

The Effect of Self-Efficacy Oriented Counselling on Controlling the Fear of Natural Delivery in Primigravida Women

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Abstract:

Fear of natural delivery is a common, complicated problem, especially in nulliparous women; the severity of this feeling of anxiety sometimes overwhelms the pregnant women and she is forced to ask for cesarean section. The purpose of this study was to investigate the effect of self-efficacy counseling on the fear of natural delivery in nulliparous women. 160 pregnant women were randomly divided in two groups of control and test, each including 53 subjects, in the present interventional study. Fear of giving birth and self-efficacy questionnaires were completed by women in both groups. In the test group, 6 counseling sessions were held at the Department of Health and the control group received only routine pregnancy care. There was a significant decrease in the mean of fear of delivery ($P < 0.001$) and a significant increase in the mean of self-efficacy score in the test group after intervention ($P < 0.001$); however, fear of delivery did not show any significant difference ($P = 0.542$) and self-efficacy decreased significantly ($P = 0.46$) in the control group. Self-efficacy-based counseling could reduce the fear of delivery and elevate self-efficacy in pregnant women. Therefore, using this approach as a complementary, effective, low-cost, non-invasive midwifery intervention method is recommended to reduce the fear of delivery in pregnant women.

Keywords: Self-Efficacy, Fear of Natural Delivery, Women, Hamadan, Iran.

INTRODUCTION

Childbirth is a multidimensional process with physical, emotional, social, physiological, cultural and psychological dimensions, and it is considered as a critical experience in the life of women [1]. Although cesarean delivery is essential in order to save the lives of the mother and the child, it has become unnecessarily common in medical practices. Although World Health Organization has set the expected cesarean rate to be 10-15% by midwifery indices, reports from the world's health show an increase in cesarean rates from 5 to 25% over the past 20 years [2]. In 2004, caesarean section accounted for 35% of all childbirths in Iran; this figure increased up to 42.3% in 2007 [3], and 50-65% in 2010 [4]. In addition to increasing the mortality and morbidity of mothers due to cesarean section, the infertility of mothers who undergo cesarean section is another complication of this medical procedure. In the studies conducted in Iran and other countries, the most common reason for choosing cesarean section by mothers was fear of normal labor pain. Of all 5 pregnant women, one has a fear of childbirth [5], and 6% of pregnant women experience severe and disabling fears that are associated with complications of midwifery, negative birth experience and an increase in cesarean delivery [6, 7]. The majority of studies have introduced fear of delivery as the main cause of choosing cesarean over natural childbirth in women with no former experience of childbirth [8]. In a study, the prevalence of fear of childbirth was reported at about 59%, and the anxiety of delivery in women who had a cesarean section was higher than those who chose natural delivery [9]. Pregnant women undergo a higher level of

fear, which may be due to lack of prior experience [10], fear of unknown, pain, and loss of control, which is reported to be 10 times higher in nulliparous women in comparison to multiparous ones [11]. In general, women are afraid of childbirth because their pain is beyond their power and they are worried about their child's health. If the mother feels able to cope well with stress, the effects of stress on her health will be immune [12]. Studies show that there is a link between fear of childbirth and self-efficacy. Delivery self-efficacy implies the individual's assessment of her ability to cope with stressful situations and the implementation of essential behaviors [13, 14]; this mechanism is composed of two parts of expected outcome and expected self-efficacy, both of which play significant role in how the subject handles the delivery process. The expected outcome implies a person's belief that a particular behavior leads to a particular outcome, while the self-efficacy expectation refers to a person's belief in his ability to succeed in a particular behavior under his or her control of a particular condition [15]; if the mother realizes that she cannot handle the difficulty of the labor, she will, inevitably, choose cesarean section over natural delivery, even without any specific medical reasons [13, 14]. While decreasing emotional excitement, self-efficacy will increase for early onset and delivery. Women who have a better level of protection against labor have less pain in labor and are predicted to be more able to cope with stress in labor. The aim of this study was to determine the effect of self-efficacy counseling on the fear of normal delivery in primigravida women.

MATERIALS AND METHODS

This interventional study was conducted on 106 primigravida women referring to health centers in Toyserkan city. The inclusion criteria included the first single pregnancy, the gestational age of 26 to 32 weeks, the score of 28 and above in the attitude towards delivery questionnaire, the lack of medical and midwifery problems, and the literacy of reading and writing. The exclusion criteria included hazardous medical conditions during pregnancy, the lack of participation in a counseling session and the occurrence of any stressful event. An initial number of 335 eligible pregnant women filled fear of labor questionnaire and 106 women who had a fear of delivery, and were 28 years and older, were selected and randomly assigned to two groups of test and control (53 subjects for each group). After obtaining written consent of the subjects, questionnaires were completed by the individuals themselves in both the experimental and control groups. After conducting necessary coordination, pregnant women in the test group, in addition to receiving a common pregnancy care service, participated in 6 weekly counseling sessions in groups of 10 or 11. Pregnant women in the control group received only routine pregnancy services. The content of the sessions was designed to increase the self-efficacy of the subjects (Table 1). Consultation was conducted using various methods of speech, question and answer, group discussion, demonstration techniques, and the use of peers. Educational pamphlets on respiratory techniques, relaxation, cesarean sectional effects, and maternal birth benefits were delivered to the subjects. At the end of counseling sessions, pregnant mothers in both

groups completed the questionnaire of fear of delivery and labor self-efficacy. Data analysis was performed using SPSS version 20 software and $P < 0.05$ was considered as significant level [16, 17].

Data Collection Tools

1. **Childbirth Attitude Questionnaire (CAQ):** Questionnaire with 14 items of 4 Likert points including lack of fear, very low, medium and high fears, from 1 (at all) to 4 (high) scores. The range of points is between 14 to 56 and in case of a score of over 28, the fear of delivery was confirmed. The validity and reliability of the questionnaire, was tested using Cronbach's alpha, and turned out to be 0.85 in Iran [18]. In the present study, the reliability of the questionnaire was calculated using the Cronbach's alpha and it turned out to be 0.93.
2. **Childbirth self-efficacy inventory (CBSEI):** Questionnaire consisted of two parts of outcome expectancy and self-efficacy expectancy. Each section had 18 questions. Various studies have reported high reliability and validity for this alpha-Cronbach- based tool (91%)[12-14, 19]. In the present study, the reliability of the questionnaire was calculated using the Cronbach's alpha and it turned out to be 0.94.

RESULTS

The mean age of mothers was 25.5 ± 3.5 in the test and 25.7 ± 4.6 years in the control group; the mean gestational age of the test group was 28.4 ± 2.4 and that of the control group was 28.2 ± 2.4 weeks.

Table 1. The objectives and the content of self-efficacy counseling sessions

Sections	Goals	Content	Times
First	Familiarity of mothers, Promoting awareness about natural delivery and cesarean delivery	Preliminary presentation of the anatomy and physiology of the reproductive system of women and the process of natural delivery, generalizations on how to perform cesarean section and its complications. Discussion on the benefits and delivery times of natural and cesarean delivery.	60 minutes
Second	Increased vital strength through physiological excitability by following Sports programs	Teaching muscle relaxation, encouraging mothers to exercise and walking, training on the use of respiratory techniques during pain and walking in the interval of pain; Finalizing summary, assignment and feedback	60 minutes
Third	Exposure to successful experiences by arranging accessible goals, increasing the ability to achieve performance.	During this session, mothers were asked to take the relaxation and exertion techniques they were trained at the previous session, and they were encouraged to do their mother tasks properly, and it was reminded that, as they succeeded in doing so, they would probably succeed in the delivery. .	60 minutes
Fourth	Verbal encouragements and persuasions for successful performance	Encouraging mothers to express their successful experiences in different fields and their ability to control stressful situations. A collective discussion about the success of mothers in life and keeping them in a position to succeed.	90 minutes
Fifth	Exposing the subject to experiences which she can master and enriching her sense of confidence	Inviting mothers who have experienced natural delivery and asking them to share their experiences with those who are overwhelmed with fear	60 minutes
Sixth	Identifying harmful thoughts, providing solutions to irrational thoughts and replacing rational thoughts	Teaching the use of religious prayers during pain, teaching behavioral techniques, distracting the senses during pain, such as thinking of the neonates and other family members, and concentrating on a particular subject during pain, as well as teaching positive induction during labor.	60 minutes

Table 2. Comparison of fear of delivery before and after intervention in each of the two groups of test and control and between the two groups

Fear of Delivery Groups	before the Intervention		After the Intervention		paired-t-test	p-value
	Mean	SD	Mean	SD		
Test	4.35	6.11	30.77	8.5	9.461	< 0.001
Control	39.39	6.31	39.79	7.06	- 0.614	0.542
T-independent	0.797		- 5.93		-	
p-value	0.427		< 0.001		-	

Table 3. Comparison of outcome expectancy before and after intervention in each of the two groups of test and control and between the two groups

Outcome expectancy Groups	before the Intervention		After the Intervention		paired-t-test	p-value
	Mean	SD	Mean	SD		
Test	135.2	32	151.73	27.83	- 3.915	< 0.001
Control	145.81	27.4	136.75	29.34	2.618	0.012
T-independent	- 1.83		2.697		-	
p-value	0.07		0.008		-	

Table 4. Comparison of self-efficacy expectancy before and after intervention in each of the two groups of test and control and between the two groups

Self-efficacy expectancy Groups	Before the Intervention		After the Intervention		paired-t-test	p-value
	Mean	SD	Mean	SD		
Test	246.43	57.7	292.6	54.24	- 6.8	< 0.001
Control	258.67	48.86	246.75	54.22	2.042	0.046
T-independent	- 1.186		4.352		-	
p-value	0.238		< 0.001		-	

There was no significant difference between the two groups in terms of the age of mothers ($P=0.725$) and pregnancy ($P=0.612$). Also, there was no significant difference between demographic and midwifery characteristics in two groups ($P>0.05$). The mean scores of childbirth fear, which had no significant difference before the intervention between the two groups, showed a significant reduction after the intervention in the women of the test group; thus, there was a significant difference between the mean scores of fear of delivery in the two groups after the intervention (Table 2). Also, the mean score of outcome expectancy, which had no significant difference before the intervention, was significant between the two groups after the intervention, because the rate of outcome expectancy increased significantly in the women of test group and this caused the mentioned difference (Table 3). Also, the mean of self-efficacy scores was not significantly different between the two groups before intervention; however, given the considerable increase of this factor in the subjects in the test group, there was a significant difference between the scores of the two groups after the intervention (Table 4).

DISCUSSION

Fear of giving birth is a significant psychological, social, and physiological phenomenon in the life of pregnant women and their families, and it is of special importance because it can be a factor in the choice of delivery for

cesarean section and, even in acute conditions, prevent pregnancy. Meanwhile, there is a significant relationship between the choice of cesarean section and psychological variables [33]; for example, negative thoughts, such as catastrophic pain, are known as one of the cognitive factors associated with fear and experience of the subject [20]. The catastrophic pain is associated with an increase in pain, anxiety, distress, and emotional processes [21, 22]. In contrast to the positive attitude of pregnant women before delivery, these types of thoughts function as major factors in the choice of cesarean section over natural delivery [23]. In this regard, self-efficacy of labor, which refers to the woman's perceived ability to perform successfully in childbirth, is considered as the most important prerequisite for presenting appropriate behavior under stress [24]. The present study examined the effect of counseling on reducing the fear of giving birth in primigravida women. Several studies confirm the role of mother's self-efficacy in using over-the-counter adaptation methods during childbirth [25, 26]. In the present study, the intervention program first began with providing adequate information about the process of delivery and its methods and the complications arising from the cesarean section, which had an important role in achieving the goals of the study. Hajian showed that effective pregnancy training aimed at improving the awareness of pregnant women in regard with pregnancy and the process of delivery in order to reduce the

fear and stress of pregnancy and improve self-efficacy in women [27]. Howharn's study investigated the impact of training classes on increasing self-efficacy in order to overcome maternal mortality [28]. Since negative cognitive assessment of pain can intensify physiological arousal, physical allergy, and muscle tension, muscle relaxation exercises, respiratory techniques, and behavioral distraction techniques tend to create a sense of happiness and energy in pregnant women, because there is significant relationship between vitality and a few mental and physical health indicators, such as physical and functional symptoms of the body, emotional tendencies, and personality traits, and people who believe that they are suffering chronic pains which might make them unable to work and live a normal life, tend to be less vital [29, 30]. Through convincing methods, pregnant women are encouraged to express successful experiences in life, and other ladies the power of the ability to control stressful situations through positive experiences. Additionally, meeting mothers who had experience of natural delivery helped primigravida women to model successful behaviors and consequently reduce fear; more importantly, it would be helpful to eliminate the ineffective thoughts of primigravida pregnant women regarding the premature delivery of labor, as it is estimated to be catastrophic because it causes overestimation of pain and underestimation of abilities [31, 32]. It has been shown that those who overestimate pain expect more severe pains and experiences less recovery, in comparison to those who don't do such a thing [31]. In addition to the strong correlation with fear, catastrophizing, as an intermediary agent, plays an important role in increasing the fear of childbirth by reducing the threshold of pain in pregnant women [33]. The important thing in the present study was the free interaction of the members of the group, which gradually resulted in their enjoyment of knowledge, training and support, which would allow pregnant women to get a more realistic picture of their conditions through direct interaction with each other. Such a condition will give the mother the confidence that they will be able to go through the experience quite successfully. The results of SYDSJO study showed that most primigravida women who were afraid of childbirth were seeking education and counseling about natural labor [34]. By reviewing studies conducted on this subject, Tilden concluded that labor-induced autoimmunity is a psychological factor that can be affected by self-efficacy enhancement interventions [35]. Self-efficacy interventions can reduce the active phase of labor. In addition, increased self-efficacy of childbirth is associated with a significant increase in perinatal outcomes [36]. It is also acknowledged that fear of labor and weak self-efficacy enhances the possibility of the incidence of post-traumatic stress; as stated by Gökçe, women who received pre-natal education and had a higher level of self-efficacy experiences less fear and more control during labor in comparison to those who did not receive such trainings; they, also, less post-traumatic stress disorder symptoms after labor [37]. Various studies carried out in Iran have been conducted to determine the method of delivery [38, 39]. With respect to the relationship between self-efficacy and maternal complications. It has been claimed that self-

efficacy of natural delivery and labor time is closely associated with the number of delivery and the choice of delivery method, and the mean of self-efficacy is higher in the second-trimester pregnant women and those who chose natural delivery [40]. Based on the results of the present study, self-efficacy oriented counselling was able to improve the efficiency of delivery of pregnant women significantly and reduce the fear of natural delivery in primigravida women. Therefore, using this approach as a complementary, effective, low-cost, non-invasive midwifery intervention method is recommended to reduce the fear of delivery in pregnant women.

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