. E. (2007). Anxiety sensitivity as a prospective predictor of alcohol use disorders. Behavior Modification, 31(2), 202-219. [CrossRef]
15. Colley, S., Kao, C.-H., Gau, M., & Cheng, S.-F. (2018). Women's perception of support and control during childbirth in The Gambia, a quantitative study on dignified facility-based intrapartum care. BMC pregnancy and childbirth, 18(1), 413. [CrossRef]