Psychiatr. Pol. ONLINE FIRST Nr 71 1–14
Published ahead of print 10 June 2017
www.psychiatriapolska.pl
ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
DOI: https://doi.org/10.12740/PP/OnlineFirst/64194

Social support as a determinant of life satisfaction in pregnant women and women after surgical delivery

Grażyna Gebuza, Marzena Kaźmierczak, Estera Mieczkowska, Małgorzata Gierszewska

Faculty of Health Sciences, Nicolaus Copernicus University in Torun

Summary

Aim. The aim of the study was to determine whether social support obtained by women in the third trimester of pregnancy and in the postpartum period differs significantly with respect to the mode of delivery and whether there is a difference in the life satisfaction of the studied women.

Material and Methods. The study included 195 women in the third trimester of pregnancy and 182 women from the same group after delivery. The Berlin Social Support Scales (BSSS) and the Satisfaction with Life Scale (SWLS) were used in the study.

Results. As early as in the third trimester of pregnancy, women who later underwent Caesarean section received significantly more support of all types than women who gave birth physiologically. In the postpartum period, post-Caesarean women received significantly more support of only instrumental nature. No statistically significant differences were found with respect to life satisfaction of the studied groups of women.

Conclusions. The results of the present study demonstrate that Caesarean section does not provide greater life satisfaction. Instrumental support plays a crucial role in meeting the caring needs of post-Caesarean women in the postpartum period. The study reveals which type of support is needed by women and highlights the significant role of fathers during childbirth.

Key words: Caesarean section, social support, life satisfaction.

Introduction

Childbirth is an important event, which is highly desired by most young individuals in their reproductive period. The analysis of literature indicates that the perinatal period may constitute a stressful experience in the life of women, while assuming a new role in life may lead to a decrease in life quality in terms of both physical [1, 2] and psychological functioning [2, 3]. It has to be stressed that women who have positive emotional experiences related to parturition express long-lasting satisfaction with

childbirth and gain a sense of fulfillment [4]. Positive perception of childbirth contributes to the heightening of the sense of self-efficiency, self-confidence [5] and life satisfaction of women [6]. However, some women may find pregnancy and delivery to be among the most traumatic life experiences [7], and memories of childbirth may be recalled for many years to come or even for the whole life [8]. Negative experiences from childbirth determine the occurrence of postpartum depression and post-traumatic stress disorder [7]. A review of research on the subject demonstrated that post-Caesarean women more frequently experienced anxiety and helplessness, and had problems with childcare and breastfeeding [9]. Delivery by Caesarean section may be experienced as detrimental, cause the occurrence of a post-traumatic stress disorder [10], and lessen the satisfaction with childbirth [11].

Many researchers are of the opinion that one of the most effective means of coping with stressful life events is social support which determines a person's health and well-being [12, 13]. Receiving sufficient social support from significant others and partners is thus crucial in the period of childbirth as it contributes to enjoying positive childbirth-related experiences and satisfaction with life. Continuous social support obtained from close partners during childbirth reduces the level of fear and is evaluated higher than that obtained from other significant others [14]. Conversely, a lack of social support from partners and family is one of the factors in the reduction of life quality and the occurrence of postnatal depression [14, 15]. Received social support, particularly of instrumental and emotional nature, is especially significant for the physical and emotional well-being of women in the postpartum period, in which they have to cope with fulfilling the social role of a mother [14, 16].

The present paper draws attention to social support received by women giving birth physiologically and via Caesarean section, as well as to their satisfaction with life in that period. Both in Poland and worldwide, the percentage of deliveries by Caesarean section has been on the increase and amounts to nearly 40%. What is also alarming is the fact that many parturient women regard surgical birth as a safe method of labour and express their satisfaction with this type of mode of delivery [17]. A study of social support received during and after pregnancy with reference to the mode of delivery may determine whether women are susceptible to a lack of support and a decrease in life satisfaction experienced in the said period. The results of research studies on social support and life satisfaction performed by other authors suggest that childbirth has a rather negative influence on the functioning of most marriages. Partners do not provide sufficient social support in that period, leaving women unaided and, in consequence, prone to experiencing a decrease in their satisfaction with life [18, 19]. Other researchers claim that childbirth increases life satisfaction in a short period of time following delivery, whereas in the further period of time the values return to default [6].

The aim of the present study was to determine whether social support obtained by women in the third trimester of pregnancy and in the postpartum period differs significantly with respect to the mode of delivery and whether there is a difference in the life satisfaction of the studied women.

In the present study, received social support came to be defined as the type and quantity of emotional, instrumental and informative support obtained from partners

and reported by women. The variable index was assumed as the result of the survey on received support of each type, obtained by means of the Berlin Social Support Scales (BSSS), developed by A. Łuszczyńska, M. Kowalska, M. Mazurkiewicz and R. Schwarzer, [20]. In accordance with the research tool used in this study, it was accepted that the result of 0 stands for a lack of support, while the result of 1 stands for maximum support. The Polish version of BSSS can be found on the following website: http://userpage.fu-berlin.de/~health/soc_pol.htm.

For the purposes of this study, life satisfaction came to be defined as contentedness with life expressed as a general evaluation referred to self-selected criteria – women compared their own situation with standards which they had previously established. The variable index was assumed as the result of the questionnaire assigned to the Satisfaction with Life Scale (SWLS), developed by E. Diener, R.A. Emmons, R.J. Larson, and S. Griffin, in the Polish adaptation by Z. Juczyński. The measurement result is accepted as a general rate of satisfaction with life. The results fall within the range of 5 to 35 points. The higher the result, the better the satisfaction with life. Scores in the range of 1–4 sten are to be treated as low, scores in the range of 7–10 sten – as high, and the scores of 5 and 6 sten – as average [21].

Material and methods

The present study was granted approval No. 270/10 by the Bioethics Committee at the Nicolaus Copernicus University Collegium Medicum.

The study was carried out in two stages. The first stage investigated women in the third trimester of pregnancy treated in the Ward of Pregnancy Pathology and Women's Health Outpatient Clinic of the University Hospital, Private Gynecological Examination Room, and Antenatal School. The second stage concerned women in the postpartum period on the day of hospital discharge from the Ward of Obstetrics of the University Hospital. Each stage of the study involved the same subjects. The respondents were asked to fill out questionnaires for the BSSS subscale concerning currently received social support and the SWLS subscale concerning satisfaction with life, in each stage of the study (during pregnancy and after delivery). In this study, received social support comes to be defined as the type and quantity of social support obtained from partners/husbands and reported by women. On the basis of the BSSS scale, only partners/husbands were analyzed. The help and commitment of the closest family was specified by the respondents in a different question.

The statistical analysis included 195 women in the third trimester of pregnancy, divided into two groups according to the mode of delivery. The first stage involved 76 (38.97%) subjects after Caesarean section and 119 (61.02%) subjects after physiological delivery. The second stage did not include all the women from the first stage; it investigated 182 women after delivery, including 72 (39.56%) subjects after Caesarean section and 110 subjects (60.43%) after physiological delivery. 53 (73.61%) women underwent elective (planned) Caesarean section, whereas 19 (26.38%) women were subject to the surgical procedure in emergency conditions. A significant majority of the surveyed women, that is 139 (95.20%), expressed satisfaction with the presence

of a significant other during delivery, while 7 (4.79%) women were not satisfied. 114 (78.62%) women claimed that their significant others took good care of them during labor, whereas 26 (17.93%) assessed their care negatively. Support provided by medical staff was evaluated as satisfactory by 165 (92.65%) women and as insufficient by 13 (7.34%) women. In the post-delivery period, the women were assisted with childcare by their significant others; the strongest commitment was demonstrated by husbands (141 – 81.03%), partners (25 – 14.37%), siblings and parents (4 – 2.29%). 102 (56.98%) women described their labor as a positive experience, whereas 76 (42.46%) women described it as worse than expected.

The obtained results were based on statistical methods using the Microsoft Excel 2000 software and a statistical analysis suite – STATISTICA version 10.

The level of statistical significance $p = 0.05$ was established as a reliable criterion for verifying pre-specified hypotheses.

Results

In accordance with research objectives, distinct types of support received by women and their life satisfaction with respect to the mode of delivery were analyzed. The measurement of each type of received social support consisted in assessing the quantity of conveyed support. Women declared how much support and of what nature was provided to them by their partners.

Table 1 presents received support with respect to the mode of delivery. The analysis concerned past events, that is the support which women obtained in the perinatal period. Women after physiological delivery formed a larger group and numbered 119, whereas the remaining 76 women were after Caesarean section. In accordance with the central limit theorem, group sizes allowed for the use of the Z-test in order to compare the mean values.

Table 1. **Mean values of social support with respect to the mode of delivery in the third trimester of pregnancy**

3rd trimester of pregnancy		Emotional support		Instrumental support		Informative support	
		Physiological delivery	Caesarean section	Physiological delivery	Caesarean section	Physiological delivery	Caesarean section
N		119	76	119	76	119	76
Min.		0.333	0.333	0.444	0.222	0.000	0.000
Max.		1.000	1.000	1.000	1.000	1.000	1.000
Median		0.889	1.000	0.889	1.000	0.833	0.833
Mean		0.861	0.926	0.862	0.936	0.762	0.831
SD		0.155	0.134	0.166	0.147	0.211	0.203
Z-test (z_{kr} =1.96)	z	3.12		3.26		2.29	
	p	0.002		0.001		0.02	

A significant difference was found – the mean value of emotional, instrumental and informative support is significantly higher in the group of women who gave birth by Caesarean section. This means that women who delivered by means of Caesarean section received more social support of each type already during pregnancy.

Table 2. **Mean values of social support with respect to the mode of delivery in the postpartum period**

Postpartum period		Emotional support		Instrumental support		Informative support	
		Physiological delivery	Caesarean section	Physiological delivery	Physiological delivery	Caesarean section	Physiological delivery
N		110	72	110	72	110	72
Min.		0.000	0.000	0.000	0.000	0.000	0.000
Max.		1.000	1.000	1.000	1.000	1.000	1.000
Median		0.963	1.000	1.000	1.000	0.833	1.000
Mean		0.897	0.921	0.891	0.955	0.806	0.863
SD		0.144	0.136	0.162	0.102	0.215	0.192
Z-test (z_{kr} = 1.96)	z	1.14		3.29		1.88	
	p	0.26 (ns)		0.001		0.06 (ns)	

Table 2 presents social support received in the postpartum period. Even though the mean values of emotional and informative support received after childbirth were still higher in the case of Caesarean section, the Z-test did not determine a significant difference. The mean value of instrumental support, however, is significantly higher in the group of women whose delivery was performed by Caesarean section than in the group of women after physiological delivery. This means that women who delivered by means of Caesarean section received more instrumental support in the postpartum period.

In order to compare mean values of life satisfaction measured in accordance with the SWLS, Z-test for normal distribution was applied. The results are presented in Table 3.

Table 3. **Mean values of life satisfaction in the postpartum period across groups with different modes of delivery**

	Parameters	Mode of delivery	
		Physiological delivery	Caesarean section
Life satisfaction according to the SWLS in the postpartum period	N	109	72
	Min.	9	15
	Max.	35	34
	Median	26	27
	Mean	25.56	26.06
	SD	4.97	4.33

table continued on the next page

Z-test (z_{kr} = 1.96)	z	0.71
	p	0.48 (ns)

No significant differences were found between the studied groups in terms of their satisfaction with life in accordance with the SWLS parameters.

The present study investigated whether social support received by women in the postpartum period was subject to change after pregnancy. For that purpose, an assessment was made of support received by a select group of women in the third trimester of pregnancy, followed by an assessment made after delivery in the same group of women. The obtained results were then correlated. Preliminary analysis indicated that the assumptions of the Student's t-test for paired samples were not met. For that reason, the Wilcoxon test was used to correlate the results obtained in the third trimester of pregnancy and in the postpartum period. Results of the analyses of social support received by women with respect to the mode of delivery and the urgency of Caesarean section are presented below.

Table 4. **Comparison of social support received in the third trimester of pregnancy and in the postpartum period with respect to the urgency of Caesarean section**

Social support	Urgency of Caesarean section	N	T	Z	p
Emotional	Elective	28	193.000	0.228	0.820
	Emergency	12	30.000	0.706	0.480
Instrumental	Elective	20	79.000	0.971	0.332
	Emergency	4	4.000	0.365	0.715
Informative	Elective	29	182.500	0.757	0.449
	Emergency	11	30.000	0.267	0.790

The analysis presented in Table 4 indicates no statistically significant differences in all types of received social support between women after elective and emergency Caesarean section.

The present study investigated whether women's satisfaction with life is associated with received social support. Table 5 presents the analyzed variables.

Table 5. **Correlations between life satisfaction and received social support in the third trimester of pregnancy with respect to the mode of delivery**

Mode of delivery	Social support	N	R	t (N – 2)	p
Total	Emotional	199	0.360	5.417	0.000
	Instrumental	199	0.354	5.316	0.000
	Informative	199	0.225	3.238	0.001
Physiological delivery	Emotional	119	0.371	4.319	0.000
	Instrumental	119	0.370	4.306	0.000
	Informative	119	0.243	2.708	0.008

table continued on the next page

Caesarean section	Emotional	76	0.343	3.136	0.002
	Instrumental	76	0.315	2.856	0.006
	Informative	76	0.234	2.075	0.041

Table 6. **Correlations between life satisfaction and received social support in the postpartum period with respect to the mode of delivery**

Mode of delivery	Social support	N	R	t (N – 2)	p
Total	Emotional	181	0.287	4.012	0.000
	Instrumental	181	0.326	4.616	0.000
	Informative	181	0.260	3.604	0.000
Physiological delivery	Emotional	109	0.379	4.232	0.000
	Instrumental	109	0.373	4.164	0.000
	Informative	109	0.267	2.861	0.005
Caesarean section	Emotional	72	0.158	1.336	0.186
	Instrumental	72	0.249	2.149	0.035
	Informative	72	0.232	1.995	0.050

Satisfaction with life in the third trimester of pregnancy and in the postpartum period is significantly correlated with received social support.

Table 7. **Correlations between life satisfaction and received social support in the third trimester of pregnancy with respect to the urgency of Caesarean section**

Urgency of Caesarean section	Social support	N	R	t (N – 2)	p
Elective	Emotional	56	0.322	2.496	0.016
	Instrumental	56	0.391	3.119	0.003
	Informative	56	0.304	2.344	0.023
Emergency	Emotional	20	0.410	1.908	0.072
	Instrumental	20	-0.007	-0.028	0.978
	Informative	20	0.034	0.145	0.887

Satisfaction with life in the third trimester of pregnancy is significantly correlated with received social support in the group of women subject to elective Caesarean section.

Table 8. **Correlations between life satisfaction and received social support in the postpartum period with respect to the urgency of Caesarean section**

Urgency of Caesarean section	Social support	N	R	t (N – 2)	p
Elective	Emotional	53	0.294	2.200	0.032
	Instrumental	53	0.322	2.430	0.019
	Informative	53	0.220	1.611	0.113
Emergency	Emotional	19	-0.337	-1.475	0.158
	Instrumental	19	-0.048	-0.197	0.846
	Informative	19	0.413	1.872	0.079

Satisfaction with life in the postpartum period is significantly correlated with the values of emotional and instrumental support in the group of women subject to elective Caesarean section. The above study investigated whether women's satisfaction with life in the postpartum period was subject to change after delivery. For that purpose, an assessment was made of life satisfaction of a select group of women in the third trimester of pregnancy, followed by an assessment made after delivery in the same group of women. The obtained results were then correlated. Preliminary analysis indicated that the assumptions of the Student's t-test for paired samples were not met. For that reason, the Wilcoxon test was used to correlate the results obtained in the third trimester of pregnancy and in the postpartum period. Table 9 below present the analyzed variables with respect to the mode of delivery and the urgency of Caesarean section.

Table 9. **Comparison of satisfaction with life (SWLS) in the third trimester and in the postpartum period with respect to the mode of delivery**

Mode of delivery	N	T	Z	p
Total	125	2244.500	4.171	0.000
Physiological delivery	78	898.000	3.200	0.001
Caesarean section	49	320.500	2.905	0.004

A comparison of the values of life satisfaction during pregnancy and after delivery indicated significant changes within the surveyed group of 125 (68.68%) women. Significant changes were observed in 78 women after physiological delivery and in 49 women after delivery through Caesarean section.

Table 10. **Comparison of satisfaction with life (SWLS) in the third trimester and in the postpartum period with respect to the urgency of Caesarean section**

Urgency of Caesarean section	N	T	Z	p
Elective	35	192.000	2.015	0.044
Emergency	14	15.000	2.354	0.019

The analysis indicated significant changes related to satisfaction with life in women subject to both elective (35 women) and emergency Caesarean section (14 women).

Discussion

The present research study offered an opportunity to devote attention to the significance of social support received by women during pregnancy and directly after childbirth for their satisfaction with life. The study found that women who delivered by means of Caesarean section received more social support of each type already in the period of pregnancy than women who gave physiological birth (Table 1). It can be assumed that the increase in support received during pregnancy by women whose mode of delivery was Caesarean section is associated with anxiety and concern expressed by partners and with planned surgical treatment.

Knowing about planned delivery by Caesarean section, partners might have provided their partners with more support already during pregnancy presuming that surgical delivery is hazardous and associated with pain and long-lasting recovery. An increase in the percentage of Caesarean sections is still being reported throughout the world, the growing tendency being noted in Poland as well (in the present study, it amounted to nearly 40.00%). Even so, no improvement related to postpartum mortality and morbidity rates has been reported so far. Many women undergo planned Caesarean section due to indications for elective surgery (it has to be pointed out that as many as 73.68% of the surveyed women delivered by elective Caesarean section, while only 26.31% underwent emergency Caesarean section, conditioned by the need to save the life of the child or the mother).

The above analysis indicated no significant changes in social support received during and after pregnancy between women subject to elective and emergency Caesarean section. Planned Caesarean sections provoke a lot of discussion on their validity. According to Pomorski et al, it should be considered whether the growing number of non-obstetric indications and percentage of performed Caesarean sections might be associated with the fear of natural childbirth in the light of the lack of legal grounds in Poland for performing Caesarean section due to psychological indications. The authors worry that Caesarean sections performed due to non-obstetric indications are often de facto “on request” [22].

Numerous indications for elective Caesarean section include breech fetal position in primigravidas, surgical delivery in secundigravidas whose first child was delivered by Caesarean section and who do not consent to delivery through natural passages, as well as more frequent indications prescribed by other specialists. Another factor contributing to the increase in the percentage of Caesarean sections is the application of specialist procedures in the perinatal period, such as continuous fetal heart rate monitoring or labor induction.

Another reason why women received more social support of each type could be the indication for Caesarean section due to breech fetal position in primigravidas. Numerous research studies suggest that women in their first pregnancy receive more social support from their partners – not only by virtue of the lack of partnership conflicts in relatively new relationships but also life experience in young women giving their first birth [23].

Women who deliver spontaneously are in a better physical condition that women after Caesarean section, even though the former mode of delivery takes a longer time.

Women after surgical birth remain immobilized in the lying position for a few or, if needed, over ten hours. During that time, they face difficulties associated with child care and breastfeeding resulting from the fact that their physical efficiency is limited to some extent by analgesia and postoperative pain [2, 9, 24]. Support provided by a significant other is thus crucial. Nowadays, every hospital follows the rooming-in practice whereby a mother and her child remain together on a 24-hour basis. The mother takes care of the child while medical personnel oversees and assists the care. Midwives normally provide nursing care to numerous parturient women at a time, which means that they are not always available to take care of each woman. As a result, a more active involvement of a child's father is needed in assisting both the child and its mother. In the present study, the majority of surveyed women assessed the care provided by midwives high (92.66%), and only 7.24% of women expressed a negative opinion on this issue.

In the present study, women after Caesarean section received more social support of each type from their partners in the postpartum period than women after physiological delivery (Table 2), but a statistically significant difference pertained to instrumental support only. The lack of difference between received social support of emotional and instrumental nature testifies to the mobilization of support and a greater involvement of partners in each of the studied groups of parturient women. Women after physiological delivery were in need of assistance, by virtue of which they received a high level of social support, comparable to that received by post-Caesarean women. Hence the lack of differences. What is more, it has to be noted that in contemporary Poland, the role of a child's father with regard to childbirth has been recognized as more significant. Men are actively involved in various activities associated with child care which have until recently been undertaken usually solely by mothers. Thanks to the help and support which women receive from their close ones during hospitalization, they can manage their personal hygiene, rest, and sleep.

Exceptional circumstances in which support was provided were undoubtedly especially important to all the studied women because, as other researchers point out, support received from partners in stressful situations is evaluated higher [14]. It can therefore be assumed that support received by the respondents from their partners, particularly that of instrumental nature, had a positive influence on the way those women experienced motherhood.

Numerous research studies have demonstrated that partners' support provided after childbirth was especially significant for an early initiation and continuation of breastfeeding [25–27]. Due to the immobilization of parturient women and substantial deficits in their self-care, partners' assistance is of great importance, especially in terms of handing the baby to its mother or holding the baby properly. The obtained results reflect women's post-surgical limitations in functioning as well as a greater involvement of partners in assisting post-Caesarean women, which undoubtedly points to the genuine commitment of fathers and the significance of their role. In the case of surgical birth, obtained instrumental support seems to be especially expected and desirable by women, as it helps them experience the fullness of motherhood and fulfill the social role of a mother. Researchers emphasize the significance of social support, particularly of instrumental nature, as a key buffer against postpartum depression [16].

Despite the significantly higher level of instrumental support received by women after Caesarean section, no statistically significant differences were found with respect to life satisfaction in the surveyed women after physiological delivery and Caesarean section (Table 3). Furthermore, an increase in life satisfaction was observed in the second measurement in each of the analyzed groups of women irrespective of the mode of delivery or the urgency of Caesarean section (Table 9 and 10). According to some researchers, Caesarean section may be considered by women as a traumatic experience, significantly reducing satisfaction with life and contributing to postpartum depression [7, 9–11]. An analysis of the above presented data demonstrated a correlation between satisfaction with life and received social support in each stage of the study irrespective of the mode of delivery. It also indicated that received social support was particularly significant for life satisfaction in women after elective Caesarean section (Table 7 and 8). Such values were not observed in women after emergency Caesarean section, despite the higher threat to the well-being of the fetus or the mother. The obtained results might testify to the direct impact of social support and reduced risk perceived in relation to a planned surgical procedure.

It can be said that at the time of the birth of the child, receiving adequate social support from the loved ones and partners is essential to strengthening positive experiences of childbirth and lives satisfaction in women. It is also worth highlighting once again that constant social support from partners during childbirth reduces anxiety and is assessed higher than support received from other close relatives [14]. On the other hand, lack of social support from partners and family was one of the factors contributing to lowering quality of life and postpartum depression [14, 15]. First and foremost, instrumental and emotional support is particularly important for the physical and emotional well-being of postpartum women when they have to cope with the social role of mothers [14, 16].

According to researchers, satisfaction with life increases after childbirth, but later in life it is subject to decrease and remains at that level. A major role, however, is played here by partnership relations [6]. In the present study, women received a high level of support of each type, which may be indicative of good partnership relations which contribute to a person's well-being [13]. Nonetheless, no research study has been found which would analyze life satisfaction with respect to the mode of delivery. It has only been discovered that women who deliver physiologically without instrumental assistance feel greater satisfaction with childbirth than women who undergo Caesarean section [11]. Caesarean section performed for vital reasons is a procedure saving the fetus in life-threatening conditions, as well as the life of the mother [28]. Yet, it has to be emphasized that many women are of the opinion that Caesarean section is a better and safer method of delivery and choose to give birth by this method regardless of a lack of medical indications [17]. Advancements in medicine and medical care have contributed to the fact that the level of safety of mothers subject to Caesarean section is high. It is worth remembering, however, that the risk associated with surgery and anesthesia is still genuine. According to American researchers, morbidity of post-Caesarean mothers is six – to sevenfold higher than after natural childbirth [29]. In Poland, over a half of maternal deaths concerns cases of delivery through Caesarean section [30].

The common belief about the better status of children born though Caesarean section is the underlying cause of pressure exerted on obstetricians by pregnant women and their significant others. Other researchers claim that statistically fewer complications were observed in children born though emergency Caesarean section than in children of the same age group born through elective Caesarean section [31].

To conclude, the results of the present study are of great importance due to not only the lack of such data in Poland, but also the need to focus on Caesarean section as a mode of delivery which does not guarantee a greater satisfaction with life. The research study may contribute to a change in the preferences of women as to the mode of delivery, as well as to drawing a closer attention of the medical milieu to the crucial role and commitment of fathers during childbirth, and the social support they provide. Receiving social support both during pregnancy and after delivery is essential for mothers as it benefits their quick return to normal functioning, adaptation to motherhood and experiencing satisfaction with life.

Conclusions

1. Women subject to Caesarean section received significantly higher levels of each type of social support already during pregnancy than women who gave birth physiologically.
2. Women who delivered by Caesarean section received significantly higher levels of instrumental support in the postpartum period than women after physiological delivery.
3. Women's satisfaction with life increases after childbirth and does not differ with respect to the mode of delivery and the urgency of Caesarean section.
4. Satisfaction with life of women in the third trimester of pregnancy and in the postpartum period significantly correlates with social support received from partners/husbands.

References

1. Torkan B, Parsay S, Lamyian M, Kazemnejad A, Montazeri A. *Postnatal quality of life in women after normal vaginal delivery and caesarean section*. BMC Pregnancy Childb. 2009; 30: 9–4.
2. Rowlands I, Redshaw M. *Mode of birth and women's psychological and physical wellbeing in the postnatal period.* BMC Pregnancy Childb. 2012; 12: 138–156.
3. Da Costa D, Dritsa M, Rippen N, Lowensteyn I, Khalife S. *Health-related quality of life in postpartum depressed women.* Arch. Women. Ment. Hlth. 2006; 9(2): 95–102.
4. Waldenström U, Hildingsson I, Rubertsson C, Rådestad I. *A negative birth experience: prevalence and risk factors in a national sample*. Birth. 2004; 31(1): 17–27.
5. Gao L, Sun K, Chan S. *Social support and parenting self-efficacy among Chinese women in the perinatal period*. Midwifery. 2014; 30(5): 532–538.
6. Dyrdal GM, Roysambu E, Bang Nes R, Vitterso J. *Can a happy relationship predict a happy life? A population-based study of maternal well-being during the life transition of pregnancy, infancy, and toddlerhood*. J. Happiness Stud. 2010; 12(6): 947–962.

7. Beck C. *Post-traumatic stress disorder due to childbirth: the aftermath*. Nurs. Res. 2004; 53(4): 216–224.
8. Hodnett E. *Pain and women's satisfaction with the experience of childbirth: A systematic review.* Am. J. Obstet. Gynecol. 2002; 186(5): 160–172.
9. Karlstöm A, Engström-Olofsson R, Norbergh K, Sjöling M, Hidingsson I. *Postoperative pain after cesarean birth affects breastfeeding and infant care*. J. Obstet. Gynecol. Neonatal. Nurs. 2007; 36(5): 430–40.
10. Tham V, Ryding E, Christensson K. *Experience of support among mothers with and without post-traumatic stress symptoms following emergency cesarean section.* Sex. Reprod. Healthc. 2010; 1(4): 175–80.
11. Shorten A, Shorten B. *The importance of mode of birth after previous cesarean: Success, satisfaction, and postnatal health*. J. Midwifery Wom. Health. 2012; 57(2): 126–132.
12. Aktan NM. *Functional status after childbirth and related concepts*. Clin. Nurs. Res. 2010; 19(2): 165–180.
13. Stapleton L, Schetter D, Westling E, Rini C, Glynn L, Hobel C, Sandman A. *Perceived partner support in pregnancy predicts lower maternal and infant distress.* J. Fam. Psychol. 2012; 26(3): 453–63.
14. Sapkota S, Kobayashi T, Takase M. *Impact on perceived postnatal support, maternal anxiety and symptoms of depression in new mothers in Nepal when their husbands provide continuous support during labour*. Midwifery. 2013; 29(11): 1264–1271.
15. Webster J, Nicholas C, Velacott C, Cridland N, Fawcett L. *Quality of life and depression following Childbirth: impast of social support.* Midwifery. 2011; 27(5): 745–749.
16. Negron R, Martin A, Almog M, Balbierz A, Howell E. *Social support during the postpartum period: Mothers' views on needs, expectations, and mobilization of support*. Matern. Child Hlth J. 2013; 17(4): 616–623.
17. Fenwick J, Personel L, Gamble J, Creedy D, Bayesa S. *Why do women request cesarean section in a normal, healthy first pregnancy?* Midwifery. 2010; 26(4): 394–400.
18. Doss BD, Roades GK, Stanley SM, Markman HJ. *The effect of transition to parenthood on relationship quality: An 8-year prospective study*. J. Pers. Soc. Psychol. 2009; 96(3): 601–619.
19. Hansen T. *Parenthood and happiness: A review of folk theories versus empirical evidence*. Soc. Indic. Res. 2012; 108: 26–64.
20. Łuszczyńska A, Kowalska M, Mazurkiewicz M, Schwarzer R. *Berlińskie Skale Wsparcia Społecznego (BSSS): Wyniki wstępnych badań nad adaptacją skal i ich własnościami psychometrycznymi.* Stud. Psychol. 2006; 44(3): 17–27.
21. Juczyński Z. *Narzędzia pomiaru w promocji i psychologii zdrowia*. Warsaw: Psychological Test Laboratory of the Polish Psychiatric Association; 2001, 134-139.
22. Pomorski M, Woytoń R, Woytoń P, Kozłowska J, Zimmer M. *Cięcie cesarskie a porody siłami natury – aktualne spojrzenie.* Ginekol. Pol. 2010; 81: 347–351.
23. Świerczek M. *Być matką – konfrontacja oczekiwań i rzeczywistości w kontekście wsparcia społecznego*. Chowanna. 2004; 2(23): 129–143.
24. Tulman L, Fawcett J, Groblewski L, Silverman L. *Changes in functional status after childbirth*. Nursing Research. 1990; 39: 70–75.
25. Rowe-Murray HJ, Fischer JR. *Baby friendly hospital practices: cesarean section is a persistent barrier to early initiation of breastfeeding*. Birth. 2002; 29(2): 124–131.
26. Ingram J, Johnson D, Greenwood R. *Breastfeeding in Bristol: teaching good positioning, and support from fathers and families*. Midwifery. 2002; 18(2): 87–101.

27. Morhason-Bello IO, Adedokun BO, Ojengbede OA. *Social support during childbirth as a catalyst for early breastfeeding initiation for first-time Nigerian mothers*. Int. Breastfeed J. 2009; 10: 4–16.
28. Kuhnpradit S, Travender E, Lumbiganon P, Laopaiboon M, Wasiak J, Gruen RL. *Non-clinical interventions for reducing unnecessary cesarean section. Cochrane database of systematic reviews*. 2011; 6. Art. No. CD005528 DOI. 10.1002/14651858.CD005528.pub2.
29. Clark SL, Belfort MA, Dildy GA, Herbst MA, Meyers JA, Hankins GD. *Maternal death in the 21st century: Causes, prevention, and relationship to cesarean delivery*. Am. J. Obstet. Gynecol. 2008; 199(1): 36.e1-5; discussion 91-1.e7-11.
30. Troszyński M, Niemiec T, Wilczyńska A. *Cięcie cesarskie – dobrodziejstwo czy zagrożenie*. Perinatologia, Neonatologia i Ginekologia. 2008; 1(1): 8–10.
31. Farrell S. *Cesarean section versus forceps-assisted vaginal birth: It's time to include pelvic injure in the risk – benefit equation*. CMAJ. 2002; 166: 337–338.

Address: Grażyna Gebuza
Nicolaus Copernicus University in Torun
Faculty of Health Sciences
85-067 Bydgoszcz, Jagiellońska Street 13-15