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PRACA ORYGINALNA

Social support and the ability to control emotions in women hospitalized due to the risk of premature birth

Wsparcie społeczne i umiejętność kontroli emocji u kobiet hospitalizowanych z powodu zagrażającego porodu przedwczesnego

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Abstract

Introduction and Objective. Social support and emotional management during hospitalization due to obstetric complications can positively contribute to shaping one's health condition and coping with difficult news or events. The aim of the study was to assess the level of social support and the ability to control emotions in pregnant women hospitalized due to a risk of preterm labour.

Materials and method. The study was conducted on a group of 120 women using standardized tools: Berlin Social Support Scales (BSSS) and the Courtauld Emotional Control Scale (CECS).

Results. Statistical analysis showed that age significantly influences the perception of available support (p=0.021) and currently received instrumental support (p=0.038). In the scale of buffering and protective support, the professional status is of significant importance (p=0.031). Financial situation is an important factor in terms of received emotional (p=0.038) and instrumental (p=0.030) support. Planning a pregnancy is important for the perception of available support (p=0.002), currently received support (p=0.006), emotional support (p=0.040) and buffering and protective support (p=0.018). The time of hospitalization affects the perception of information support received (p=0.036). The ability to control emotions depends on the place of residence (p=0.027) and education (p=0.030). The place of residence had an impact on the ability to suppress depression (p=0.015).

Conclusions. The social dimension of life plays a role in the emotional coping mechanism. Emotional intelligence issues should be included in the care plan for a woman hospitalized due to the risk of preterm labour.

Key words

pregnancy, emotion control, preterm labour, social support

Streszczenie

Wprowadzenie i cel pracy. Wsparcie społeczne udzielane rodzącym kobietom i zarządzanie przez nie własnymi emocjami w czasie hospitalizacji z powodu powikłań położniczych może pozytywnie wpłynąć na ich stan zdrowia oraz radzenie sobie przez nie z trudnymi wiadomościami czy wydarzeniami. Niniejsza praca ma na celu ocenę poziomu wsparcia społecznego i umiejętności kontroli emocji u kobiet ciężarnych hospitalizowanych z powodu zagrażającego porodu przedwczesnego.

Materiał i metody. Badanie przeprowadzono na grupie 120 kobiet z wykorzystaniem narzędzi standaryzowanych: Berlińskich Skal Wsparcia Społecznego (Berlin Social Support Scales, BSSS) oraz Skali Kontroli Emocji (Courtauld Emotional Control Scale, CECS).

Wyniki. Analiza statystyczna wykazała, iż wiek kobiet istotnie wpływa na spostrzeganie dostępnego wsparcia (p=0,021) oraz aktualnie otrzymywane wsparcie instrumentalne (p=0,038). W skali wsparcia buforująco-ochronnego duże znaczenie ma ich status zawodowy (p=0,031). Czynnikiem istotnym dla otrzymywanego wsparcia emocjonalnego (p=0,038) oraz instrumentalnego (p=0,030) jest sytuacja materialna. Planowanie ciąży jest istotne dla spostrzeganego dostępnego wsparcia (p=0,002), aktualnie otrzymywanego wsparcia (p=0,006), wsparcia emocjonalnego (p=0,040) oraz wsparcia buforująco-ochronnego (p=0,018). Długość hospitalizacji wpływa na postrzeganie otrzymywanego wsparcia informacyjnego (p=0,036). Umiejętność kontroli emocji jest zależna od miejsca zamieszkania (p=0,027) oraz od wykształcenia (p=0,030). Na umiejętność tłumienia depresji wpływ miało miejsce zamieszkania (p=0,015).

Wnioski. Społeczny wymiar życia odgrywa rolę w mechanizmie radzenia sobie z emocjami. Zagadnienia inteligencji emocjonalnej powinny być wpisane w plan opieki nad kobietą hospitalizowaną z powodu zagrożenia porodem przedwczesnym.

Słowa kluczowe

ciąża, kontrola emocji, poród przedwczesny, wsparcie społeczne

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INTRODUCTION

Pregnancy is a unique time in a woman's life which is accompanied by many emotions. The new social role – the role of a mother – is associated with joy and a sense of fulfillment, but in a way it is also a challenge for a woman. Even when pregnancy is normal, it is often accompanied by stress and anxiety related to the entire perinatal period. A number of concerns during pregnancy relate mainly to the birth and health of the newborn, especially when complications appear. Experienced fear may negatively affect the quality and satisfaction with life of pregnant women, and may initiate the appearance of symptoms of depression, anxiety disorders or phobias. In addition, the emotional state of a pregnant woman may affect the health of the newborn. Everyday problems, poor-quality relationships with a partner and the pathological course of pregnancy, including the risk of premature birth, are sources of stress [1,2,3].

According to World Health Organization, the percentage of premature births in the world ranges from 5–18%, and about 1 million children die each year due to complications of prematurity [4]. High-quality maternity care plays a crucial role in preventing complications from preterm labour, and should include not only the clinical assessment of the well--being of the foetus or mother's health, but also the promotion of mental health, early identification of symptoms of mental disorders, and promotion of support systems for women in difficult situations [5].

Social support is defined as helping a person in a difficult situation. Depending on human needs, certain types of support can be distinguished, e.g. emotional (e.g. showing empathy, calming somebody down), instrumental (e.g. indicating what to do in the event of vaginal bleeding), and informative (e.g. advice on coping with stress). The social support received can help to reduce stress and anxiety, and therefore reduce the risk of adverse pregnancy outcomes [6]. For pregnant women, especially those whose pregnancy is at risk, it is very important to obtain support from relatives and medical professionals. Social support is a factor improving the mechanism of coping with stressful events, especially in such a difficult situation as hospitalization. Closeness and kindness shown to the patient gives a sense of security and helps in mobilizing the overcoming of fear and helplessness [1].

Apart from support, an important issue is working on the emotions, which is aimed at coping with a difficult life situation. Working with emotions is about sharing experiences with loved ones and medical staff. By establishing a relationship with a patient, a midwife can encourage her to share her concerns, calm her down and make her feel comfortable. The ability to control emotions also involves trying to distract attention from the negative effects of a stress stimulus and 'occupying the mind' with something else. This method often involves lying to loved ones about conditions experienced or avoiding sharing information about general well-being, which would inhibit the attention span. Managing own emotions can positively contribute to shaping health and dealing with difficult news or events [7].

OBJECTIVE

The aim of this study is to assess the level of social support and the ability to control emotions in women hospitalized due to the risk of premature birth.

MATERIALS AND METHOD

The study was conducted in Poland, from April – August 2021, among hospitalized pregnant women who were at risk of premature birth at the Sub-Carpathian Provincial Hospital (Wojewódzki Szpital Podkarpacki) in Krosno, south-east Poland. The research was conducted in accordance with the assumptions of the Helsinki Declaration, and approved by the managers of health care units.

The research tool was a proprietary questionnaire that enabled characterization of the studied group. In addition, two standardized tools were used: the Berlin Social Support Scales (BSSS, Berlin Social Support Scales) by Schwarzer, in the Polish adaptation of Łuszczyńska and Kowalska, and the Emotional Control Scale (CECS, Courtauld Emotional Control Scale) by Watson and Geer, adapted to Polish conditions by Juczyński. Before starting the research, each of the respondents was informed about the anonymity, voluntary participation in the research and the purpose of using the obtained results. The gestational age of the surveyed women was assessed on the basis of medical records. Preterm labour was divided into three subcategories: extremely preterm (less than 28 weeks), very preterm (28–32 weeks) and moderate to late preterm (32-o 37 weeks).

The BSSS questionnaire consists of five scales to measure the cognitive and behavioural aspects of social support: 1) perceived available support (8 statements), 2) need for support (4 statements), 3) seeking support (5 statements), 4) currently received support (15 statements) and 5) buffering and protective support (6 statements). In addition, on a scale of 4, the results for emotional, instrumental and informational support were distinguished. The answers are given on a scale from 1-o 4 (definitely no, probably no, rather yes, definitely yes). The higher the score on each scale, the greater the social support. The scale reliability coefficient (Cronbach's alpha) ranged from 0.74–0.90 [8].

The second tool was the Polish version of the Emotion Control Scale, which consists of 3 subscales regarding the level of anger, depression and anxiety suppression, each of which contains 7 statements. The overall emotional control score is the sum of the scores for all subscales and ranges from 21–84 points, while the level of emotional suppression in individual subscales is between 7–21 points. The higher the score, the higher the level of negative emotion suppression. Cronbach's alpha coefficient was 0.80 for anger control, 0.77 for depression control, 0.78 for anxiety control, and 0.87 for overall emotion control coefficient [9].

The obtained results were analyzed statistically. A significance level of $p < 0.05$ was adopted, indicating the existence of statistically significant differences or relationships. The database and statistical research were carried out on the basis of the STATISTICA 13.0 computer software (StatSoft, Poland). The values of the analyzed measurable parameters were presented with the use of the mean (M), standard deviation (SD), median (Me), minimum (Min) and maximum (Max), and for non-measurable ones by the count (n) and

percentage (%). Appropriate statistical tests were used to investigate the differences between parameters. The normality of the distribution of variables in the studied groups was checked using the Shapiro-Wilk normality test. The parametric t-Student test and the non-parametric Mann-Whitney test were used to test the differences between the two groups, while the Kruskal-Wallis test was used for more than two groups. Pearson's r correlation was used to check the relationship between the selected variables, and for ordinal variables, the Spearman's rho correlation. In order to evaluate the variables, a regression analysis was performed taking into account the moderation factors. A significance level of $p < 0.05$ was adopted, indicating the existence of statistically significant differences or relationships.

RESULTS

The study included 120 pregnant women hospitalized due to being at risk of preterm labour. The age of the examined women was in the range of 20–41 years. The majority of the studied group were women who lived in the village (66.67%), with higher education (51.67%), in a relationship (91.67%), working / on sick leave due to pregnancy (65.00%), assessed their financial situation as good (58.33%). When analyzing the data concerning current pregnancy, the majority of women were in their first pregnancy (56.67%), between the 33rd – 37th week of pregnancy (43.33%), and the pregnancy was planned (81.67%). Hospitalization time was usually less than 5 days (75.00%) (Tab. 1).

Table 2 presents the analysis of social support and the mean scores for emotional control in pregnant women at risk of preterm labour. The highest values of social support were obtained on the scales: perception of the available instrumental support (3.66) and currently received support (3.61), while the lowest values were obtained on the scales: seeking support (2.96) and the need for support (3.01). The mean scores for emotional controls were 15.37 for anger control, 16.25 for depression control, and 16.68 for anxiety control, respectively. The mean overall score on the scale for emotional control was 48.13.

The performed statistical analysis showed significant positive correlations between the perception of available support and the search for support, the currently received emotional, instrumental and informational support, between the need for support and the search for support, and between the buffering and protective support and general emotional control and control of depressive symptoms. The correlations ranged from 0.256–0.840.

There were also negative correlations between perception of available support and buffering and protective support, general emotional control, anger, depression and anxiety control, and between buffering and protective support and currently received support. Moreover, negative correlations were observed between the ability to control emotions and received emotional support, and between the ability to control depression and information support. The correlations ranged from -0.525 to -0.266 (Tab. 3).

Statistical analysis showed that age significantly influenced the perception of the available support (p=0.021) and the currently received instrumental support (p=0.038). Support in the above scales increased with age. For the results obtained on the buffer-protective support scale, the professional status of the respondents is of significant importance (p=0.031). Non-working women had a higher score compared to working women. The factor significantly influencing the self-esteem of the received emotional (p=0.038) and instrumental (p=0.030) support, and at the limit of significance of information support (p=0.069), was the financial situation.

Table 1. Characteristics of the studied group

Characteristics of the studied group		N (120)	% (100)
Age	19 - 25 y/o	30	25.00
	26 - 30 y/o	36	30.00
	> 30 y/o	54	45.00
Residence	Urban	40	33.33
	Rural	80	66.67
Education	Primary	10	8.33
	Secondary	48	40,00
	Higher	62	51.67
Relationship status	Married	110	91.67
	Single	10	8.33
Professional status	Working / on a sick leave	78	65.00
	Does not work	42	35.00
Financial situation	Very good	26	21.67
	Good	70	58.33
	Average	24	20.00
No. of pregnancies	1	68	56.67
	2	28	23.33
	≥ 3	24	20.00
Week of pregnancy	<28 Hbd	36	30.00
	28-32 Hbd	32	26.67
	33-37 Hbd	52	43.33
Planned pregnancy	Yes	98	81.67
	No	22	18.33
Time of hospitalization	1-5 days	90	75.00
	≥5 days	30	25.00

Table 2. Average scores on the Berlin Social Support Scale and Emotion Control Scale

	Scales	M	Me	SD
BSSS - Berlin Social Support Scales	Perceived available support	3.66	3.88	0.55
	Need for support	3.01	3.00	0.41
	Seeking support	2.96	3.00	0.64
	Currently received support	3.61	3.87	0.70
	Emotional support	3.67	4.00	0.69
	Instrumental support	3.67	4.00	0.66
	Information support	3.44	4.00	0.81
	Buffering and protective support	2.04	1.83	0.76
	Scales	M	Me	SD
CECS - Courtauld Emotional Control Scale	Anger	15.37	15.00	4.66
	Depression	16.25	16.00	5.29
	Anxiety	16.68	17.00	4.66
	Total	48.13	47.50	12.36

BSSS - Berlin Social Support Scales: 1 - perceived available support; 2 - need for support; 3 - seeking support; 4 - currently receiving support; 5 - buffering and protective support; CECS - Courtauld Emotional Control Scale

Table 3. Correlations between the Berlin Scales of Social Support and Emotional Control Scale

	BSSS 1	BSSS 2	BSSS 3	BSSS 4	EMO	INSTR	INF	BSSS 5
BSSS 2	0.139	-						
BSSS 3	**0.256 ***	**0.486 ***	-					
BSSS 4	**0.526 ****	0.071	0.103	-				
EMO	**0.481 ***	0.009	0.114	**0.840 ***	-			
INSTR	**0.536 ***	0.079	**0.300 ***	**0.710 ***	**0.708 ***	-		
INF	**0.436 ***	0.200	0.219	**0.685 ***	**0.461 ***	**0.493 ***	-	
BSSS 5	**-0.462 ****	0.016	0.110	**-0.525 ****	**-0.485 ****	**-0.454 ****	**-0.401 ****	-
CECS	**-0.406 ****	0.026	-0.038	-0.120	-0.143	-0.085	-0.235	**0.347 ****
Anger	**-0.370 ****	0.156	0.044	-0.138	**-0.275 ***	-0.144	-0.222	0.216
Depression	**-0.392 ****	-0.011	-0.138	-0.114	-0.099	-0.102	**-0.292 ***	**0.382 ****
Anxiety	**-0.266 ***	-0.008	0.061	-0.039	-0.023	0.053	0.010	0.236

BSSS – Berlin Social Support Scales: 1 – perceived available support; 2 – need for support; 3 – seeking support; 4 – currently receiv support; EMO – emotional; INSTR – instrumental; INF – informational; 5 - buffering and protective support; CECS - Courtauld Emotional Control Scale; * p <.05; ** p <.01

The lowest level of support was assessed by people in average financial situation, and the highest by people in good financial situation. (Tab. 4 and 5).

Table 6 presents significant differences between pregnancy planning and the perception of available support (p=0.002), currently received support (p=0.006), as well as the subscale of emotional support (p=0.040) and buffer-protective support (p=0.018). Women who had planned the pregnancy received greater support on the scales of perception of available support, currently received support and perception of received emotional support, and had a lower result on the buffer--protective support scale compared to women who did not plan pregnancy. The time of hospitalization was a factor influencing the perception of the information support received (p=0.036). In pregnant women hospitalized for more than five days, information support was rated higher compared to those who were hospitalized for a shorter period of time.

Statistical analysis showed that the ability to control emotions (general score) was dependent on the place of residence (p=0.027) and on the education level (p=0.030) of the respondents. Women living in a city who hde completed higher education had a lower ability to control emotions, compared to women living in the village with primary or secondary education. The place of residence had an influence on the

Table 4. Analysis of relationship between socio-demographic data and Berlin Social Support Scales (subscales 1-4)

Socio-demographic data		BSSS 1			BSSS 2			BSSS 3			BSSS 4		
		M.	Me	SD	M.	Me	SD	M.	Me	SD	M.	Me	SD
Age	19-25 y/o	3.34	3.75	0.74	3.12	3.00	0.52	2.83	2.60	0.83	3.28	3.73	1.02
	26-30 y/o	3.78	3.88	0.31	3.04	3.00	0.31	2.93	3.00	0.52	3.84	3.93	0.27
	> 30 y/o	3.75	4.00	0.50	2.94	3.00	0.40	3.05	3.00	0.60	3.63	3.87	0.63
			H=7.660; p=0.021			*H=1,157; p=0.561*			*H=1.294; p=0.524*			*H=2.038; p=0.219*	
Education	Primary	3.40	3.88	0.96	3.25	3.25	0.40	3.20	3.00	0.76	3.27	3.80	1.28
	Secondary	3.71	3.88	0.35	3.10	3.00	0.40	2.93	3.00	0.69	3.72	3.87	0.41
	Higher	3.66	3.88	0.60	2.90	2.75	0.40	2.95	3.20	0.59	3.58	3.87	0.76
			H=0.305; p=0.859			*H=4.922; p=0.086*			*H=0.469; p=0.791*			*H=0.464; p=0.793*	
Relationship status	Married	3.70	3.88	0.48	3.03	3.00	0.40	2.95	3.00	0.63	3.60	3.87	0.72
	Single	3.25	3.75	1.06	2.80	2.75	0.48	3.04	3.20	0.74	3.69	3.87	0.38
			Z=0.695; p=0.487			*Z=1.150; p = 0.250*			*Z = -0.241; p = 0.810*			*Z = 0; p = 1*	
Professional status	Working	3.73	3.88	0.46	3.00	3.00	0.41	2.94	3.00	0.65	3.74	3.93	0.52
	Does not work	3.54	3.88	0.68	3.04	3.00	0.42	3.00	3.00	0.62	3.36	3.80	0.91
			Z =-0.798; p =0.425			*Z = 0.194; p = 0.846*			*Z = 0.395; p = 0.693*			*Z = -1.868; p = 0.062*	
Financial situation	Very good	3.72	3.75	0.32	3.06	3.25	0.40	3.03	3.00	0.78	3.82	4.00	0.32
	Good	3.77	3.88	0.45	2.98	3.00	0.37	2.97	3.00	0.62	3.70	3.87	0.56
	Average	3.28	3.50	0.83	3.06	2.88	0.54	2.85	3.00	0.55	3.09	3.27	1.07
			H = 3.800; p = 0.147			*H = 0.971; p = 0.616*			*H = 0.559; p = 0.756*			*H = 5.316; p = 0.070*	

BSSS - Berlin Social Support Scales: 1 - perceived available support; 2 - need for support; 3 - seeking support;
4 - currently receiving support; Z - Mann-Whitney test; H - Kruskal-Wallis test; p - probability

Table 5. Analysis of relationship between socio-demographic data and Berlin Social Support Scales (subscales 4 - emotional, instrumental and informational support currently received, and subscale 5)

Socio-demographic data		BSSS 5			BSSS 4 - EMO			BSSS 4 - INSTR			BSSS 4 - INF		
		M.	Me	SD	M.	Me	SD	M.	Me	SD	M.	Me	SD
Age	19-25 y/o	2.12	2.17	0.80	3.38	3.78	1.02	3.29	4.00	1.04	3.43	4.00	1.08
	26-30 y/o	1.90	1.67	0.75	3.88	4.00	0.28	3.93	4.00	0.24	3.47	3.75	0.65
	> 30 y/o	2.08	1.83	0.77	3.69	3.89	0.63	3.70	4.00	0.49	3.43	4.00	0.76
		H = 4.257; p = 0.119			*H = 4.257; p = 0.119*			***H = 6.527; p = 0.038***			*H = 0.830; p = 0.660*		
Education	Primary	2.20	2.33	0.92	3.33	3.89	1.31	3.40	4.00	1.34	2.70	2.50	1.30
	Secondary	2.06	2.00	0.80	3.77	4.00	0.37	3.79	4.00	0.39	3.71	4.00	0.55
	Higher	1.99	1.67	0.73	3.64	4.00	0.76	3.61	4.00	0.69	3.35	3.50	0.82
		H =. 311; p = 0.856			*H = 0.288; p = 0.866*			*H = 0.950; p = 0.623*			*H = 5.348; p = 0.069*		
Relationship status	Married	2.06	1.83	0.75	3.65	4.00	0.72	3.70	4.00	0.66	3.44	4.00	0.82
	Single	1.73	1.17	0.93	3.84	4.00	0.29	3.33	3.33	0.71	3.50	4.00	0.71
		Z =1.043; p =0.297			*Z = -0.425; p =0.649*			*Z = 1.237; p = 0.204*			*Z =-0.013; p =0.989*		
Professional status	Working	1.90	1.67	0.71	3.79	4.00	0.51	3.79	4.00	0.44	3.54	4.00	0.68
	Does not work	2.29	2.33	0.80	3.43	3.89	0.91	3.44	4.00	0.92	3.26	4.00	1.00
		Z = 2.154; p = 0.031			*Z =-1.534; p =0.125*			*Z =-1.178; p =0.239*			*Z =-0.798; p =0.425*		
Financial situation	Very good	2.18	2.17	0.94	3.83	4.00	0.33	3.79	4.00	0.48	3.77	4.00	0.60
	Good	1.89	1.83	0.63	3.80	4.00	0.53	3.82	4.00	0.37	3.47	4.00	0.69
	Average	2.32	2.25	0.86	3.11	3.33	1.08	3.08	3.17	1.09	3.00	3.25	1.15
		H = 2.135; p = 0.344			***H = 6.529; p = 0.038***			***H = 6.999; p = 0.030***			*H = 5.340; p = 0.069*		

BSSS - Berlin Social Support Scales: 4 - currently received support; EMO – emotional; INSTR – instrumental; INF – information; 5 - buffering and protective support; Z - Mann-Whitney test; H - Kruskal-Wallis test; p - probability

ability to suppress depression (p=0.015). Women living in the countryside suppressed symptoms of depression more strongly than people living in the city (Tab. 7).

DISCUSSION

Social support, analyzed in this study with the help of the Berlin Social Support Scales, is the kind and amount of support described by the patients during their stay in hospital. In the case of obstetric complications, apart from the treatment process, it is very important to emphasize the patient's well-being and provide her with support. Pregnant women who require hospitalization especially need help and various forms of support, both from their relatives and health care workers. Emotional stability and minimizing the level of anxiety are factors associated with successful delivery outcomes [7]. The support provided has a positive effect on the effectiveness of obstetric care and helps to alleviate the negative emotions associated with obstetric complications and hospitalization. It is a kind of a buffer against the stress affecting a woman and helps in the process of coping with a difficult situation and can prevent psychological problems in the perinatal period [2,10]. Support from relatives and medical staff can prevent mental crises and help build a sense of self-efficacy during hospitalization [11,12].

Insufficient social support, a tendency to hide emotions and unsatisfactory relationships with loved ones can cause a feeling of loneliness, emotional instability, and other psychological problems [1,2]. Shishehgar et al. report that social support reduces stress experienced during pregnancy [11]; Ghosh et al. suggest that support given to a woman by a partner may modify the impact of stress on increasing the risk of preterm labour [13]. Similar relationships were presented by Fu et al. who discovered that satisfaction in the relationship with a partner can be a buffer against the effects of stress on a pregnant woman [14]. Tani and Castagna report that the perception of social support is an important protective factor against the development of symptoms of postpartum depression [15].

The results of the current study suggest that pregnant women at a risk of preterm labour assess the availability of support as well as receiving emotional, instrumental and informative support during hospitalization quite well. Skurzak et al., while studying social support in pregnant women, report that the fact of pregnancy planning significantly affects the perception of available support, and the average score on this scale was higher in pregnant women whose pregnancy was consciously planned [16]. The results of own research confirm this data dependency. Moreover, the increase in support in the pregnant group was determined by the number of pregnancies and deliveries, as well as participation in childbirth classes [16]. In turn, the current study indicates that pregnancy planning is an important factor additionally for the buffering and protective support and currently received support in the overall assessment and in the emotional support subscale. Women in planned pregnancies declared a higher level of received support and a lower level of buffering and protective support.

Bedaso et al. indicate that pregnant women who were single and had a difficult financial situation significantly more often reported low social support, compared to women who were in a relationship and in a better economic situation [1]. The following study also indicates the financial situation as a factor significant for receiving emotional and instrumental social support, while the relationship status was not significantly related to any of the scales examining social support.

The surveyed women who stayed in the hospital for more

Table 6. Analysis of relationship between pregnancy data and the Berlin Social Support Scales

PREGNANCY DATA		BSSS 1			BSSS 2			BSSS 3			BSSS 4		
		M	Me	SD	M	Me	SD	M	Me	SD	M	Me	SD
Number of pregnancies	1	3.60	3.88	0.68	3.02	3.00	0.40	2.98	3.00	0.62	3.65	3.87	0.73
	2	3.79	4.00	0.26	3.16	3.13	0.40	3.14	3.20	0.59	3.66	3.80	0.41
	3 and more	3.67	3.75	0.37	2.81	2.88	0.41	2.70	2.90	0.70	3.44	3.80	0.87
		H=0.774; p=0.680			*H=3.695; p=0.158*			*H=3.127; p=0.209*			*H=1.503; p=0.471*		
Week of pregnancy	< 28 Hbd	3.76	4.00	0.54	3.07	3.00	0.40	2.91	3.10	0.66	3.71	3.90	0.70
	28-32 Hbd	3.76	3.81	0.20	3.06	3.00	0.36	3.09	3.00	0.65	3.53	3.83	0.80
	33-37 Hbd	3.53	3.88	0.68	2.94	3.00	0.45	2.92	3.00	0.63	3.58	3.90	0.65
		H=4.001; p=0.135			*H=1.084; p=0.582*			*H=0.750; p=0.688*			*H=1.628; p=0.443*		
Planned pregnancy	Tak	3.75	3.88	0.50	3.01	3.00	0.38	2.93	3.00	0.65	3.75	3.93	0.49
	Nie	3.27	3.38	0.62	3.05	3.00	0.53	3.11	3.00	0.59	2.96	3.13	1.07
		Z=3.124; p=0.002			*Z=-0.010; p=0.992*			*Z=-0.621; p=0.535*			***Z=2.732; p=0.006***		
Time of hospitalization	1-5 dni	3.67	3.88	0.51	2.99	3.00	0.39	2.90	3.00	0.62	3.56	3.87	0.77
	≥5 dni	3.64	3.88	0.67	3.07	3.00	0.48	3.15	3.00	0.67	3.74	3.93	0.41
		Z=-0.290; p=0.772			*Z=-0.495; p=0.621*			*Z=-0.939; p=0.348*			*Z=-0.837; p=0.403*		
PREGNANCY DATA		BSSS 5			BSSS 4 - EMO			BSSS 4 - INSTR			BSSS 4 - INF		
		M	Me	SD	M	Me	SD	M	Me	SD	M	Me	SD
Number of pregnancies	1	1.89	1.67	0.71	3.72	4.00	0.71	3.64	4.00	0.77	3.54	4.00	0.79
	2	2.18	2.08	0.80	3.69	3.94	0.46	3.76	4.00	0.44	3.32	3.50	0.75
	3 i więcej	2.28	2.25	0.84	3.50	3.83	0.87	3.64	4.00	0.56	3.29	3.75	0.94
		H=3.240; p=0.198			*H=2.540; p=0.280*			*H=0.472; p=0.790*			*H=2.166; p=0.339*		
Week of pregnancy	< 28 Hbd	1.78	1.67	0.60	3.75	4.00	0.70	3.70	4.00	0.73	3.61	4.00	0.80
	28-32 Hbd	1.99	2.00	0.68	3.65	4.00	0.78	3.88	4.00	0.27	3.25	3.75	0.95
	33-37 Hbd	2.24	2.33	0.87	3.62	3.89	0.65	3.51	4.00	0.76	3.44	3.75	0.73
		H=3.268; p=0.165			*H=1.785; p=0.410*			*H=2.688; p=0.261*			*H=2.276; p=0.321*		
Planned pregnancy	Tak	1.94	1.67	0.75	3.80	4.00	0.49	3.75	4.00	0.57	3.54	4.00	0.68
	Nie	2.48	2.33	0.67	3.10	3.33	1.11	3.30	3.67	0.92	3.00	3.00	1.16
		Z = -2.369; p = 0.018			***Z=2.054; p=0.040***			*Z=1.624; p=0.104*			*Z=1.290; p=0.197*		
Time of hospitalization	1-5 dni	2.02	1.83	0.74	3.62	3.89	0.77	3.63	4.00	0.70	3.32	3.50	0.87
	≥5 dni	2.09	2.17	0.85	3.82	4.00	0.33	3.78	4.00	0.53	3.80	4.00	0.41
		Z=-0.128; p=0.898			*Z=-0.819; p=0.413*			*Z=-0.913; p=0.413*			***Z= -2.097; p=0.036***		

BSSS – Berlin Social Support Scales: 1 – perceived available support; 2 – need for support; 3 – seeking support; 4 – currently receiving support; EMO – emotional; INSTR – instrumental; INF – informative; 5 – buffering and protective support; Z – Mann-Whitney test; H – Kruskal-Wallis test; p – probability

than 5 days declared that they received all types of support at a higher level than women hospitalized for a shorter period of time. However, this difference was statistically significant only in terms of received information support. What should be emphasized, according to the conducted statistical analysis, the higher the level of information support, the lower the ability to suppress emotions related to depressive symptoms. Although the ability to suppress emotions is a feature of highly socialized people, unrepressed negative emotions can be the basis of many mental disorders [9]. The level of emotional control, assessed using the Emotion Control Scale, is understood as a subjective belief in the ability to control one's reactions in response to difficult situations. The mean results obtained in the overall assessment of emotional control and in the individual subscales of suppressing anger, depression and anxiety are similar to the means presented in the normalization study of the scale [9].

The results of the authors' own research indicate that women living in rural areas and women with primary education had significantly higher tendencies to control negative emotions. The higher perception of support and receiving support were perceived, the better the respondents had the ability to express negative emotions. Asselmann et al. indicate that more extroverted women who are able to name and express their emotions, much less often develop symptoms of depression in the perinatal period compared to women who suppressed all negative emotions [3]. Fu et al. also describe that the ability to identify emotions and express them is an important buffer of stress and anxiety in the perinatal period and helps women to adapt and deal with difficult situations [14].

The surveyed women, who rated the availability of support higher, indicated a lower level of emotional suppression on the general scale and in all subscales: anger, depression and anxiety. This may be a confirmation of the thesis that the immediate environment of a person creates an atmosphere favorable or unfavorable to self-expression and readiness to sympathize with difficult emotions [17,18].

Table 7. Analysis of relationship between socio-demographic and pregnancy data and CECS subscales

SOCIO-DEMOGRAPHIC AND PREGNANCY DATA		CECS - Total			CECS - anger			CECS - depression			CECS - anxiety		
		M.	Me	SD	M.	Me	SD	M.	Me	SD	M.	Me	SD
Age	19-25 years	49.33	47.00	15.41	15.40	15.00	6.01	16.27	15.00	5.82	17.67	17.00	5.60
	26-30 years	49.28	49.50	12.19	14.89	15.00	3.97	17.39	18.50	5.33	17.00	17.00	4.84
	> 30 years	46.70	47.00	10.86	15.67	15.00	4.39	15.48	16.00	5.03	15.93	17.00	3.98
		H = 0.162; p = 0.922			*H = 0.032; p= 0.984*			*H = 1.177; p= 0.555*			*H = 0.127; p= 0.938*		
Residence	Urban	42.90	46.00	11.27	13.70	14.50	4.18	13.85	15.00	3.87	15.35	15.50	4.73
	Rural	50.75	50.00	12.18	16.20	16.00	4.71	17.45	19.00	5.54	17.35	17.00	4.54
		Z = 2.211; p = 0.027			*Z = 1.741; p = 0.082*			***Z = 2.438; p = 0.015***			*Z = 1.41; p = 0.158*		
Education	Primary	59.80	57.00	11.82	19.60	18.00	3.51	20.80	23.00	5.40	19.40	17.00	5.08
	Secondary	48.71	49.00	9.97	14.79	15.00	4.32	16.29	16.00	4.47	17.63	18.00	3.65
	Higher	45.81	46.00	13.31	15.13	15.00	4.84	15.48	15.00	5.64	15.52	16.00	5.07
		H = 7.016; p = 0.030			*H = 5.107; p= 0.078*			*H = 3.856; p= 0.146*			*H =5.175; p = 0.075*		
Relationship status	Married	48.71	47.00	12.05	15.38	15.00	4.67	16.51	16.00	5.20	17.00	17.00	4.55
	Single	41.80	50.00	15.50	15.20	18.00	5.02	13.40	15.00	6.11	13.20	15.00	4.92
		Z = 0.588; p = 0.556			*Z = -0.187; p= 0.851*			*Z = 1.043; p = 0.297*			*Z = 1.538; p = 0.124*		
Professional status	working	46.10	47.00	9.80	14.90	15.00	4.45	15.62	16.00	4.78	15.85	17.00	3.56
	Does not work	51.90	50.00	15.66	16.24	15.00	5.02	17.43	18.00	6.09	18.24	18.00	6.01
		Z = 1.542; p = 0.123			*Z = 0.907; p = 0.365*			*Z = 1.155; p = 0.248*			*Z = 1.782; p = 0.075*		
Financial situation	Very good	47.77	50.00	12.32	15.77	17.00	4.51	15.69	17.00	5.47	16.31	18.00	3.99
	Good	47.60	47.00	10.36	15.06	15.00	4.23	16.20	16.00	5.09	16.63	17.00	4.22
	Average	50.08	48.00	17.80	15.83	15.00	6.18	17.00	15.50	6.05	17.25	16.50	6.59
		H = 0.108; p = 0.947			*H = 0.587; p= 0.746*			*H = 0.211; p= 0.900*			*H= 0.0148; p=0.993*		
Number of pregnancies	1	48.06	46.50	13.32	15.41	14.50	5.28	16.00	15.00	5.67	16.94	17.00	5.09
	2	45.43	48.00	14.21	15.00	15.00	4.56	15.71	15.50	5.70	14.71	16.00	4.83
	3 and more	51.50	52.50	5.23	15.67	16.00	2.81	17.58	18.50	3.58	18.25	18.00	1.86
		H = 2.163; p = 0.339			*H = 0.271; p= 0.873*			*H = 0.921; p= 0.631*			*H = 4.322; p= 0.115*		
Week of pregnancy	<28 week	45.22	46.50	15.83	14.22	14.50	4.75	15.17	15.00	6.11	15.83	16.50	5.86
	28-32 week	50.44	53.00	8.42	16.56	17.00	3.52	17.13	18.50	4.41	16.75	17.00	3.45
	33-37 week	48.73	48.00	11.74	15.42	15.00	5.15	16.46	16.00	5.26	17.23	17.50	4.46
		H = 1.880; p = 0.391			*H = 3.599; p= 0.166*			*H = 1.092; p= 0.579*			*H = 0.823; p= 0.663*		
Planned pregnancy	Yes	47.57	49.00	12.75	15.45	15.00	4.65	16.06	16.00	5.52	16.27	17.00	4.69
	Not	50.64	47.00	10.62	15.00	15.00	4.90	17.09	16.00	4.23	18.55	17.00	4.23
		Z = -0.210; p = 0.834			*Z = 0.363; p = 0.717*			*Z = -0.344; p= 0.731*			*Z = -1.127; p= 0.260*		
Time of hospitalization	1-5 days	48.09	49.00	13.47	15.44	15.00	4.74	16.29	16.00	5.67	16.58	17.00	4.95
	≥5 days	48.27	47.00	8.57	15.13	16.00	4.56	16.13	16.00	4.14	17.00	17.00	3.78
		Z = 0.068; p = 0.946			*Z = 0.077; p = 0.939*			*Z = 0.179; p = 0.858*			*Z = -0.495; p= 0.621*		

CECS – Courtauld Emotional Control Scale; Z – Mann-Whitney test; H – Kruskal-Wallis test; p – probability

The tendency to suppress emotions was higher in women who indicated higher scores on the buffer-protective support scale. This may be interpreted as protecting relatives from negative information obtained during hospitalization, and also intended to conceal any problems and difficulties experienced. The ability to understand, express and regulate one's emotions is important for minimizing the effects of stress and finding ways of coping with it. Repressing negative feelings, also as a result of excessive concern, can lead to deterioration of health, and even the development of symptoms of depression [19, 20].

This study is limited due to the small sample size and the lack of distinction between the support received from relatives and health professionals. Moreover, the relationship between experienced stress or anxiety and emotional support or control was not investigated. Several dependencies which occurred at the limit of statistical significance, among other, between the need for support and the level of education, or between the place of residence and education and the ability to control anger, can be a stimulus to continue research in this field. Emotional intelligence issues should be included in the care plan for a pregnant woman hospitalized due to the risk of preterm labour.

CONCLUSIONS

1) The highest values of social support were obtained on the scales perception of available instrumental support and currently received support, the lowest values were obtained on the scales seeking support and demand for support.

2) Socio-demographic factors – age, professional status, financial situation are related to social support.
3) The ability to use emotional and informational support reduces the suppression of negative emotions.
4) The availability of social support is related to the ability to control negative emotions – anger, depression and anxiety.

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