The Influence of Mother-Daughter Communications on Anxiety During Labor

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Full Text: Headnote ABSTRACT: Clinical observations of the behavior of labor patients and their families along with the recognition of the unique aspects of the mother-daughter relationship directed attention to mother-daughter communication as an influence on the level of anxiety that a woman may experience at the onset of her first labor. Studies on the physiology of labor have provided substantial evidence that as epinephrine levels increase, as a result of anxiety, uterine contractions are less effective and labor is prolonged. Two hundred ninety-six primiparous daughters, 114 white and 182 black were contacted during their postpartum hospitalization. The length of latent phase of labor for each of them was determined by direct questioning and findings of physical examinations on hospital records. The mothers of these daughters were interviewed to elicit recall of childbirth experience and expressions of attitudes toward childbirth. Bivariate analysis of data showed that daughters whose mothers expressed strong attitudes toward childbirth had a significantly shorter labor than daughters whose mothers expressed moderate attitudes. Multivariate analysis revealed different predictors according to race. For many years, women have been led to believe that difficult labor is the result of lack of knowledge or unreasonable fear that developed as social structures became more complex. However, anthropologists have found clear evidence that difficult or prolonged labor is not limited to women in complex industrialized societies but is found in all types of cultural settings.12 The practice of modern obstetrics with all of its sophisticated technology and diagnostic techniques is still unable to explain the etiology of prolonged labor in the majority of cases that occur. Emmanuel Friedman, one of America's leading authorities on human labor, found that 55.8% of the cases of difficult labor that he observed were virtually unexplained.3 When Schulman replicated Friedman's studies, he was unable to explain the cause of prolonged labor in 88.3% of the cases he examined.4 Studies on the physiology of labor over the past 20 years have provided substantial evidence that as epinephrine levels increase, as a result of anxiety, uterine contractions are less effective and labor is prolonged. Reynolds, Garcia, Gunther and Belville and more recently, Lederman, all found statistically significant evidence of this relationship.,5-8 Still, efforts to prepare pregnant women or women in early labor have been hampered by the lack of substantiated evidence of factors which may be the source of anxiety. Repeated clinical observations of the behavior of labor patients and their families, along with the recognition of the unique aspects of the mother-daughter relationship, directed attention to mother-daughter communication as a possible influence on the level of anxiety that a woman may experience at the onset of her first labor. Earlier studies with a similar focus were inconclusive because they gathered data on mother-daughter communications only from the daughter. This data was too limited and inaccurate for serious consideration. In this study, data related to motherdaughter communication was collected primarily from the mothers. The length of the latent or earliest phase of labor was chosen as the outcome measure because it is during this part of labor that uterine contractions may be most under control of hormonal influence. Consideration was given, to the extent possible, to all sociodemographic variables which could also be considered sources of daughters' anxiety or influences on mothers' perceptions. Four hundred and four daughters who had been recently delivered of their first pregnancy were contacted in the postpartum units of two teaching hospitals. From these contacts, a study sample of 296 daughters and their mothers was obtained. All of the daughters had received antepartal care in clinic settings from multiple caretakers, housestaff or midwives, under the direction of the same administrative system. The measurement of the length of latent phase of labor involved careful questioning of the daughters, as well as the findings from their hospital records. Indicators of mother-daughter

communication on the subject of childbirth were the mother's recall of her own childbirth experience and her current attitude toward childbirth. These were measured by analysis of data collected in structured face-to-face interviews with the mothers of the women who were recently delivered. Along with questions about age, educational level, and occupation, the mothers were asked about their experience in childbirth. Reports considered as problems were prolonged labor (more than 24 hours) and specific complicating illnesses frequently associated with childbirth. A category for other problems was provided for recording responses, which included a varied list of conditions, both physical and emotional, which were poorly understood by the respondents, but perceived as having a negative impact on the childbirth experience. In addition to the direct questions that were asked in the interview, respondents were asked to indicate levels of agreement or disagreement with 24 statements on a Likert-type forced-choice attitude scale. This scale, reduced to 16 items for analysis, had a reliability of .73 computed as an Alpha Co-efficient using a variance-covariance matrix. Inter-item correlation significant at P less than .05 indicated moderate construct validity. (See Appendix). The statements chosen for the attitude-toward-childbirth scale were drawn from direct conversations and listening to comments made by clinic patients to one another as they waited to be seen. They were written, verified, and scored as positive or negative by nurses and midwives whose combined experience represented 50 years of exposure to such communications. The study sample was, to some extent, homogenous, since all subjects were receiving care from the same source. However, it was biracial: 60% black and 40% white. Preliminary analysis showed significant differences in the variables of age of both mothers and daughters, marital status, family size, preparation for childbirth and mothers' attitudes toward childbirth according to race. The latter part of the analysis was, therefore, carried out for the total sample, then separately according to race. There were no significant differences according to race in the mean length of daughters' latent phase of labor or mothers' reports of problems during their own childbirth experience. However, the direction of responses to the statements on the scale was quite obviously different between black and white mothers; the black mothers agreeing more with negative statements, and white mothers agreeing with positive statements. When the effect of these expressions of attitudes on daughters' anxiety was measured in length of latent phase, the difference according to race was even more apparent. The black daughters whose mothers expressed strongly negative attitudes had the shorter labor and the white daughters whose mothers expressed strongly positive attitudes had the shorter labor (see Figure 1). Attempts to interpret this finding by examination of the impact of other variables on length of labor by multivariate analysis revealed still more differences between the races. In the white sample, the most significant predictor of length of labor was mothers' report of two or more other problems in childbirth. Daughters of these mothers had a significantly longer adjusted mean length of latent phase of labor. (Figure 2). For the white daughters, exposure to a sister's childbirth experience resulted in a shorter adjusted mean length of latent phase of labor. For the black daughters, these effects were not seen.

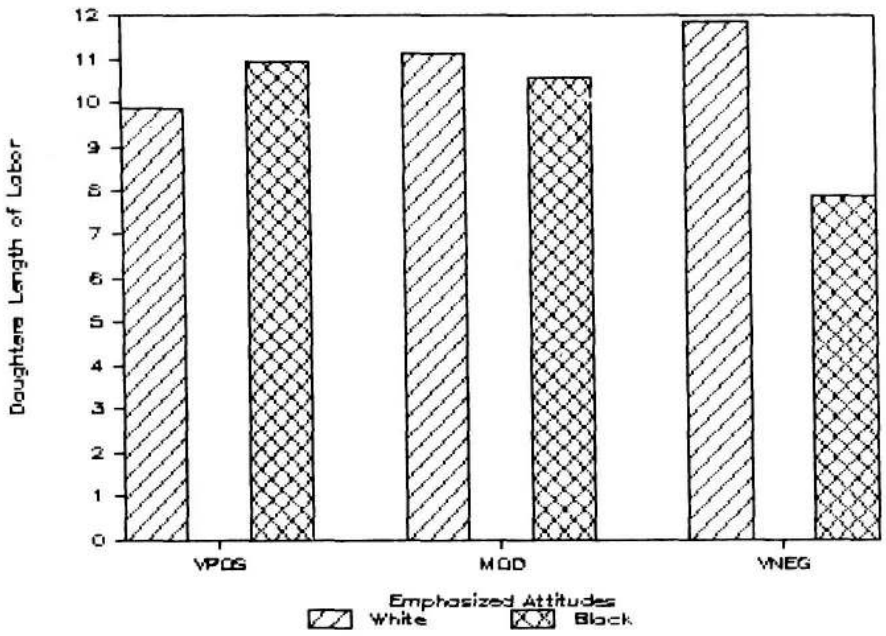

Figure 1
Labor by Strength of Attitude*
(in hours)

In the black sample, mother's occupation appeared as the most significant predictor of length of latent phase of labor, with the daughters of mothers who were employed in clerical or professional occupations having a significantly shorter adjusted mean length of latent phase (see Figure 3). The current method of health assessment of clinic patients who present for prenatal care places emphasis on physical assessment but rarely looks carefully at the social influences which could indicate special needs for education that could more adequately prepare certain of these women for the stress that they will experience at the onset of labor. While the widely used childbirth preparation classes may be quite helpful to women who feel in control of the situation at the onset of labor, more personalized desensitization methods may be necessary to help women who doubt their ability to be in control.

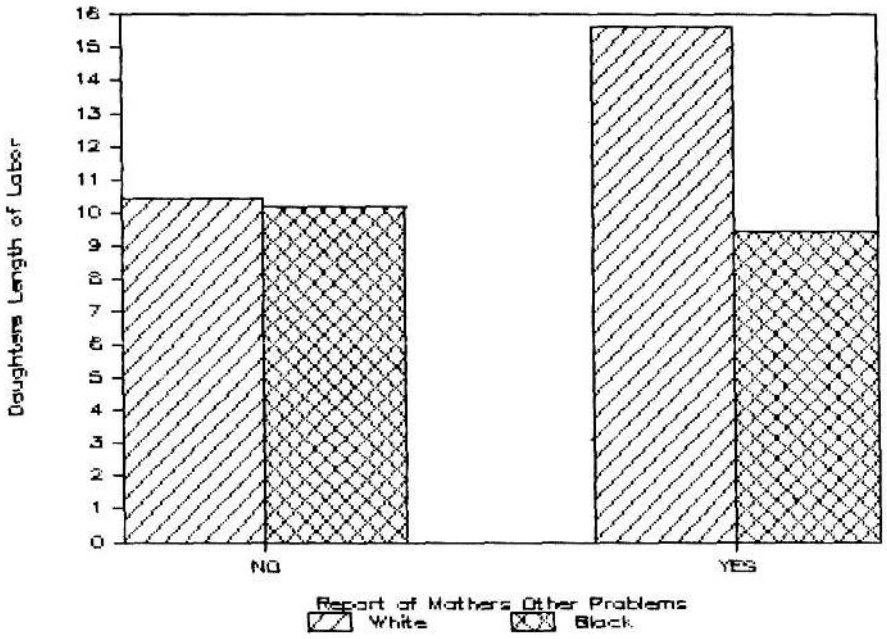

Figure 2

Labor by Report of Other Problems*
(in hours)

The findings from this study lend support to the premise that a woman brings to her first childbirth experience multiple influences which shape her perception of her identity and capability for coping with stressful events. The perception of a woman's ability to have control of events that may occur in her adult life and feelings of helplessness to exert control during labor can be influenced by direct or overheard accounts from a mother who recalls problems, but cannot recall the exact nature of these problems. Contrarily, a black woman whose mother was able to achieve status in a career, in spite of handicaps imposed by a discriminatory society, is likely to feel confident that a woman can shape her own destiny and face challenges from a position of strength.

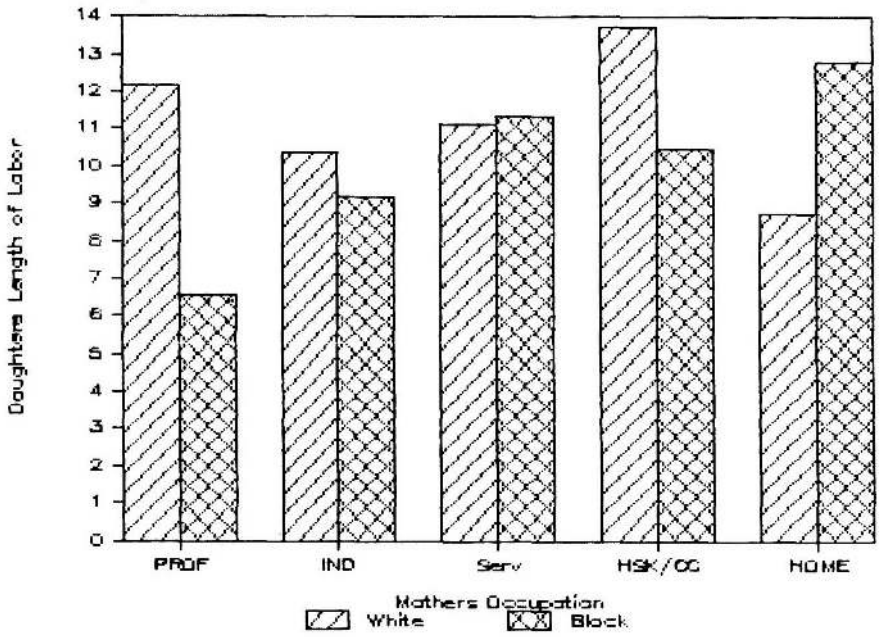

Figure 3

Length of Labor by Mothers Occupation*
(in hours)

The differences seen between the black and white samples in the effect of strong negative versus strong positive attitudes emphasize the need for greater understanding of differences in patterns of childrearing and communication that exist in various cultures. Through gaining this understanding, the needs of individual women for reduction of anxiety in anticipation of childbirth can be more realistically met. SUMMARY The results of this study show that social influences can affect the level of anxiety and in turn the course of labor. The birth of a child, an exciting life event, can thus be seen more clearly as a bridge between the past and the future. Communication about this important life event, between one generation and the next can be a source of the strength needed by women to cope with the challenge of bearing a child. Footnote * Graphs were developed by M. Kay Cresci, R.N., M.S., Instructor, The Johns Hopkins University School of Nursing. References REFERENCES 1. Ford, C.S. (1945). A comparative study of human reproduction. Yale University Publications in Anthropology, 31, 1. 2. Spenser, R.R. (1949). Primitive obstetrics. CIBA Symposia, 11, 1158. 3. Friedman, E.A. (1978). Labor: Clinical evaluation and management, 2nd Ed, Appleton-Century-Crofts. 4. Schulman, H. (1976). Prolonged and abnormal labor. American Journal of Obstetrics and Gynecology, 93, 732. 5. Reynolds, S.R.M., Harris, J.R., &Kaiser, I.H. (1954). Clinical measures of uterine forces in pregnancy and labor. Charles C. Thomas Publishers. 6. Garcia, C.R., &Garcia, J.S. (1955). Epinephrine-like substances in the blood and their relation to uterine inertia. American Journal of Obstetrics and Gynecology, 65, 812. 7. Gunther, R.E., &Bellville, J.W. (1972). Obstetrical and Caudal Anesthesia: II. A Randomized Study Comparing 1 Percent Mepivacaine with 1 Percent Mepivacaine Plus Epinephrine. Anesthesiology, 37, 288. 8. Lederman, R.P., Lederman, E., Work, B.A. &McGann, D.S. (1978). The Relationship of Maternal Anxiety, Plasma Cathecholines, and Plasma Cortisol to Progress in Labor. American Journal of Obstetrics and Gynecology, 132, 495. AuthorAffiliation Leah Bonovich, R.N., Sc.D. AuthorAffiliation Leah Bonovich, R.N., Sc.D. is at the Johns Hopkins University School of Nursing, 600 North Wolfe St., Houck Building, Rm. 375C, Baltimore, MD 21205. The graphs used in this article were prepared by M. Kay Cresci, R.N., M.S.

APPENDIX

Attitude Toward Childbirth Scale

Directions to Respondent: I am going to read some statements that women often make about having babies. Please tell me if you think the statement is always true (strongly agree), often true (agree), often not true (disagree), never true (strongly disagree).

(N) Negative Statement
(P) Positive Statement

1. A woman who does not want to become pregnant should not have sex.
   SA _____ A _____ D _____ SD _____ (N)
2. A good education is more important than getting married.
   SA _____ A _____ D _____ SD _____ (N)
3. A woman who has been brought up right won't cry or carry on when she is in pain.
   SA _____ A _____ D _____ SD _____ (N)
4. A woman doesn't enjoy sex as much once she has a baby.
   SA _____ A _____ D _____ SD _____ (N)
5. A man will try to make a woman pregnant so she will stay at home.
   SA _____ A _____ D _____ SD _____ (N)
6. It is taking care of children that makes a woman a mother.
   SA _____ A _____ D _____ SD _____ (P)
7. A child owes his/her mother love and respect.
   SA _____ A _____ D _____ SD _____ (N)
8. Boys are less worry to a mother than girls because they can't get pregnant.
   SA _____ A _____ D _____ SD _____ (N)
9. Having a baby is more important to a woman than getting a good job.
   SA _____ A _____ D _____ SD _____ (P)
10. Taking someone else's child to raise is not the same as being a mother.
    SA _____ A _____ D _____ SD _____ (N)
11. Some women are not good mothers.
    SA _____ A _____ D _____ SD _____ (P)
12. There is no other kind of pain exactly like the pain of labor.
    SA _____ A _____ D _____ SD _____ (N)
13. If you talk to children too much about sex, they will want to try it.
    SA _____ A _____ D _____ SD _____ (N)
14. A woman who cries and screams when she is in labor does this because the pain is so bad.
    SA _____ A _____ D _____ SD _____ (N)
15. Women in this country still die in childbirth.
    SA _____ A _____ D _____ SD _____ (N)
16. Most women don't expect labor pains to be as bad as they are.
    SA _____ A _____ D _____ SD _____ (N)
17. Men would love their children more if they knew how hard it is to have a baby.
    SA _____ A _____ D _____ SD _____ (N)
18. A pregnant woman should not be frightened by being told too much about labor.
    SA _____ A _____ D _____ SD _____ (N)
19. A pregnant woman should not be frightened by being told too much about labor.
    SA _____ A _____ D _____ SD _____ (N)
20. Men couldn't stand the pain that women have when they are in labor.
    SA _____ A _____ D _____ SD _____ (N)
21. If girls knew how painful childbirth is, there would be fewer babies.
    SA _____ A _____ D _____ SD _____ (N)
22. A woman who cries and screams when she is in labor does this because she is scared.
    SA _____ A _____ D _____ SD _____ (P)
23. It is impossible to tell anyone what labor is really like.
    SA _____ A _____ D _____ SD _____ (N)
24. When a woman has gone through labor she knows how strong she really can be.
    SA _____ A _____ D _____ SD _____ (P)

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