Stress and Coping in First Pregnancy: Couple-Family Physician Interaction

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First pregnancy and childbirth produce life changes and require adaptation. This pilot study examined the role of the family physician in caring for nine couples during first pregnancy through the postpartum period. Interviews of individuals and couples were conducted to evaluate their support, stresses, and coping styles. Concurrently, physicians were interviewed for their knowledge of these dimensions. Interactions between physicians and couples were observed in third trimester and at labor and delivery.

Each of the participants perceived predelivery stresses relating to the pregnancy and to concomitant life changes. Emotional and technical support was high; only two of the nine husbands felt a marked lack of emotional support from any source. All women felt a high level of support. While pregnancy related concerns and support were perceived by all physicians, general stresses and sources of emotional support were infrequently known. Significantly more was known about the women than their husbands. Attention to psychosocial issues appeared to depend on physician style of interaction with the couple. When recognized, stresses were reduced by provision of information, discussion, and reassurance.

First pregnancy is a time of major change, representing a transition from being a couple to being parents.[1] While pregnancy has been described as a time of unusual well-being,[2] it also has been characterized as a "maturational crisis" akin to puberty and menopause with concomitant psychological disturbance[3] as well as a time of "personality crisis."[4] Various observations have linked environmental stresses and negative attitudes in pregnancy with emotional and physical difficulties during that time.[5-7] Cohen described the positive effects of a stable, supportive husband.[8] In contrast, Liebenberg reviewed the range of stresses reported by expectant fathers.[9] The value of social support has been shown by Sussman, who described the mutual aid provided by family and extended networks despite geographic and social mobility.[10] The importance of network support for maintenance of an individual's psychological well-being in an urban environment was shown by Kleiner and Parker.[11] Other studies have shown the buffering support of family, kin, and friend networks in mediating stressful situations.[12-15] In an outcome study of primipara, Nuckolls et al showed social support to be a significant protective factor in the presence of stressful circumstance.[16] Since the physician often represents a

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significant figure in this transition time, it is important to examine his or her functional role. In an analysis of physician-patient interaction during pregnancy, Danziger suggested that ascertaining medical expertise during the interaction process influenced the outcome.[17]

This pilot study examined the nature of support and stresses experienced by nine couples from the third trimester of first pregnancy through the initial eight weeks of parenthood. It focused particularly on the effectiveness of the family physician, not only in medical "technical" skill, but especially for his ability to assess the need for and to provide emotional support, both to the childbearer and to her partner in this unique period of life.

Methods

Nine couple volunteers were recruited for study from the University of Washington Family Medical Center obstetric population. Twelve couples were approached to obtain the nine participants. The following criteria were satisfied:

1. Informed consent of both members of the couple and their physician
2. Couple married or living together
3. First child for both partners
4. Entry into the study in the third trimester of pregnancy

Data were collected as follows:

1. Individual interviews of wife, husband, and physician upon entry to the study
2. Observation of the couple with their physician at a routine prenatal visit using a one-way mirror
3. Couple interviews immediately after first observation
4. Physician interview immediately after first observation
5. Observation of labor and delivery
6. Individual interviews of husband, wife, and physician after an eight-week postpartum visit.

First Participant Interview (third trimester): This interview included demographic data on the family of origin (including parenting styles, affection, and discipline), birth order of participants, recent and anticipated life changes and stresses, availability and means of emotional and practical support, background information and concerns pertaining to the pregnancy, labor, delivery, and future parenting, and expected and perceived role of the family physician.

First Physician Interview: This session explored the physician's knowledge of life stresses and supports for both partners and his knowledge of their concerns related to pregnancy as well as his perception of their expectation of his role in the pregnancy.

Couple Interview (near labor and delivery): This interview explored additional stresses, supports, and concerns at the later part of pregnancy, couple's reactions to first interview, couple's style of relating to each other and to the interviewer, and couple's reactions to their previous clinic visit and to the pregnancy.

Second Physician Interview (near labor and delivery): This interview was an exploration of the physician's knowledge of new concerns, stresses, or any changes in support for either member of the couple as well as changes in his relationship to either husband or wife.

Observation of Physician with the Couple: This took place primarily to observe how the physician interacted with each member of the couple.

Observation of Labor and Delivery: This provided an opportunity to observe the interactions between each couple as well as those of the physician and other support staff with the wife and the husband. Included were reactions to unexpected procedures or delays.

Final Participant Interview (approximately eight weeks postpartum): This interview reviewed the labor and delivery process stresses (eg, the influence of the addition of the baby) and coping of each member of the couple. Individual participants also stated their perception of the meaning of having a child as well as future expectations of their physicians.

Final Physician Interview (eight weeks postpartum): Similar issues were explored from the physician's point of view to ascertain congruence of expectations and the physician's knowledge of stresses and coping in the couple.

Semistructured interview formats included five-point scaling as well as open ended questions.*

The same investigator interviewed the same member of the couple in each of the individual

*All forms available from the authors upon request.

interviews, and each investigator interviewed an approximately equal number of men and women to distribute any error that might be due to the interviewer. Charts were reviewed at the outset of each couple's involvement, and they provided information on medical risks and special wishes of the couple regarding birth plans.

Because this was a small study and because the authors participate as regular members of the Family Medical Center, their involvement was close. For example, one of the authors is a family physician (ECE) and when present as an observer of labor and delivery, she also supervised the resident physician. While this precluded maximal objectivity, it permitted the investigators increased rapport with couples and freer exchange of information, which in itself served as an intervention (see Discussion).

All interviews were tape recorded. Typed transcripts were made of the first participant interviews. Abbreviated transcripts of the remaining taped interviews were made using the interview forms as guides to code answers to each question. The tape recorded notes made during observations of the physician and couple interviews, and during labor and delivery, were transcribed.

Content analysis was conducted by compiling information from all transcripts according to major categories for each participant and physician. These categories included the following areas:

1. Major stresses and life changes perceived by each individual
2. Major perceived sources of support
3. Pertinent background information and relationship of childhood experiences to anticipated parenting style and noted apprehensions
4. Major concerns regarding pregnancy, labor and delivery, and parenting
5. Physician knowledge of concerns, stresses, and supports for both members of the couple
6. Perceived role of the physician by couple
7. Actual role of the physician
8. Outcome of pregnancy
9. Other notes of interest, eg, role of investigator(s), meaning of pregnancy to participant, self-ratings by participants

Evaluation of the content was necessarily subjective and included self-ratings by participants, recorded perceptions of individuals and couples, and consensus of the investigators. For each participant the following assessments were made:

1. Types, degree, and timing of stresses
2. The perceived need for support
3. The couple's preparation for coping with this life change
4. The physician's management of labor, delivery, and the puerperium in conjunction with his knowledge of the psychosocial dimensions of pregnancy for each couple
5. Estimation of unmet emotional or medical needs
6. Observed changes in the relationship of the couple to their physician throughout the study.

Results

For the couples in this study, pregnancy was but one of a cluster of general life changes, some of which were perceived as stressful by husband and/or wife. Issues which surfaced included health concerns (other than pregnancy), financial concerns, recent geographic moves, job changes, perceptions of isolation from spouse, concerns relating to new roles, cultural issues, and difficulties with parents. Pregnancy itself raised predictable questions and concerns for both husbands and wives, including stress if the pregnancy was unplanned, the normalcy of the fetus (ongoing concerns regarding diet and drugs), fear of pain during labor and delivery, apprehension about complications during labor and delivery, a desire to be actively involved in all facets of management, and pregnancy related sexual concerns.

Available support varied for individuals and was obtained from a variety of sources. Usual sources of emotional support included spouse, friends, parents, family physician, and church. Technical support in preparation for and during labor and delivery came from spouse, physician, and Childbirth Education Association classes. The usual source of financial help in this sample was parents. Table 1 summarizes the self-ratings of stresses and supports reported by husbands and wives in this study.

The physicians in this sample were well aware of pregnancy related concerns and also of the pregnancy related supports for husbands and wives in their population. However, physician awareness of general stresses and emotional or financial supports was less consistent and seemed

Table 1. Patients' Self-Ratings of Stresses and Supports

	Husbands (n=9)		Wives (n=9)	
	Number	$\bar{X}$ Level*	Number	$\bar{X}$ Level*
Stress				
General				
Health	1	5.0	1	5.0
Money	5	3.2	3	2.7
Geographic move	4	2.8	2	3.5
Job	8	3.1	3	3.0
Isolation from spouse	3	3.7	3	4.0
New role	8	2.8	2	3.5
Cultural	1	4.0	1	1.0
Parents	2	4.0	1	4.0
Pregnancy related				
Unplanned	1	2.0	—	—
Normalcy	3	2.3	4	2.8
Pain: Labor and delivery	2	1.0	4	3.0
Complications	3	1.7	4	3.0
Management: Labor and delivery	4	3.5	4	3.8
Sexual concerns	—	—	2	3.0
Support				
Emotional				
Spouse	8	4.4	9	5.0
Friends	8	3.6	9	4.0
Parents	8	4.0	9	4.0
Physician/Staff	9	4.2	8	4.8
Church	3	4.0	4	4.5
Technical				
Husband	—	—	9	5.0
Physician/Staff	—	—	9	5.0
CEA classes**	9	5.0	9	5.0
Financial				
Parents	6	4.4	6	3.7

*Mean levels of stress or support reported. Scale 1-5; 5=maximal stress or support
**Childbirth Education Association

to depend on physician style. In general, more was known consistently about wives than about their husbands in all areas (Figure 1).

Discussion

The Study as an Intervention

The close involvement of the authors in this pilot study served at times as an intervention and provided useful additional insights. As examples, the investigators learned that five of the couples and especially the prospective fathers were unclear about their physician's interest in concerns other than biomedical pregnancy related issues. In the course of the interviews, several unresolved psychosocial or biomedical issues surfaced for one or both members of the couple. These initial discussions often led to further ventilation by the couple alone, with the interviewers, or with their family physician.

In one case, following a first interview which included self-ratings of perception of support by the husband as well as the wife, the husband real-

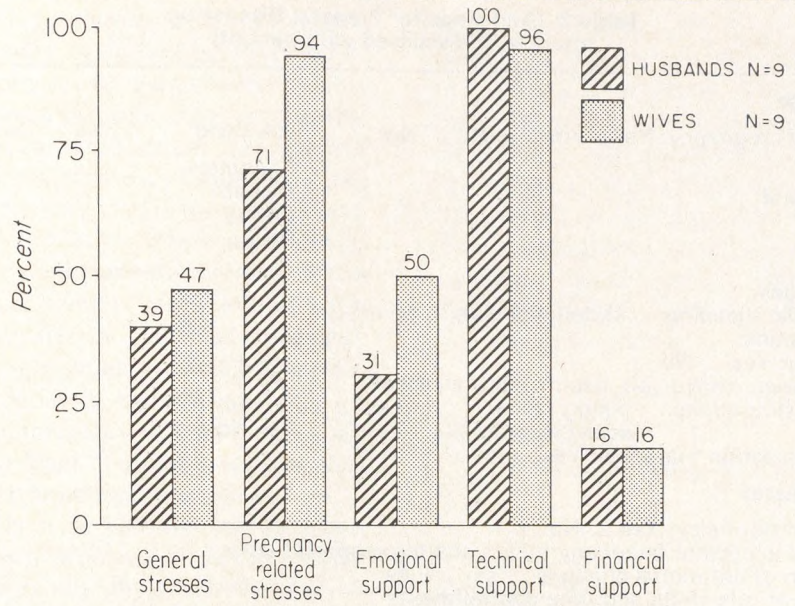

Figure 1. Physician recognition of couples stresses and supports

ized his extreme feelings of isolation and subsequently invited his father to visit at the time of birth. In another, the couple was able to verbalize their appreciation of their physician's attentiveness to their financial and medical concerns, which subsequently allowed them to form a more comfortable bond with their physician after an initial "adversary" relationship.

The view often expressed was that physicians were interested only in the medical well-being of mother and child. Explicit interest (by the authors of the anticipated role shifts, financial concerns, perception of support, and physical health of the husband, for example) served to initiate relevant discussions and to educate the couple in this regard. Similarly, after being interviewed as part of the study, several physicians asked questions about stresses and supports and specifically involved husbands as a focus in subsequent patient encounters.

The Physician as Doctor for the Family

One couple illustrated that the family physician often must clarify and assert that his role is not only to give medical care to the pregnant wife and to the infant after delivery, but also to provide general care for the husband. The style of this couple replicated each of their backgrounds insofar as both the husband and his father were somewhat isolated, although main providers for their families. Picking up on the sense of isolation perceived by the husband could have provided a unique opportunity for the physician to facilitate a more evenly balanced relationship between husband and wife. This husband's psychosocial needs were particularly great, since he felt cut off from easy support from his peers and since his wife had her own special developing interests during pregnancy and her preoccupation with the new infant. In this case the husband's needs seemed intensified by the number of major life changes the couple had made on short notice. Sensitivity to the husband's concern regarding his ability to provide for the new family might also have facilitated inclusion of the husband in the health care of the family by the family physician. Awareness of this couple's style of coping with life changes could prove useful to the family physician in predicting similar patterns during future changes: the husband did not easily ask for support but nonetheless readily talked about his own needs when drawn

Table 2. Guidelines for Prenatal Discussion
(mark ✔ if discussed with patient)

First Trimester

Acceptance of pregnancy:	Yes	Ambivalent	No
Patient	__	__	__
Expectant father	__	__	__

Life Style:	Yes	Quantity	No
Cigarettes	__	__	__
Alcohol	__	__	__
Coffee	__	__	__
Drugs	__	__	__

Medications: __
Normal changes: __
Danger signals: bleeding __ abdominal pain __ fever __
Nutrition/vitamins: __
Breastfeeding: Yes __ No __
General stresses: (move, job, health, cultural, other) __
Financial considerations: billing office: Yes __ No __
social worker: Yes __ No __
Pregnancy education materials: Yes __ No __

Second Trimester

Knowledge of normalcy: Yes __ No __
Offer time for expectant father/any others sharing responsibilities __
Anticipation of emotional changes __ sex issues __
Discussion of role shifts and time commitments __

Childbirth education classes: Yes __ No __

	Patient	Expectant Father
Social support	__	__
Coping style	__	__
Other health concerns	__	__

Premature labor __
Other concerns __

Third Trimester

Tour of labor/delivery facilities: Yes __ No __

Emotional changes associated with:	Patient	Expectant Father/Others
provider role	__	__
sex issues	__	__
anticipation of labor	__	__
anticipation of delivery	__	__
indications/cesarean section	__	__
new baby/sleep lack	__	__
parenting	__	__

Signs of onset of labor __ How to contact physician __ Circumcision __
Breastfeeding __ Infant care arrangements __ (working mothers)

Postpartum contraception: __
Parenting education materials: Yes __ No __

out by a sympathetic listener. The wife was more outgoing and seemed more forthcoming with feelings and concerns, but both awaited cues of interest regarding personal matters from their physician and did not spontaneously offer information or concerns.

Another couple did not present major concerns (either medical or psychological) for their physician, and yet he played a critical role in the pregnancy—that of monitoring the normalcy of the process, educating each to anticipate likely changes, and developing the needed rapport with understanding of the couple to ensure his optimal and continuing effectiveness as their family physician. It is instructive to note that it took no more than the usual amount of time at each prenatal visit to achieve these prototypical family physician goals. Further, this physician's view of his role clearly helped to educate this couple to expand their expectations of him in their future care.

In the case of three couples with special concerns, optimal joining of forces between themselves and their physicians was observed. This was attributed to the physicians' readiness to offer time for discussion early in prenatal visits, and to address possible areas of stress or conflict during pregnancy, labor, delivery, and in the puerperium.

The needs of still another couple, relevant to the physician, were predominantly medical. These two people were extremely supportive of each other and had close friends and family who met support needs. The physician ascertained the area of need and appropriately restricted specific involvement. This emphasizes that all couples do not demand a high level of psychosocial or supportive involvement from their physician.

In a couple in which the husband was not forthcoming with his own problems, it became strikingly clear that the family physician often had to be quite direct regarding his role. The authors hypothesize that it is necessary for the physician to direct explicit questions regarding role changes, stress, and support perceived by both the wife and the husband to help educate them to the appropriateness of the physician's role in the care of the family as a unit. First pregnancy presents an opportunity uniquely suited to this education and to negotiation of the appropriate role of the family physician with the family members.

In summary, different kinds of couples in different life circumstances need different things from their family physician, who, in turn, needs the flexibility to see these differences and respond accordingly. This study raises several interesting hypotheses: (1) careful interviewing of the prospective father and mother by the physician can assure assessment of each of their needs, (2) careful interviewing can also lead to a better perception of the physician's role by the couple, and (3) including assessment during first pregnancy of the psychosocial concerns of husband and wife (eg, allowing ventilation, promoting communication between husband and wife, linking couple with additional support should that be needed), rather than singular attention to medical concerns, allows the physician to give optimal care.

Table 2 provides guidelines to the physician for assessing the range of potential needs and issues with husband and wife during the course of first pregnancy. In order to generalize from the inferences of this small pilot study, it will be necessary to examine a larger population at other practice settings. All the couples in this study were married and attended childbirth education classes together. Moreover, they obtained health care at the University Family Medicine Residency site. Further research could involve both single and married patients in obstetric clinics, in both urban and rural communities, cared for by a spectrum of caregivers. Such studies might provide an expanded definition of the role of the family physician in first pregnancy.

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