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Original Article

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SIGNIFICADO DO MEDO NO PARTO: PERCEPÇÃO DAS MULHERES EM UM CENTRO DE PARTO NORMAL

MEANINGS OF FEAR IN CHILDBIRTH: WOMEN'S PERCEPTIONS IN A NORMAL BIRTH CENTER

SIGNIFICADOS DEL MIEDO EN EL PARTO: PERCEPCIONES DE LAS MUJERES EN UN CENTRO DE PARTO NORMAL

RESUMO

Objetivo: rastrear os significados do medo no parto na percepção de mulheres atendidas em um Centro de Parto Normal. **Metodologia:** estudo qualitativo, fundamentado no método cartográfico, realizado por meio de uma pesquisa de campo mediante a entrevista semiestruturada, onde participaram 20 puérperas e o tratamento dos dados utilizou-se análise de conteúdo categorial. **Resultados:** emergiram quatro categorias: dor; emoções; sentimentos; alívio. O medo mostrou-se multifatorial, capaz de interferir impactando na progressão do parto. A presença da enfermagem obstétrica na sala; o alívio da dor, o acompanhante, a comunicação adequada, ambiente favorável e a prevenção da violência

obstétrica surgem como estratégias de alívio do medo. **Conclusão:** o medo pode prejudicar a evolução do parto e criar sensação de sofrimento. Existem estratégias para seu alívio, que ajudam a ressignificar essa vivência, tornando-a mais positiva.

DESCRITORES: Percepção; Medo; Parto; Gestantes; Corpo humano.

ABSTRACT

Objective: to track the meanings of fear during childbirth as perceived by women attending a Birthing Center. **Methodology:** qualitative study, based on the cartographic method, carried out through field research using semi-structured interviews, in which 20 postpartum women participated and data processing used categorical content analysis. **Results:** four categories emerged: pain; emotions; feelings; and relief. Fear proved to be multifactorial and capable of negatively impacting labor progression. The presence of an obstetric nurse in the room; pain relief; a companion; adequate communication; a supportive environment; and the prevention of obstetric violence emerge as strategies for alleviating fear. **Conclusion:** fear can hinder the progress of labor and create a feeling of suffering. There are strategies for alleviating this fear, which help to reframe this experience, making it more positive.

DESCRIPTORS: Perception; Fear; Childbirth; Pregnant women; Humans body.

RESUMEN

Objetivo: rastrear los significados del miedo durante el parto según lo perciben las mujeres que asisten a un Centro de Maternidad. **Metodología:** estudio cualitativo, basado en el método cartográfico, realizado a través de investigación de campo mediante entrevistas semiestructuradas, en el que participaron 20 puérperas y el procesamiento de los datos utilizó análisis de contenido categórico. **Resultados:** surgieron cuatro categorías: dolor; emociones; sentimientos; y alivio. El miedo demostró ser multifactorial y capaz de impactar negativamente la progresión del trabajo de parto. La presencia de una enfermera obstétrica en la habitación; el alivio del dolor; un acompañante; una comunicación adecuada; un ambiente de apoyo; y la prevención de la violencia obstétrica surgen como

estrategias para aliviar el miedo. **Conclusión:** el miedo puede obstaculizar el progreso del parto y generar una sensación de sufrimiento. Existen estrategias para aliviar este miedo que ayudan a replantear la experiencia, haciéndola más positiva.

DESCRIPTORES: Percepción; Miedo; Parto; Mujeres embarazadas; Cuerpo humano.

INTRODUCTION

The childbirth experience involves emotions and feelings expressed through pain, pleasure, and fear,[1] making it both a physiological and symbolic event. In this context, fear stands out—frequently silenced in technicist discourses—permeating the practice of professionals involved in the scenario and raising questions about how to alleviate the various types of fear experienced by women in this context.

For vaginal birth to occur naturally, the woman must feel safe, and the hospital environment interferes with the physiology of childbirth.[2] As it is a moment of great vulnerability, it becomes essential that professionals understand each woman's fears and develop personalized and effective care.

This study relates to national and global efforts to improve childbirth care, aligning with the National Guidelines for Normal Childbirth Care,[3] the 2030 Agenda goal of reducing maternal mortality,[4] and the principles of the Alyne Network, which proposes humanized obstetric care grounded in reproductive justice, equity, and the fight against maternal and neonatal mortality.[5]

Available studies on the topic from the woman's perspective, particularly in the more peripheral regions of Brazil, are still scarce and often lack adequate methodological quality, impairing their clinical applicability.[6] Therefore, this study makes it possible to broaden understanding, improve care, strengthen female autonomy, and reduce negative outcomes related to childbirth, in addition to offering support for obstetric nursing practice and the development of future research.

Nursing is the profession that best understands the real needs of women in labor, as nurses spend much time at their side. Deepening knowledge on the topic therefore allows

care to be enhanced. In this sense, the present study sought to answer: What are the meanings of fear in childbirth, from the perspective of women who gave birth in a Normal Birth Center? And it aimed to: Identify the meanings of fear in childbirth from the perspective of women assisted in a Normal Birth Center.

METHOD

This is a qualitative study supported by the cartographic method, which encourages the researcher to deviate from traditional methods and look toward approaches that favor the understanding of subjectivity.[7,8]

The study was conducted following the method's tracks: Track 2 – The functioning of attention in the cartographer's work, by Virgínia Kastrup, composed of four gestures: Tracing; Touch; Landing and Attentive Recognition; and Track 7 – To map is to inhabit an existential territory, by Johnny Alvarez and Eduardo Passos.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) was also used as a guide, which presents 32 items to ensure quality and transparency in qualitative studies.[9]

The research was carried out at the Normal Birth Center (CPN) of a Maternal and Child Hospital in Boa Vista, Roraima, through semi-structured interviews with twenty (20) postpartum women, individually, with audio recordings made using a portable device and fully transcribed for analysis.

Data collection took place from August 16 to September 7, 2024, during morning and afternoon shifts, in private and individualized rooms, respecting a minimum interval of two hours postpartum to avoid interference with breastfeeding.

The data collection instrument was structured with sociodemographic and obstetric information, followed by nine (09) open-ended questions aimed at the proposed objectives. Sampling was intentional by criterion, including adult postpartum women who had vaginal births at the site, who were at least two hours postpartum, whose mother and child were well, and who agreed to participate in the study. Exclusion criteria: those who

did not understand the Portuguese language, who had complications during childbirth or postpartum, and those who chose to withdraw from the study.

Participation was voluntary, with consent and signature of the Free and Informed Consent Form (TCLE), and to ensure anonymity, participants were subsequently identified with the letter M followed by an Arabic numeral (M1... M20).

The analysis used Categorical Content Analysis,[10] following pre-analysis, exploration of the material, and treatment of results, inference, and interpretation of data.

The study followed all ethical principles for research, in accordance with Resolution 466/2012, which regulates research involving human beings in Brazil, ensuring participants' rights to anonymity and confidentiality, and was approved by the Research Ethics Committee (CEP) of the Federal University of the State of Rio de Janeiro, under opinion 6.996.392 and CAAE 80560724.1.0000.5285.

RESULTS

The section is divided into two parts, consisting of the participants' profile and the synthesis of the categories that emerged after data processing.

The profile of the postpartum women showed that: most were Brazilian (90%); from Roraima (85%); brown-skinned (75%); single (45%); with complete high school education (75%); homemakers (50%); and an average age of 25 years. The mean gestational age was 39 weeks; one previous pregnancy; seven prenatal consultations; and (100%) had no complications during pregnancy or childbirth.

The synthesis of the categories in this section highlights the narratives that presented significant relevance based on the categorical content analysis, through the identification of registration units (UR), considering aspects extracted from the participants' statements. Below are the four categories that emerged: Category 1: PAIN (24 occurrences) – One of the most prominent elements. Uterine contractions were the most frequently mentioned aspect in this category. It was observed that the fear of pain affected the labor process, making them feel insecure and, in some situations, even

preventing their movements due to the fear that something serious could happen to them or their child, as portrayed in the following statements:

> *...It felt like they were tearing my body from the inside. It was unbearable. (M9)*
> *…the pain was so intense that I lost track of time.* (M14)

These statements indicate an interweaving of physical and emotional pain, forming a perceptible triad: fear of feeling pain; fear because they were feeling pain; and pain intensified by fear.

Category 2: EMOTIONS (26 occurrences) – Some women showed difficulty recognizing their emotions, describing feelings such as shame related to body exposure, tiredness, the weight of responsibility for not succeeding, discouragement, disbelief, security, insecurity, a sense of incapacity, the desire to give up, and a sense of vulnerability. Before the baby's birth, emotions appeared to be more intense. Here are some examples:

> *...There was a moment when I laughed out of nowhere. And then I started to cry. Everything was very intense. (M13)*
> *…I felt everything at the same time—fear, anxiety, joy. It's hard to explain.* (M17)

After the baby's birth, signs of transformation can be observed. The following stand out:

> *...when she was born, I laughed and cried at the same time. It was magical. (M5)*
> *…the emotion was so strong that all I could do was smile and give thanks. (M12)*

Category 3: FEELINGS (38 occurrences) – Feelings were also present. Sometimes silenced, they emerged as powerful markers of the childbirth experience, influencing both the lived experience and physiological progression.

The participants reported a desire to give up on vaginal birth, associated with the feeling of being incapable of giving birth.

> *...I told the nurse that I wanted to leave, that I couldn't take it anymore. (M4)*
> *…I said that I didn't want it anymore, that I wanted to run away. Fear took over.* (M14)

The fear of obstetric violence appeared significantly in the reports. Hearing negative experiences, the fear of being mistreated, ignored, or subjected to procedures without consent generate anguish and distrust.

> *...my biggest concern was being ignored when I needed help. (M8)*
> *…I thought they were going to perform procedures without telling me, and that terrified me.*(M11)

The lack of information about labor during prenatal care was identified as a source of fear. They point out:

> *...they didn't tell me it would hurt that much. I was terrified when it started. (M10)*
> *…I went to the maternity ward thinking I knew what to expect, but I knew nothing. That made me afraid.* (M19)

The fear of death emerged, both regarding their own finitude and the possibility of losing the baby, fueled by previous negative experiences or reports. We can observe this in some statements:

> *...I was afraid of a lack of oxygen… of him dying… (M10)*
> *…my fear was of dying… because some people who lived with me kept scaring me.* (M2)

Category 4: RELIEF (62 occurrences) – Factors that contributed to relieving fear during childbirth were identified, allowing for greater calm, support, and safety, which also reflected in the relief of physical pain.

They highlighted the importance of obstetric nursing support, with continuous and attentive presence, as a fundamental factor for relieving fear during childbirth and reducing feelings of insecurity and vulnerability.

This support manifested in several ways, such as: pain relief; encouragement and motivation through the promotion of autonomy and empowerment of the birthing woman; prevention of obstetric violence; comfort in moments of loneliness; greater reassurance regarding fetal well-being; and, above all, relief from the fear of death.

The following stand out:

> *...just seeing that she was there with me made me feel calmer. (M4)*

> *…the nurse talked to me, and that gave me confidence.* (M9)

Pain relief through non-pharmacological methods was of great importance in relation to the relief of fear, such as warm shower bathing, breathing guidance, massage, freedom of movement, instructions, support, and encouragement.

> *...they taught me how to breathe and the pain decreased. Then I became less scared. (M5)*
> *…they applied a hot water bag and that helped me a lot.* (M6)

The presence of a companion, by itself, already increases the feeling of comfort, safety, and emotional relief, and when this companion is prepared to take on their role actively, the childbirth experience becomes more positive.

> *...having my mother with me meant everything. She gave me strength with her words and her presence. (M3)*
> *…just seeing him there beside me made me feel that I wasn't alone.* (M10)

The way professionals communicate with women can either help or hinder the process. They suggest effective communication, with a gentle tone of voice and respectful delivery of information about the childbirth process, encouragement, and support, which reduces anxiety and increases self-confidence.

> *...the way they spoke to me, with affection, made all the difference. (M8)*
> *…the communication was what calmed me the most… it made me feel safe*(M17)

The environment also makes all the difference in relieving fear:

> *...everything there conveyed peace. I felt safe just being in that space. (M10)*
> *…there was an atmosphere of care in the air. That made me lose my fear.*(M20)

It is clearly noticeable another triad related to women's fear during the progression of labor: fear–tension–impact on progression. The triad demonstrates that these factors can generate tension (physical, emotional, or both) in the birthing woman, which may result in an impact on the natural progression of the labor process, favoring unnecessary

interventions that could be avoided through fear relief.

Mapping these women in this setting made it possible to identify phenomena related to the meaning of fear based on their lived experiences, which contributes to the development of indicators and strategies for more effective obstetric care.

DISCUSSION

The findings show that fear in childbirth is configured as a multifaceted experience, making it a complex phenomenon with physical, emotional, cultural, and relational dimensions, which can interfere with the physiology of childbirth and compromise the physical and emotional well-being of the birthing woman.

Physical pain was one of the main causes related to fear in childbirth, in agreement with the literature,[11] which describes pain as both a physiological and emotional event, primarily caused by uterine contractions triggered by oxytocin, which reduces oxygenation of the muscle, releasing lactic acid and other inflammatory substances that irritate local nerve endings.

Consequently, reports of pain in other regions are supported by the same literature, which notes that the baby's passage through the maternal pelvis and vagina causes pain in these areas due to pressure on joints and ligaments. Relaxin helps increase joint mobility in the hips, favoring ligament stretching in this region and causing pain.

The "fear–tension–pain" triad proposed by Dick Read is reflected in the interviewees' accounts.[12] It reinforces that pain is both physical and emotional and can be alleviated with adequate information on the subject, making childbirth a more pleasant experience.

It is essential that professionals recognize pain in its broad dimension, as it may impact labor progression and contribute to increased unnecessary interventions.[13]

Emotions go beyond sensations and are considered affective–expressive relationships,[14] which was observed among participants. This is related to the fact that, before childbirth, they were surrounded by information of questionable quality, which

triggered various emotions aligned with this and other studies,[15] reporting that some women feel unprepared for childbirth, arriving at the hospital without knowing what to think or do.

However, complaints such as fear and pain among women assisted at Normal Birth Centers tend to be accompanied by satisfaction with the nursing care provided and the comfort of the setting. After birth, many describe the experience as one of satisfaction and relief.[6] These findings align with this study and reinforce consistency between this care model and positive maternal experiences.

Feelings go beyond sensations, being deeper and more long-lasting in the body, as they require more complex and profound processes than emotions, involving reflection on what is felt.[14] Within this perspective, fear, as a feeling, determines a global response of immobilization and vital withdrawal, with a sensation similar to apparent death, contributing to a desire to flee.[16] This sensation was also reported by participants. In the childbirth context, this struggle in the form of non-acceptance of the process creates a mismatch in natural physiological mechanisms, making childbirth slower and more painful.[13]

Women experience fear of obstetric violence, which may occur physically, psychologically, or institutionally, making childbirth a frightening event.[17,18] The results also highlighted that this fear is often complex to define and identify, making recognition and resolution difficult.

Childbirth is permeated by fears arising from historical–cultural constructions and from local realities concerning the care provided to women during moments of vulnerability,[1] which aligns with this study's findings and with what women hear prior to childbirth, often influenced by previous birth experiences. This may even be a determining factor in choosing the mode of delivery.[1]

Throughout obstetric history, many changes have occurred, including the institutionalization of childbirth, which can generate feelings of loss of autonomy and

confidence,[2] reinforcing interviewees' accounts of fearing they would not be able to give birth successfully.

Lack of prenatal information interferes with childbirth experience, especially for first-time mothers, increasing fear and insecurity.[20] Multiparous women also reported needing information, as each childbirth is unique and different for each woman.

Postpartum women reported that direct assistance from obstetric nursing itself was a factor that relieved fear, consistent with studies showing that care involving respectful, comprehensive support from prenatal to postpartum, providing guidance and emotional support, contributes to more positive childbirth experiences.[6,21,22]

Another form of fear relief is pain relief through non-pharmacological methods, which are non-invasive techniques that promote safety and relaxation, calming the woman and facilitating the woman–professional relationship.[19,23,24] Respectful care and a welcoming, comfortable environment[6,22] also contribute to a more positive childbirth experience.[23] Use of these methods is a strategy that helps relieve fear during childbirth, making it less painful, less prolonged, and perceived as more positive.[19,23,24]

Anxiety and fear can be reduced by clear and empathetic communication from nurses.[6,22] Clear and welcoming communication was one of the essential factors for relieving fear among the participants. The presence of professionals explaining each stage calmly and effectively encouraged women and helped alleviate fear, making childbirth safer and more positive.

Another aspect to consider is obstetric violence in both public and private settings,[25] which aligns with the participants' fear of experiencing such practices. When a woman suffers obstetric violence, negative repercussions occur in many areas of her life, making it essential that public policies be developed to address this issue.[25] Obstetric nursing can help reduce or eliminate this practice, contributing to healthier childbirth experiences.

The obstetric nurse, being the professional who remains continuously by the

woman's side during childbirth, must observe her individual needs and plan ways to relieve fear so as to favor the childbirth environment and support a positive experience.

It is important to emphasize that the childbirth experience is permeated by fears that generate discomfort and insecurity, potentially prolonging labor, increasing pain, and even turning childbirth into suffering. Moreover, nurses working in Normal Birth Centers have greater potential to support fear relief, which may serve as an incentive for this care model.

The cartography method incorporated into this research enabled critical and reflective thinking, helping overcome fragmented knowledge and generating new questions on the topic. Therefore, the study contributes to strengthening the practice of professionals who care for birthing women, especially obstetric nurses, by expanding understanding of the meanings of fear in childbirth and indicating paths for its relief.

CONCLUSION

The study made it possible to trace the meanings attributed to fear in childbirth by women assisted at a Normal Birth Center, revealing it as a multifactorial phenomenon and highlighting the complexity and subjectivity involved in the birthing process and in the fears experienced by women at this moment, which may make childbirth longer, more painful, and perceived as suffering.

Given this context, women need to be observed and heard as an effective action mechanism for professionals, allowing the development of strategies to relieve fear, which can be systematized by obstetric nursing during the act of giving birth.

The study was limited to 20 postpartum women and a single Birth Center, which opens possibilities for comparative studies between different care models and with more diverse samples.

However, it contributes to the improvement of obstetric care, especially in contexts of greater social and geographical vulnerability.

Finally, it reinforces the need for sensitive and individualized care practices that

consider the subjectivity of the birthing woman and promote safe, welcoming, humanized, and evidence-based environments.

In this way, it provides important guidance for the formulation of public policies aimed at improving maternal and child health care, with a focus on promoting positive childbirth and birth experiences.

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