Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

September 2022. Volume 9. Number 3

Research Paper

Analyzing the Relationship Between Spiritual Well-being and Fear of Childbirth in Pregnant Women

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Please cite this article as Rabiepour S, Etesami E. Analyzing the Relationship Between Spiritual Well-being and Fear of Childbirth in Pregnant Women. Health Spiritual Med Ethics. 2022; 9(3):133-144. http://dx.doi.org/10.32598/hsmej.9.3.135.1

doi: http://dx.doi.org/10.32598/hsmej.9.3.135.1

Article info:
Received: 26 Feb 2022
Accepted: 23 May 2022
Publish: 01 Sep 2022

Keywords:
Spiritual well-being, Fear of childbirth, Pregnant women

ABSTRACT

Background and Objectives: Fear of childbirth is a psychological reaction that depends on various reasons during labor. This study aims to investigate the relationship between spiritual well-being and fear of childbirth in pregnant women referred to the public hospitals of Urmia City, Iran, in 2020.

Methods: This descriptive-correlational study was conducted on 300 pregnant women who referred to public hospitals in Urmia city, Iran, via the available sampling method. Data collection tools included a questionnaire regarding demographic and obstetrics information, the fear of childbirth questionnaire by Wijma and Rose (1988), and the spiritual well-being questionnaire by Paloutzian and Ellison (1983). The data were analyzed via SPSS software, version 16. Meanwhile, the independent t-test, analysis of variance, and the Pearson correlation index were analyzed at a significance level of 0.05.

Results: The results demonstrated a meaningful statistical relationship between education level, occupation, income, owning a house, religious beliefs, number of miscarriages, marital satisfaction, and the lack of previous treatment for sterility with spiritual well-being and fear of childbirth ($P<0.05$). Additionally, all aspects of spiritual well-being, such as religious well-being and existential well-being showed a statistically significant positive relationship with fear of childbirth ($P<0.0001$).

Conclusion: Based on the results of this study, higher spiritual well-being is accompanied by reduced fear of childbirth. Accordingly, considering programs to improve the spiritual well-being of pregnant women can alleviate one of the stressful and major difficulties of this population.

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Introduction

Fear of childbirth (FOC) is a psychological reaction that depends on various reasons, such as the mother's characteristics and her physical and mental calmness during labor [1]. Severe FOC can result in nightmares, complaints about physical health and problems in concentration, and disruption in life [2], along with side effects such as an intensified feeling of pain more than reality and post-labor depression, feeling of loneliness during pregnancy [3-5], and more importantly, more elective caesareans with unwanted ill-consequences. The rate of cesarean because of FOC in Iran is 5 times higher than the world rate [6].

Up to now, various approaches have been used to control FOC. Employing sedative approaches, the presence of a team of consultants to support the mother and control FOC, psychological consultations, obstetricians' emotional support, and cognitive-behavioral consultations are among the tactics that have been used to control FOC [7]. Some studies have maintained that higher spiritual intelligence in pregnant women can reduce their FOC [8]. Other studies have reported a meaningful negative correlation between spirituality and FOC and higher spirituality can help in choosing natural childbirth instead of cesarean, thereby preparing women for a safer child delivery [9].

Spirituality is a reflection of emotional, cognitive, and behavioral aspects, along with the 2 aspects of religious and existential spirituality [10]. In other words, spirituality is a dynamic procedure and the individual defines the meaning of life as being with a grand entity [11]. However, religion is a set of behavioral norms [12]. Having these two aspects together can result in spiritual well-being [10]. Spiritual well-being is the newest aspect of health that is placed next to other areas of health, namely physical, mental, and social [13]. Spiritual well-being is described as having a sense of acceptance, positivity, and a positive mutual connection with the existing powers [14]. Even though the results of various studies demonstrated a positive effect of spirituality on mental health, it should be considered that religious beliefs may bring about negative results with encouragements to leave or withdraw from the treatment, not having a timely visit to prevent diseases, and avoidance from preventives measures for the health the individual [15]. In contrast to these studies, some researchers have reported a lack of correlation between spiritual intelligence and FOC [16]. Other researchers have maintained that in terms of the effect of spirituality on FOC, intervention studies with large samples should be conducted [17]. Some authors have reported the positive effect of spirituality on reducing the pain of labor and making the experience pleasant [18].

Considering the excellent status of spirituality and spiritual well-being in the field of health, the roots and depth of spirituality in Iran, and the penetration of spiritual beliefs in every aspect of Iranian society, along with the utmost and undeniable importance of the presence of FOC, contradictory results from national and international studies and having no similar national investigation, and considering that spiritual well-being is a new aspect of health, studying this new part of health and its connection to special circumstances requires research. Women have a changing and sensitive psychological situation during pregnancy; therefore, this study aims to investigate the relationship between spiritual well-being and FOC in pregnant women who referred to public hospitals in Urmia City, Iran, in 2020.

Methods

This was a descriptive-correlational study on 300 out of 2000 pregnant women who were referred to public hospitals in Urmia city, Iran, during the first half of 2020. The study population was selected based on the available sampling method. The inclusion criteria were providing consent to participate in the study, inclination, and possibility of having natural childbirth, and the lack of known contradiction for natural childbirth. Those pregnant women who did not meet the inclusion criteria were excluded from the study. After receiving approval from the Ethics Committee of the university and stating the study objectives to the participants, along with their approval and signed consent letters to participate in the study, we started sampling and conducting the research, following the ethical guidelines. Data gathering tools included 1) the questionnaire for demographic and obstetrics information, 2) the Wijma delivery expectancy/experience questionnaire, version A (W-DEQ), and 3) the spiritual well-being scale (SWB). All the questionnaires were completed by interviewing pregnant women who referred to the above-mentioned hospitals, after receiving their consent letters to participate in the study.

The demographic and obstetrics questionnaire contained questions regarding education level, occupation, spouse's educational level, spouse's occupation, income, the number of miscarriages, marital satisfaction, use of assisted reproductive methods, and receiving psychological support and spouse's support.

W-DEQ-version A was developed in 1988 by Wijma and Rose. This questionnaire includes 33 questions and 6 factors, namely the lack of positive prediction, fear, the lack of self-efficacy, loneliness, fear of injury to the fetus, and the lack of control. This tool is scored based on a 6-point Likert scale and with questions such as "I stay unfriendly with those who are moderate to me" investigates FOC. The questions are rated from 0 to 5, defined as "never", "very little", "little", "moderate", "very", and "a lot", respectively. In this questionnaire, questions 1, 4, 5, 9, 10, 13, 14, 16, 17, 18, 21, 22, 23, 26, 28, 29, and 30 were inversely scored. The minimum score is equal to 0 and the maximum score is 165. Accordingly, a score of 37 or lower is defined as low fear, a score of 38 to 65 is minimum fear, and a score of 66 to 84 is considered extreme fear. The cutoff score is 85; therefore, scores above 85 confirm FOC [19]. The validity and reliability of this questionnaire were obtained at 0.87 via the Cronbach α method in Australia [20]. The validity and reliability of the Persian version in Iran were obtained at 0.64 via the Cronbach α method by Aabedi et al. [21]. In the present study, to calculate the reliability of the questionnaire, firstly, the questionnaire was distributed among 30 individuals of the study sample who did not participate in the investigation processes of the research. The reliability of the questionnaire was obtained at 0.71 via the Cronbach α method.

The SWB questionnaire [22] was developed by Paloutzian and Ellison in 1983. SWB includes 20 questions that are scored based on a 6-point Likert scale from 1 (totally disagree) to 6 (totally agree). This scale is divided into two subscales, namely religious and existential well-being. Each subscale has 10 phrases and is scored from 10 to 60. Additionally, spiritual well-being is classified into 3 subcategories, namely low-level (scores from 20 to 40), mid-level (scores from 41 to 99), and high-level (scores from 100 to 120). Higher scores in this questionnaire demonstrate higher spiritual well-being. In this tool, the variable of "spiritual wellbeing" is considered the core philosophy of life and can show the satiation of needs, such as goal, meaning, love, and forgiveness. Meanwhile, existential well-being is considered the sense of goal orientation, satisfaction from life, and religious well-being as the result of being in contact with a higher power that is God. The validity and reliability of this questionnaire were obtained at 0.93, 0.91, and 0.91 via Cronbach α for religious well-being, existential well-being, and the total scale [23]. This scale was standardized in Iran by Omidvari et al. and obtained a Cronbach α of 0.91. In addition, a Cronbach α of 0.82 was obtained by Abbasi et al. [24]. The validity of the questionnaire was confirmed via content validity, and to obtain the reliability of this scale, similar to W-DEQ-Version A scale, we employed the 30 individual who did not participate in the investigation part of the research and the tool obtained the Cronbach α of 0.79.

The questionnaire was filled out for illiterate participants by the researchers and other participants filled out the questionnaire individually. Finally, the data were analyzed via the SPSS software, version 16, and the significance level of 0.05 was used for statistical analysis. For quantitative data, we used Mean±SD and for qualitative data, we reported the frequency and percentage. The normality distribution of the scores of the W-DEQ-Version A scale and SWB scale was tested and approved by the Kolmogorov-Smirnov test. To compare the mean score of spiritual well-being and FOC, we used the independent t-test and analysis of variance, and to check the correlation between the quantitative variables, we used the Pearson correlation test.

Results

Demographic characteristics of the study population are provided in Table 1. The results showed that the previous mode of child delivery of women who were studied was natural childbirth (61.2%). The majority of the participants (27.8%) had a university education while the majority of their spouses (41.1%) had a diploma. Many of the mothers who participated in this study were housewives (64.2%), had sufficient income (53.2%), many lived in rented houses (48.8%), were followers of Islam (97.3%), Azari women comprised nearly half of the population (53.5%), faith in religion was high (83.3%), wanted pregnancy was high as well (70.9%), and more than half of the population had no miscarriages (59.9%). Meanwhile, the results of this Table demonstrate that the majority of the studied women (98.7%) had a history of chronic diseases. In addition, 251 participants reported using medications and more than half of the population (60.7%) received mental support from their spouses and this support was in the mid-level (54.7%). Additionally, family support in our participants was around mid-level (13.40%). Finally, in analyzing the frequency distribution of the 3-month pregnancy, many of the women (12.36%) were in the second 3 months of their pregnancy period.

In Table 2, we have listed the correlation between demographic features with spiritual well-being and FOC in pregnant women who referred to public hospitals of Urmia city, Iran, namely Army Hospital and Imam Reza Hospital in the first half of 2020. The results demonstrate that demographic variables such as higher educa-

Table 1. Demographic characteristics of the study population

Qualitative Variables	Level	Absolute Abundance	Relative Abundance
Previous childbirth	Yes	183	61.2
Previous childbirth	No	116	38.8
Education level	Illiterate	30	10.0
Education level	Below diploma	128	42.8
Education level	Diploma	58	19.4
Education level	University	83	27.8
Occupation	Housewife	192	64.2
Occupation	Employee	70	23.4
Occupation	Other	34	11.4
Spouse's education level	Illiterate	13	4.3
Spouse's education level	Below diploma	90	30.1
Spouse's education level	Diploma	123	41.1
Spouse's education level	University	72	24.1
Spouse's occupation	Unemployed	11	3.7
Spouse's occupation	Employee	114	38.1
Spouse's occupation	Worker	72	24.1
Spouse's occupation	Free work	102	34.1
Income	Sufficient	89	29.8
Income	Relatively sufficient	159	53.2
Income	Insufficient	49	16.4
Housing status	Personal	113	37.8
Housing status	Rented	146	48.8
Housing status	Parents	39	13
Religion	Islam	291	97.3
Religion	Christian and Jewish	7	2.3
Mother tongue	Persian	21	7.0
Mother tongue	Azari	160	53.5
Mother tongue	Kurdish	117	39.1
Religious belief	Very High	249	83.3
Religious belief	To some extent	32	10.7
Religious belief	Low	18	6.0
Wanted pregnancy	Yes	212	70.9

Qualitative Variables	Level	Absolute Abundance	Relative Abundance
Wanted pregnancy	No	86	28.8
Miscarriages	Does not have	179	59.9
Miscarriages	1	98	32.8
Miscarriages	2 or more	22	7.4
History of chronic disease	Do have	4	1.3
History of chronic disease	Does not have	295	98.7
Marital satisfaction	Complete satisfaction	184	61.5
Marital satisfaction	Relative satisfaction	105	35.1
Marital satisfaction	No satisfaction	9	3.0
History of assisted reproductive methods	Yes	64	21.4
History of assisted reproductive methods	No	234	78.3
Source of mental support	Spouse	211	70.6
Source of mental support	Parents	68	22.7
Source of mental support	Friends	3	1.0
Source of mental Support	Other relatives	17	5.6
Spouse's support	Low	39	13.0
Spouse's support	Mid	142	47.5
Spouse's support	High	118	39.5
Other relative's support	Low	72	24.8
Other relative's support	Mid	120	40.13
Other relative's support	High	107	35.78
3-months of pregnancy	First 3-months	86	28.76
3-months of pregnancy	Second 3-months	105	35.11
3-months of pregnancy	Third 3-months	108	36.12

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

tion level, being an employee, having sufficient income, owning a house, and strong religious beliefs, in addition to fewer miscarriages, high marital satisfaction, and the lack of previous treatment for sterility have a meaningful statistical relationship with spiritual well-being and FOC ($P<0.05$, for all).

The Mean±SD of spiritual well-being in this study was 37.114±89.14 and its aspects, namely existential well-being equaled 65.57±11.16, and religious well-being were obtained at 72.56±92.8. Meanwhile, the Mean±SD of FOC in this study equaled 21.138±38.27. To investigate the relationship between spiritual well-being and its aspects with FOC, we used the Pearson correlation test. The results demonstrated that all aspects of spiritual well-being have a negative and meaningful relationship with FOC ($P<0.0001$). Accordingly, the rate of this correlation in religious well-being was r=-0.88, for existential well-being it was obtained at r=-0.85, and for spiritual well-being, it equaled r=-0.88 (Table 3).

Table 2. Finding the relationship between demographic variables and obstetrics with spiritual well-being and fear of childbirth in the study population

Variables / Level		Mean±SD	P	Mean±SD	P
		Spiritual Well-being		Fear of Childbirth	
History of childbirth*	No	114.56±14.65	0.87	138.51±27.73	0.88
	Yes	114.27±15.06		138.4±27.25	
Education Level**	Illiterate	110.33±18.90	0.002[a]	13.63±35.14	<0.100[a]
	Below diploma	110.31±19.05		145.11±16.55	
	Diploma	117.58±9.79		132.31±33.6	
	University	111.86±17.62		129.56±34.75	
Occupation*	Housewife	116.28±12.19	0.001[a]	126.40±36.22	<0.100[a]
	Free	115.21±13.25		137.12±28.5	
	Employee	108.56±20.37		142.66±22.04	
Spouse's education level **	Illiterate	115.62±13.09	0.68	143.00±23.77	0.55
	Below diploma	115.08±14.16		138.88±26.65	
	Diploma	115.02±14.25		139.48±25.93	
	University	112.22±17.05		134.42±31.11	
Spouse's occupation**	Unemployed	111.73±18.40	0.22	127.91±37.86	0.075
	Employee	113.23±16.09		135.23±3.39	
	Worker	113.07±16.44		136.94±28.78	
	Free	116.86±11.47		143.52±2.11	
Income**	Sufficient	118.85±6.68	0.003[a]	147.37±9.62	0.001[a]
	Relatively Sufficient	113.00±16.29		135.29±3.38	
	Insufficient	111.43±18.25		132.41±33.43	
Housing Status**	Rented	120.00±0.009	0.038[a]	149.71±1.13	0.017[a]
	Personal	114.13±15.39		137.71±28.13	
	Parents	113.12±16.10		135.64±29.59	
Religion*	Islam	114.38±14.88	0.86	138.16±27.40	0.96
	Christian and Jewish	113.43±17.38		138.57±30.23	
Mother tongue**	Persian	110.38±19.24	0.12	134.67±32.40	0.47
	Azari	113.44±15.93		137.31±28.02	
	Kurdish	116.32±12.25		14.69±24.76	

Variables	Level	Mean±SD	P	Mean±SD	P
		Spiritual Well-being		Fear of Childbirth	
Religious beliefs**	Very High	119.14±5.17	<0.001[a]	146.80±12.97	<0.001[a]
	To some extent	96.28±23.83		105.16±40.97	
	Low	81.00±18.01		78.61±26.41	
Wanted pregnancy**	Yes	114.90±14.36	0.32	139.33±26.22	0.25
	No	113.03±16.19		135.34±3.12	
History of miscarriage**	Does not have	116.37±11.91	0.006[a]	141.61±23.72	0.014
	1	112.40±17.36		134.68±30.22	
	2 or More	107.14±21.06		126.41±36.55	
History of chronic diseases	Does not have	114.48±14.75	0.84	138.28±27.25	0.93
	Does Have	114.07±15.42		137.99±27.96	
Marital satisfaction**	Low	99.44±24.38	<0.001[a]	142.28±22.70	0.001[a]
	Mid	110.59±18.32		132.90±31.74	
	High	117.22±10.84		115.11±41.39	
Assisted reproductive methods*	Does have	109.59±19.36	0.004[a]	140.07±25.27	0.21
	Does not have	115.65±13.23		131.13±33.54	
Source of mental support**	Spouse	114.73±14.38	0.69	137.93±27.56	0.67
	Parents	114.40±15.13		140.63±25.66	
	Friends	108.50±23.00		126.75±37.17	
	Other relatives	111.19±18.97		134.50±31.07	
Support of the spouse**	Low	112.90±16.32	0.29	139.08±27.11	0.069
	Mid	113.41±16.19		134.50±30.70	
	High	116.03±12.57		142.36±22.40	
Other relative's support**	Low	117.40±10.71	0.1	145.31±18.45	0.026
	Mid	117.02±11.15		144.23±18.47	
	High	113.15±16.20		135.38±30.12	

* t-test, ** Analysis of variance, [a]: P<0.05

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Qom University of Medical Sciences

Discussion

This study aimed to investigate the relationship between spiritual well-being and FOC in pregnant women who referred to the public hospitals of Urmia City, Iran. The results of the first part of the study demonstrated the analysis of the relationship between demographic features and spiritual well-being and FOC in pregnant women. Accordingly, among the demographic variables, higher education level, sufficient income, religious beliefs, high marital satisfaction, and not having previous experience of miscarriage and sterility correlated with higher spiritual well-being and lower FOC. In addition, living in a rental house correlated more with lower spiritual well-being and higher FOC.

Table 3. The mean scores of FOC and spiritual well-being in the first, second, and third 3 months of pregnancy. By employing the test of one-way of analysis of variance, a meaningful difference was not observed between the scores of spiritual well-being and FOC (P<0.05).

Variables		Mean±SD	P
Fear of childbirth	First 3-months	99.41±16.78	0.157
Fear of childbirth	Second 3-months	109.93±12.72	0.157
Fear of childbirth	Third 3-months	114.18±15.65	0.157
Spiritual well-being	First 3-months	116.29±15.27	0.498
Spiritual well-being	Second 3-months	112.15±13.33	0.498
Spiritual well-being	Third 3-months	115.13±14.89	0.498

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

In analyzing the education level of the pregnant mothers, the results of this study showed that the majority of participating women had a diploma or university education. Having higher education level was correlated with higher spiritual well-being and lower FOC in this study; hence, literacy helped in having lower FOC. In other words, the lower level of FOC in the participants of this study can be attributed to their level of knowledge. Following the results of the present study, the findings of Hojjati et al. also showed the predictive power of education level for spiritual well-being [25].

Additionally, the results of this study demonstrated the relationship between occupation status with higher spiritual well-being and lower FOC. However, the results of a study by Moradi et al. have shown that women's spiritual well-being can be improved by participating in religious group meetings [26]. Higher levels of spiritual well-being during pregnancy can act as a shelter for passing this period. Spirituality and having a connection with a higher power result in lower stress levels and anxiety while increasing the level of psychological well-being, and emotional stability. Meanwhile, this relationship helps in reducing the vulnerability of women in developing disorders during this period. The period of pregnancy is a stressful and fearful phase for mothers [27]. In a study by Naranji et al. (2017), unemployed women who had enough time to perform religious deeds, such as performing Namaz or praying, worshiping, and strengthening the relationship with God in search of better passing this period showed a reduced level of anxiety and fear [28]. This is in line with the results of the present study.

However, in a study by Nimen et al., conducted in Sweden, FOC among housewives was higher than among employed women which is in contrast with the results of this study [29]. This can be attributed to women's level of education.

The results of the present study showed that having an insufficient income is predictive of higher FOC; that is, subjects with higher income showed a lower level of FOC. Having a sound economic status and sufficient income provides improved public well-being and since one of the aspects of health is spiritual well-being, it offers improved public health and spiritual well-being of individuals. In addition, higher economic needs of the family and the pregnant woman, and providing the necessities for a newcomer to the family can result in financial issues.

In analyzing the living conditions, the results demonstrated that individuals who live in rental houses experience lower spiritual well-being and higher FOC. In other words, pregnant women who have worries, such as the cost of a house, the annual stress of moving, and the lack of enough space for the newcomer have lower spiritual well-being.

The results of the present study also demonstrated that stronger religious beliefs in women result in higher spiritual well-being. This is in line with the findings of Bradshaw et al. [30]. The participants of their study maintained that religious beliefs and performing religious deeds can improve an individual's relationship with their inner spirituality. Many beliefs and religious deeds, such as maintaining a relationship with God through prayers have been observed in pregnant women. Even though, people who find God as a secure and inner shelter show higher resilience in the face of difficulties [31]. The results of the present study showed that religious beliefs correlate with variables such as optimism, life satisfaction, and lower anxiety and depression [32]. During

pregnancy, the individual faces various situations, such as the fear of bearing the responsibility of becoming a mother, changes in physical attributes, and anxiety about the period of pregnancy and the fetus's sufficient growth. Accordingly, higher spiritual well-being during pregnancy can be a safeguard in the passing of this period [33]. Strong religious beliefs and having a relationship with a higher power, as it was mentioned previously, result in lower stress levels during pregnancy. In their study, Azino et al. have demonstrated that African mothers find having a child as an opportunity to get closer to God and spend most of this time worshiping their creator [34].

Another finding of this study was in terms of the relationship between marital satisfaction and spiritual well-being and FOC. Accordingly, pregnant women who experienced higher marital satisfaction experienced a lower level of FOC and higher spiritual well-being during pregnancy. This finding is in line with the results of a study by Badaaghi et al. and Sharifi et al. [35, 36]. Therefore, receiving proper and supportive feedback from the spouse can improve self-efficacy during childbirth. The individual views oneself more positively and evaluates their skills and potential more accurately, thereby confronting the fear of the unknown.

Meanwhile, the results of the present study demonstrated that women who had experienced miscarriages or sterility have lower spiritual well-being; that is, unpleasant experiences of pregnancy can result in higher stress and anxiety. The pregnancy condition and its dependent factors alter spiritual well-being with factors such as social psychological stress, lower life satisfaction, increased marital problems, and lower sexual self-confidence, in addition to lower quality of life. Sterility is an important psychological aspect of an individual's life and is considered one of the most important functions of a family. Therefore, the experience of this state or efforts of assisted reproductive methods impacts the spiritual well-being of pregnant women. This finding is in line with the study of Alijanpour et al. [37].

According to the findings of this study in investigating the main goal of the research, a meaningful relationship exists between spiritual well-being and FOC in pregnant women; higher spiritual well-being results in lower FOC in pregnant women. The present findings were in line with the findings of other researchers. Khodabakhshi et al. have shown in their results, which are in line with the findings of this study, that resilience in facing stress and anxiety in pregnant women who have higher spiritual well-being is higher and these women tend to deliver their baby naturally [38]. Also, the results of McCasker et al., in line with the findings of this study, demonstrate that individuals with higher spiritual well-being show more adaptability in facing new and unknown circumstances such as natural childbirth. Additionally, these people can face stressful situations and reduce their negative sides [39]. The results of Hatami et al., in analyzing the relationship between spiritual well-being and resilience with an approach to FOC in pregnant women's well-being shows that spiritual well-being can prepare women in facing the difficult situation of natural childbirth, and increase their self-control and efficacy to face this situation with concepts such as meaning and goal in life, hope for the future, and seeking support from the grand creator to manage this difficult situation. Accordingly, unpleasant psychological, emotional, physical, and economic consequences of unreasonable consequences of cesarean, in particular psychological-based caesareans, can be reduced to the minimum [16]. A study by Biglich et al. aiming at analyzing the relationship between FOC and spiritual well-being in Turkey showed a negative correlation between spiritual well-being and FOC; that is, higher levels of spiritual well-being were correlated with an 18% drop in FOC [40]. This was also in line with the findings of this study.

Hence, the first and most important factor regarding the special effect of spirituality in controlling FOC is the alteration in attitude and interpretation of the individual in terms of pregnancy. Pregnant women manage their stress based on various available sources and approaches. Accordingly, beliefs about pregnancy and childbirth can impact important cognitive evaluations in the process of confronting FOC during pregnancy and spirituality can help pregnant women to evaluate the painful experience of childbirth differently [41]. The results of a study by Akbarzadeh et al. demonstrated that spirituality in pregnancy can create a stronger sense of control and results in psychological adaptability to the stresses of pregnancy and childbirth. The belief in God who is omnipotent and dominant in all situations and observes his creations can heavily reduce the anxieties of the situation. In other words, the individual can control the uncontrollable by depending on God [42].

Conclusion

The results showed that spiritual well-being in pregnant women is correlated with lower FOC. Accordingly, considering programs to improve the spiritual well-being of pregnant women can reduce their FOC which is an important and stressful problem for them. Meanwhile, by identifying factors related to spiritual well-being and FOC, more efficacious intervention, educational, and consulting programs can be devised.

Ethical Considerations

Compliance with ethical guidelines

This research was approved by the Ethics Committee of the Medical Sciences University of Urmia (Code: IR.UMSU.REC.1396.398).

Funding

This research did not receive any grant from funding agencies in the public, commercial, or non-profit sectors.

Authors' contributions

All authors contributed equally to the writing, design, implementation, data analysis, and final draft of the manuscript of this study.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgments

We hereby thank the Deputy of Research and Technology of the Medical Sciences University of Urmia, the staff of the Public Hospitals of Urmia city, Iran, namely Army Hospital and Imam Reza Hospital, and all the pregnant women who participated in this study.

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