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Research Article

The Effect of Training Program Given to Multiple Pregnants by Motivational Interview Method on Fear of Birth and Delivery Style

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Abstract

Aim: Within the scope of our research, it was aimed to evaluate the effects of the training programs given with the motivational interview attitude given specifically to the mothers with multiple pregnancies on possible fears of childbirth and self-perception. In this direction, case and control studies were conducted with two groups. In summary, it focused on the effect of self-efficacy experienced during birth and self-efficacy experienced at the same time.

Material and Methods: Our study was carried out between August 2022 and November 2022 in Adana Seyhan State Hospital Obstetrics and Gynecology Polyclinic with 73 multiple pregnant women (intervention: 37, control: 36) who met the study. More than one pregnant mother in the sample was randomly selected according to the intervention and control groups. "Training Program Based on Motivational Interview Method for Fear of Birth" was given to 37 pregnant women in the case group, four sessions individually, once a week.

Results: In obtaining the relevant data within the scope of our study; Descriptive Personal Form, Wijma Birth Expectation/Experience Scale (W-DEQ) Versions A and B, Birth Self-Efficacy Scale (DSS) Short Version and Birth Evaluation Form were used. During the evaluation of the data, descriptive statistics such as the number of patients and the percentage of gender were recorded. Data are shown as mean±standard deviation, median (percentage). Chi-square test, Independent Groups t test, Mann Whitney U test, Wilcoxon test, repeated measures ANOVA test and Friedman test were used in statistical analysis.

Conclusion: In the training program conducted with the motivational interview approach with pregnant mothers, it was revealed that possible fears of birth were minimized, positive increases were observed in birth self-efficacy, and the effect on birth types was not much. Looking at the results of the research; In order to minimize the fear of birth in the prenatal period and to increase self-efficacy during birth, it is recommended to include it in nursing care in a training program based on the motivational interview approach for fear of birth.

Keywords: Birth fears, pregnancy, self-efficacy at birth, mode of delivery

INTRODUCTION

Every woman experiences different physical changes during the birth process. From the other point of view, the uncertainty caused by the unpredictability of the birth event, the emotional states of losing control during childbirth, and the problem of confidence in the pregnant mother's own responsibilities cause anxiety and stress for some women to reveal their fear of childbirth (1-3). Studies have shown that 6.3-75% of pregnant women experience fear of childbirth (4), and 6-10% experience fear of childbirth, which can affect their daily lives (1).

In case of birth fears; biological, psychological, social or secondary factors can play a significant role. In addition, it is stated that the gestational week and parity have an important effect on the emergence of the fear of childbirth (1,2).

As the gestational week progresses and the expectant mother approaches childbirth step by step, the fear of childbirth increases rapidly (1,2). Laursen et al. (5) stated that the number of pregnant women who had fear of childbirth in the 31st week of pregnancy was much higher than at the 16th gestational week.

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Rouhe et al. also revealed that the fear of childbirth increased after the 20th gestational week (1). As the gestational week progresses, the reason for the fear of childbirth to increase; women pay attention to pregnancy in the first trimester, their babies in the second trimester, and birth in the third trimester (3).

Rouhe et al. state that many pregnant women experience a higher level of fear of childbirth than normal pregnant women, both in the early and late stages of pregnancy (1). The factors that cause this situation; Having thoughts such as hearing negative birth stories, not being able to cope with birth pain, not being able to give birth in a healthy way (2).

This research was carried out to observe the effects of motivational interview, self-efficacy and delivery method, and the training program given to pregnant women who have fear of childbirth.

Childbirth is an issue that women often worry about. Exaggerated birth stories and inconsistent narratives cause women to fear childbirth during and even before pregnancy. Bringing a new life to the world is, of course, a miraculous and challenging process. However, it should not be forgotten that pregnancy and childbirth are quite natural for the female body. Biologically, getting pregnant and giving birth are normal for the female body when the right conditions are met. Every woman has the strength to somehow handle childbirth. Whether it is a normal birth or a cesarean delivery, thinking about the pain to be experienced during childbirth can cause expectant mothers to experience tension during pregnancy (5).

Although fear of childbirth is a comprehensive concept, it does not have a precise definition. According to the transfer of Hofberg and Brockington (6); Fear of childbirth was first noticed by the French psychiatrist Louis Victor Marcé in 1858. Marce describes primitive anxiety arising from the expectation of unknown pain; The fear of multi-born people arising from their past memories and future expectations is defined as fear of birth. In 1981, the fear of childbirth was defined as a strong anxiety that negatively affects the daily life and well-being of pregnant women.

Saisto and Halmesmaki defined fear of childbirth as an anxiety disorder or a phobic fear that includes having nightmares, physical complaints, difficulty concentrating on daily activities, and often a cesarean delivery request (7). Ryding et al. (8) defined fear of birth as a negative expectation about birth, while Wijma et al. (9) defined it as a feeling of anxiety about birth that existed before, during or after birth.

Motivational interview method is first described by scientists William R. Miller and Stephen Rollnick. It is a clinical perspectives. These scientists defined motivational interviewing as “a directive and client-centered approach used to reveal behavior change that will help clients recognize and resolve conflicting emotions (ambivalence)” (10).

The main purpose of motivational interviewing; to stimulate the individual's intrinsic motivation for change and to ensure active participation in the change process. This approach is particularly useful for individuals who are unwilling to change and/or have conflicting emotions (11).

The motivational interview technique was first developed to make behavioral changes in individuals with problematic alcohol use (11). Today, it is used in the treatment of substance addiction (12), smoking cessation, diet management and weight control (13), compliance with exercise, continuation of breastfeeding (14), ensuring the use of contraceptives, preventing sexually transmitted diseases, reducing the rates of cesarean section (15), pregnant women. It is used to create behavioral change in individuals by encouraging participation in birth preparation classes.

MATERIAL AND METHOD

Purpose of the Research

Within the scope of this study, it was performed in order to evaluate the effects of birth fears, self-efficacy during childbirth and the way of giving birth in the training program given with the motivational interview approach to mothers who are in the process of multiple pregnancy. Ethical approval was taken from Clinical Researches Ethical Committee, Diyarbakır Gazi Yaşargil Training and Research Hospital (date: 25/11/2022 and no:314).

Research Hypotheses

H1: Birth fears differ significantly from mothers who have had multiple pregnancies compared to those who did not receive training in motivational interviewing approach.

H2: Among the mothers who had multiple pregnancies, there was a significant difference between the motivational interview approach and the education fields and their self-efficacy at birth compared to those who did not.

H3: There is a significant difference between the motivational interview approach and the way of giving birth among mothers who have had multiple pregnancies compared to those who did not receive education.

Data Collection Tools

Descriptive Personal Form, Wijma Birth Expectation/ Experience Scale (W-DEQ) Versions A and B, Birth Self-Efficacy Scale (DSS) Short Version and Birth Evaluation Form scales were applied.

Mothers with multiple pregnancies were included in our study. The mother candidates who applied the training programs given with the motivational interview attitude were included. Single pregnancies are not included.

Statistical Analysis

Statistical Package for the Social Sciences version 22.0 (SPSS Inc., Chicago, IL, USA) software was used for the statistical analysis of this study. While descriptive data and frequencies were calculated with the help of computer,

the normal distribution of the data was tested with the Shapiro-Wilk test. Continuous variables were expressed as mean±standard deviation and nominal variables as numbers (percentage). Normally distributed data were compared between the two groups using Student's t-test, while those that did not fit normal distribution were tested with the Mann-Whitney U test. For categorical variables, Pearson's chi-square or Fisher's exact test was used as appropriate. P value <0.05 was considered statistically significant.

RESULTS

Findings Related to Descriptive Characteristics of Pregnants

Table 1 shows the distribution of some sociodemographic characteristics of multiple pregnant mothers according to research groups. 67.6% of the pregnants in the intervention group and 65% of the pregnants in the control group were between the ages of 18-24, 77% of the pregnants in the intervention group were in high school and undergraduate or graduate school, and 33.3% of the pregnants in the control group were in primary or secondary school. determined to be a graduate.

It was determined that 77% of the pregnant women in the intervention group and 83.3% of the control group did not work in an income-generating job, and 88.9% of the pregnant women in the intervention group and 97.3% of the control group had social security.

Table 2 shows the distribution of some obstetric characteristics of the pregnant women participating in the study according to the study groups. It was determined that 100% of the pregnants in the intervention group and 83.3% of those in the control group had planned pregnancy, 100% of the pregnants in the intervention group and 77.8% of the control group did not receive prenatal education. There was a statistically significant difference between the case group and the control groups in terms of creating a pregnancy plan and educational approach before birth (p<0.05).

Intervention group (5.4% of the pregnant women) and control group (11.1% of the pregnant women) experienced abortion, 5.4% of the pregnant women in the intervention group and 8.3% of the control group had D/C experience. It was determined that 5.4% of them and 13.9% of those in the control group had health problems during pregnancy. Although not stated in the table, ıt was observed that there was bleeding at the beginning of pregnancy in two expectant mothers in the case group, two pregnant women in the control group had urinary tract infections, and three pregnant women had bleeding in the early stages of pregnancy.

It was revealed that 91.9% of the multiple pregnant mothers in the case group and 86.1% of the multiple pregnant mothers in the control group preferred vaginal delivery. It has been clarified that the starting time of the pregnant follow-up process in the case group who participated in the study was 5.95±1.93 weeks, while it was 5.81±1.28 weeks in the control group.

In Table 3, the distribution of the mean and median scores of the pregnant women on the Obstetrics Self-Efficacy Scale (WHO) in terms of research groups and follow-up periods can be seen. No significant changes were observed between the DSQ total scores, sub-dimension of DSQ outcome expectations and DSQ efficacy expectations sub-dimension score medians of expectant mothers in the case group and the median scores of the pregnant women in the control group (p>0.05).

Pre-training DSQ total score median of the pregnants in the intervention group was 273.00 (247.00-291.00), 310.00 (302.00-317.00) and 37-40 after the training. It was determined that it was 313.00 (309.50-317.50) at the gestational week. Post-training and 37-40th pregnant women in the intervention group. According to analysis results, the median of the total score of DSQ for the week of gestation was higher than the median of the total score of DSQ before the education, and this result was statistically significant (p<0.05).

Table 1. Distribution of some socio-demographic characteristics of pregnant women according to study groups

Some sociodemographic characteristics		Intervention group (n=37)		Control group (n=36)		Total		Statistical analysis	p
		S	%	S	%	S	%		
Age	18-24	25	67.6	20	65	45	63	0.123	0.739
	25-35	12	32.4	16	35	28	27		
Educational status	Middle school	7	23	12	33.3	19	28	0.773	0.674
	High school	15	38.5	12	33.3	27	36		
	University	15	38.5	12	33.3	27	36		
Working status	Works	10	23	6	16.7	16	21.2	0.337	0.580
	Not working	27	77	30	83.3	57	78.8		
Social security	Yes	32	88.9	35	97.3	67	93.2	-	0.199
	No	5	11.1	1	2.7	6	6.8		

Table 2. Distribution of some obstetric characteristics of pregnant women according to study groups

Some obstetric features		Intervention group (n=37)		Control group (n=36)		Total		Statistical analysis	p
		S	%	S	%	S	%		
Abortus	Yes	2	5.4	4	11.1	6	8.2	-	0.410
	No	35	94.6	32	88.9	67	91.8		
D/C	Yes	7	23	12	33.3	19	28	-	0.474
	No	15	38.5	12	33.3	27	36		
Planned pregnancy status	Planned	37	100	30	83.3	67	91.8	-	**0.013**
	Not planned	0	0	6	16.7	6	8.2		
Status of receiving prenatal education in pregnancy	Received	0	0	8	22.2	8	11	-	**0.010**
	Not received	37	100	28	77.8	65	89		
Preferred mode of birth	Vaginal birth	34	91.9	31	86.1	65	89.0	4.250	0.250
	Birth by cesarean	0	0	3	8.3	3	4.1		
	Indecisive	3	8.1	2	5.6	5	6.8		

Table 3. Distribution of some obstetric characteristics of pregnant women according to study groups

Birth Self-Efficacy Scale and its sub-dimensions		Intervention group (n=37) $\bar{X}$±SD Mean (25%p-75%p)	Control group (n=36) $\bar{X}$±SD Mean (25%p-75%p)	Statistical analysis	p
BSES total score	Pre-training	267.49±31.33 273.00 (247.00-291.00)	265.86±37.38 268.50 (246.50-287.00)	-0.353	0.724
	Post training	308.65±9.52 310.00 (302.00-317.00)	-	-	-
	37-40. Pregnancy week	311.49±9.28 313.00 (309.50-317.50)	256.28±22.63 256.50 (245.25-273.75)	-7.197	**<0.001**

In our study result, it is thought that it may be due to the anxiety of pregnant women about coping with childbirth as the delivery approaches. Based on the findings, the hypothesis "Among the mothers who had multiple pregnancies, there was a significant difference between the motivational interview approach and the education fields and their self-efficacy at birth compared to those who did not (H2)" was accepted.

It has been observed that women with cesarean section mostly are influenced by fear of childbirth and this fear can be used for prediction of fear16. Within the scope of our study, it was thought that it could be effective in promoting vaginal birth in the training program according to the motivational interview approach on fear of childbirth. In this context, it was also observed that 97.3% of the mothers in the intervention group and 94.4% of the pregnant women in the control group had vaginal delivery. There was no significant difference between the delivery approaches of the pregnant women in the intervention group and the delivery approaches of the pregnant women in the control group (p>0.05). Based on these findings, “There is a significant difference between the multiple pregnant women who received training with the motivational interview method and the multiple pregnant women who did not receive education in terms of delivery type. (H3)” hypothesis was rejected.

DISCUSSION

It was revealed that the mothers in the case group of our study were similar in age, education levels, a very short information about the job they had done, education levels of the spouses, working status of the spouses, and socially similar to the prospective mothers in the control group. At the same time, it was seen that among these similarities, the presence of insurance, family type, perceived income status and the place where they lived the longest (p>0.05).

There was a statistically significant difference between pregnancy planning and prenatal education in the case group and control groups (p>0.05). There was no significant difference observed between the case and control groups when considering the experience of abortion and D/C, health problems during pregnancy, preferred delivery methods, starting time of pregnancy follow-ups, numbers in pregnancy follow-ups and gestational week (p>0.05).

It was revealed that 91.9% of all expectant mothers in the case group and 86.1% of the mothers in the control group preferred vaginal delivery (p>0.05).

It was revealed that the rate of preferring vaginal deliveries in the future period of mothers who had just given birth in the case group was significantly higher than those in the control group (p<0.05). It was determined that the birth experiences of the mothers who had just given birth in the case group were much better than the control groups (p<0.05). It was determined that postpartum women in the intervention group had higher birth satisfaction than the control group (p<0.05). The negative impact of fear of childbirth on the quality of life of pregnant women (16,17) and the increase in cesarean section rates due to the needs of mothers have made the approach to fear of birth important (18).

In our age, there are very different approaches to the

management of the fears experienced by women about childbirth. One of the most used methods is birth preparation training. Childbirth preparation trainings appear as a type that helps women to overcome their less informed opinions and cope with pains of labor. However, it has been observed that this approach has a limited effect on minimizing the woman who are feared from childbirth and acquiring skills to cope with childbirth (19). In order to minimize this fear to obtained the behaviros of wanted in patients, there are some stargies requried such as cognitive and behavioral strategies as well as didactic expression in childbirth preparation education. In this direction, the effectiveness of the birth preparation education given by method of motivational interview used in revealing the behavior change in this study was evaluated (20,21).

Results of the intervention and control groups showed that feared women from childbirth was moderate in the pre-training evaluations of the pregnant women (p>0.05). Post-training (16.46±10.29) and 37-40. It was determined that the level of fear of birth at the week of gestation (15.51±7.35) lessened comparing to the period of the pre-training (49.22±21.15) (p<0.05). 37-40 of control pregnant women. Further analysis showed that fear developed due to childbirth at the gestational week (57.50±16.33) did not change any comparison to the pre-training period (56.63±16.03) (p>0.05).

CONCLUSION

Ultimately, though; According to the motivational interview approach on birth fears, the training program shows that they are effective in reducing birth fears. There are different results in the literature review showing the impacs of preparation for the birth training (19).

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