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Counseling for childbirth fear – a national survey

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ABSTRACT

Background: Counseling by experienced midwives is offered to women with childbirth fear in most obstetric clinics in Sweden, but information about the content of such counseling is lacking.
Aim: To study comprehensiveness, content and organization of the midwife-led counseling for childbirth fear in all obstetric clinics in Sweden.
Methods: In this cross-sectional study, data were collected using a questionnaire sent to all obstetric clinics in Sweden (n = 45); a total of 43 clinics responded. Descriptive and one-way ANOVA was used in the analysis.
Results: All responding obstetric clinics in Sweden offer midwife-led counseling to women with childbirth fear. Major differences were found regarding the time allocated to counseling, with a range between 5.7 and 47.6 minutes per childbirth. Supplementary education for midwives and the availability of treatment options varied at the different clinics and were not associated with the size of the clinic.
Conclusion: The midwife-led counseling conducted at the different Swedish obstetric clinics showed considerable disparities. Women with childbirth fear would benefit from care on equal terms irrespective of place of residence. Consequently, it would be valuable to develop a national healthcare program for childbirth fear.

Introduction

New models of care and new guidelines are sometimes introduced in health care without evidence for their effectiveness. Such a situation occurred with the midwife-led counseling for women with childbirth fear that was introduced in Sweden in the early 1980s.

The Swedish healthcare system is financed primarily by public funds. According to the Swedish Health Care Act, the goal of health care is good health and health on equal terms for the entire population [1]. Antenatal care in Sweden reaches almost 100 percent of pregnant women. Midwives are the primary caregivers for women with uncomplicated pregnancies during antenatal, intrapartum and postpartum care. When complications occur, midwives collaborate with obstetricians [2].

Severe fear of childbirth affects 6–10% of pregnant women [3–5], and cesarean section on maternal request is more common among women with childbirth fear [6,7]. In Sweden, women with childbirth fear have been offered counseling by experienced midwives as treatment for their fear in most hospitals since the mid 1990s [8].

In 2004, the Swedish Association of Obstetrics and Gynecology (SFOG) published a report aimed to improve knowledge of childbirth fear and gave suggestions regarding treatment options for different severities of childbirth fear. According to the report, the goal of the counseling was to reduce such fear and make the birth experience as positive as possible, regardless of the mode of birth. Through support, information and preparation for childbirth, a woman's self-confidence in her ability to give birth could be strengthened [8].

Previous studies evaluated midwife-led counseling and showed that counseling had a minor effect in reducing childbirth fear, improving the birth experience and decreasing cesarean section rates. However, women were satisfied with the support provided [9,10]. No evidence is available to identify the best method for treating childbirth fear, but in previous studies, different types of treatment have been used to reduce fear and cesarean section rates. Due to differences in study design, measures and outcomes, comparisons of different treatment options are difficult. Group psycho-education appears to have positive effects on birth experience and childbirth fear in nulliparous women [11]. In addition, individual telephone psycho-education by midwives [12] and mindfulness-based childbirth education [13] seem to increase self-efficacy and decrease childbirth fear. A qualitative study showed that internet-based cognitive behavior therapy (CBT) led to a more positive attitude toward the upcoming birth [14]. Group psycho-education has also been shown effective in reducing cesarean section on request [11,15].

Abbreviations: CBT, cognitive behavior therapy; SFOG, Svensk förening för obstetrik och gynekologi (Swedish Society of Obstetrics & Gynecology).

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Furthermore, a Norwegian study performing crisis-oriented counseling made 86% of the women change their request for cesarean section. A follow-up showed that 69% finally gave birth vaginally and 93% of these women stated that they would prefer a vaginal birth in the future [16].

Requests for cesarean section are common during pregnancy among women with childbirth fear [17]. Cesarean section on maternal request has been identified as a problem, as it affects the health of both the mother [18,19] and the baby [20–22] and should therefore be performed solely on medical reasons. In the report "Indications for Cesarean Section on Maternal Request," which was published in 2011, the Swedish National Board of Health and Welfare suggested how the counseling team should provide care depending on the severity of the woman's fear. The report also suggests routine screening for childbirth fear in early pregnancy at the antenatal clinic. Screening makes it possible to identify women in need of support related to childbirth fear [23].

Despite the strong research interest in childbirth fear and the national recommendations about counseling as the first choice treatment, information about the content of such counseling is sparse. Such knowledge could enable development of existing treatment on a national level and could also be the basis to develop new methods for helping women with childbirth fear. The purpose of this investigation was to conduct a national overview of the midwife-led counseling available in obstetric clinics in Sweden in terms of comprehensiveness, content and organization.

Materials and methods

Design

This is a cross-sectional national study.

Sample

The sample used in this study consisted of midwives working with counseling for childbirth fear in all obstetric clinics in Sweden.

Procedure

Questionnaires were sent to the contact person at each clinic. The non-responders received reminder letters after two and four weeks.

Data collection

The questionnaire included 19 questions regarding counseling due to childbirth fear and began with the following question: "Is there a special counseling service for women with childbirth fear at your clinic?" The subsequent questions were included as open questions. The questions that dealt with issues related to the extent of the counseling support were the number of women who received counseling and which resources the clinic had concerning the time allocated for the midwives. Questions were also asked regarding the procedure: the identification of childbirth fear, the point in pregnancy at which counseling started, whether the clinic had guidelines regarding the counseling or not, whether the clinic had access to an interpreter if needed and the possibility of obtaining supervision for the team. Questions concerning the counseling team were the number of midwives who worked with counseling support, whether other professions were involved in the team and the number of cesarean sections on maternal request. The content of counseling included eleven proposed approaches based on the report from SFOG [8], with the option to add methods that were not mentioned. The approaches were as follows: review of past medical record (when appropriate), written plan of the birth, visit to the labor ward, strengthening the woman in her belief in herself and her ability to give birth, relaxation/breathing techniques, pros and cons of birth methods (i.e., vaginal vs. cesarean section), information about the birth process, encouragement to try vaginal birth, promise of early pain relief, such as epidural analgesia, induction on the mother's request, and assurance of cesarean section on request during labor.

Additional questions concerning the midwives' supplementary education, treatment options, working methods (individually, in team, mix of individually and team work), evaluations of the program and the midwives' requests regarding counseling were sent by e-mail to the person who was named as the contact person for the clinic.

Data management

Based on national statistics [24], the clinics were divided into four groups according to the annual birth rate to make comparative analysis possible. Group 1 consisted of clinics with 200–999 births/year (10 clinics). Group 2 included clinics with 1000–1999 births/year (13 clinics). Group 3 consisted of clinics with 2000–3399 births/year (11 clinics), and Group 4 included large clinics with >3400 births/year (9 clinics).

To make it possible to compare the time midwives had scheduled for counseling at different clinics, a comparative figure was generated. By dividing the total minutes per year that the midwives at each clinic had allocated for counseling by the total number of births per year in the clinic, a comparison was possible.

The design of the open questions allowed for short answers of the respondents. All statements were read through several times and the manifest content of the sentences were inductively derived from the data. The first coding was done manually. Thereafter, a binary index (presence or absence) was created using Statistical Package for the Social Sciences (SPSS) version 21 to systematically facilitate the development of categories. The midwives' responses were based on similarities and differences [25,26].

Data analysis

The data were analyzed using SPSS version 21. Descriptive statistics (sample frequencies, percentages and means with standard deviation (SD)) were used. Comparisons of means between groups were conducted using one-way ANOVA [27].

Ethical aspects

This study addressed members of the staff at the 43 obstetric clinics in Sweden, preferably midwives. In a questionnaire designed for this study, the midwives answered several questions regarding organization, comprehensiveness and the content of the counseling program at the clinic where they were involved. The participants received written information about the purpose of the study and could choose to participate or not, and what information they wanted to share. Ethical approval from The Ethics committee is not required for this research according to the Swedish law on ethical review of research involving humans (2003:460).

Results

Of 45 obstetric clinics in Sweden, 43 answered the main questionnaire and 34 responded to the supplemental questions. The clinics that did not respond included two mid-sized clinics with 2000–3399 births per year. All clinics reported providing counseling for childbirth fear.

Extent of counseling

Of the women who gave birth in 2012 at the participating clinics (n = 43), 7.1% received counseling, with a range between 2.5% and 11% (Table 1). The least time was spent on counseling at clinics with 2000–3399 births per year (Group 3).

The majority of the clinics offered mid-wife led counseling to all women regardless of parity. One clinic only offered counseling to parous women. The average time midwives had allocated to