Women's experience of midwife-led counselling and its influence on childbirth fear: A qualitative study

Birgitta Larsson\textsuperscript{a,b,*}, Ingegerd Hildingsson\textsuperscript{a,c}, Elin Ternström\textsuperscript{a}, Christine Rubertsson\textsuperscript{a,d}, Annika Karlström\textsuperscript{c}

\textsuperscript{a} Department of Women's and Children's Health, Obstetrics and Gynecology, Uppsala University, 751 85 Uppsala, Sweden
\textsuperscript{b} Research and Development Centre, Sundsvall Hospital, 846 53 Sundsvall, Sweden
\textsuperscript{c} Department of Nursing Sciences, Mid-Sweden University, 851 70 Sundsvall, Sweden
\textsuperscript{d} Department of Health Sciences, Faculty of Medicine, Lund University, 221 00 Lund, Sweden

\begin{abstract}

Background: Women with childbirth fear have been offered counseling by experienced midwives in Sweden for decades without evidence for its effectiveness, in terms of decrease in childbirth fear. Women are usually satisfied with the counselling. However, there is a lack of qualitative data regarding women's views about counselling for childbirth fear.

Aim: To explore women's experiences of midwife-led counselling for childbirth fear.

Method: A qualitative interview study using thematic analysis. Twenty-seven women assessed for childbirth fear who had received counselling during pregnancy at three different hospitals in Sweden were interviewed by telephone one to two years after birth.

Findings: The overarching theme ‘Midwife-led counselling brought positive feelings and improved confidence in birth’ was identified. This consisted of four themes describing 'the importance of the midwife' and 'a mutual and strengthening dialogue' during pregnancy. 'Coping strategies and support enabled a positive birth' represent women's experiences during birth and 'being prepared for a future birth' were the women's thoughts of a future birth.

Conclusions: In this qualitative study, women reported that midwife-led counselling improved their confidence for birth through information and knowledge. The women experienced a greater sense of calm and preparedness, which increased the tolerance for the uncertainty related to the birthing process. This, in turn, positively affected the birth experience. Combined with a feeling of safety, which was linked to the professional support during birth, the women felt empowered. The positive birth experience strengthened the self-confidence for a future birth and the childbirth fear was described as reduced or manageable.

\end{abstract}

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1. Introduction

Treatment for childbirth fear is a rising subject of research interest in the Western world. This is likely a result of the fact that severe childbirth fear is associated with women’s request for a caesarean section without medical reason and to a higher risk of obstetric complications such as prolonged labour and emergency caesarean section.\(^1\)\(^-\)\(^3\) Childbirth fear is also closely connected to women’s birth experience in two ways: women fearing birth are more prone to have a negative experience\(^6\) and a negative experience of a previous birth is the most underlying reason of childbirth fear in a forthcoming pregnancy.\(^7\)\(^-\)\(^8\)

Different methods of treatment for childbirth fear have been studied in order to reduce fear and/or decrease caesarean section rates. A reduction in caesarean section rates and request for a caesarean were shown in studies with cognitive therapy\(^9\) and crisis-orientated therapy.\(^1\)\(^0\) In addition, psychoeducative group therapy\(^1\)\(^1\) resulted in a decrease in caesarean sections and a positive birth experience. Midwife-led individual telephone psychoeducation\(^1\)\(^2\) and mindfulness-based childbirth education\(^1\)\(^3\) increased self-efficacy and reduced childbirth fear. A qualitative study showed that Internet-based cognitive behaviour therapy (ICBT) resulted in a more positive attitude toward the impending birth.\(^1\)\(^4\) A randomised controlled trial (RCT) comparing ICBT with midwife-led counselling\(^1\)\(^5\) found that women’s request for caesarean section fluctuated over the course of pregnancy and after birth regardless of treatment method. Women felt their fear was reduced and were more satisfied with face-to-face counselling compared to ICBT.

Standard care in Sweden for women with childbirth fear is counselling with a midwife who is experienced in intrapartum care, sometimes in collaboration with a psychologist or obstetrician.\(^1\)\(^6\)\(^-\)\(^1\)\(^7\) A previous national overview\(^1\)\(^6\) of the midwife-led counselling showed that every maternity clinic in Sweden provided counselling but the organisation, the extent of the counselling and the midwives supplemental education regarding childbirth fear and counselling techniques differed among the clinics. Commonly, the childbirth fear is identified when the woman discloses her fear to the antenatal midwife. The midwife then uses her clinical judgement to assess the woman’s childbirth fear and depending on the level of fear, the woman is referred to midwifery counselors or the antenatal midwife continues to counsel the woman. The use of a screening instrument, such as Fear of Birth Scale (FOBS)\(^1\)\(^8\) or similar, to detect women with childbirth fear was found to be less common.\(^1\)\(^6\)\(^-\)\(^1\)\(^9\) The counselling aims to reduce fear and make the birth experience as positive as possible, regardless of the mode of birth.\(^1\)\(^7\) There is no consensus of how the counselling should be performed, but the national overview\(^1\)\(^6\) indicated that a similar approach was used in all maternity clinics in Sweden. The counselling commonly includes information about the birth process and techniques to cope with, e.g., birth pain and worries, which aim to improve the woman’s confidence in her ability to give birth. Moreover, a visit to the labour ward is often included as well as a written birth plan comprising, for example, the woman’s fears and her needs. Women who expressed a previous negative birth experience are offered a review of the past birth record in order to understand and to reconcile the earlier birth.\(^1\)\(^6\)

Maternity care in Sweden is publicly-funded and reaches almost 100 percent of pregnant women. Midwives in Sweden have an independent role and are the primary caregivers during normal pregnancy, labour and birth. If complications occur, midwives work in collaboration with obstetricians. Antenatal and intrapartum care operates within different organisations (primary health care vs hospital-based care) and continuity of care through both antenatal care and intrapartum care is rare.

Studies have reported that women with childbirth fear who underwent counselling were satisfied with the received support but they were still assessed as fearful.\(^2\)\(^0\)\(^-\)\(^2\)\(^1\) There is a lack of qualitative data regarding women’s views about counselling for childbirth fear. To address this gap and to obtain a deeper understanding of previous quantitative results, this study aims to explore women’s experiences of midwife-led counselling for childbirth fear.

2. Participants and methods

2.1. Design

A qualitative interview study with a descriptive design.

2.2. Recruitment and Participants

Participants were recruited from the counselling arm of a RCT comparing midwife-led counselling with ICBT for women assessed with childbirth fear by scoring ≥60 at the Fear of Birth Scale (FOBS).\(^1\)\(^8\) For more information about the RCT, please see the protocol for the study.\(^2\)\(^2\)

In the RCT follow-up questionnaire two months after birth, the women responded to a question regarding participation in an interview: ‘May we contact you for a follow-up interview?’ Of the 79 women in the counselling group who responded to the questionnaire, 66 consented to participate in an interview and provided their mobile phone number in the questionnaire. The women were thereafter contacted and invited to participate in an interview.

2.3. Data collection

The interviews were conducted by the first author between September 1 and December 21, 2016. The first contact with the women was taken by sending a text-message with brief information and a proposed date and time for a telephone interview regarding the received counselling and the birth. All interviews were conducted by telephone, in Swedish, and digitally recorded. An interview guide with open-ended questions was used and the opening question asked: ‘Can you tell me about your fear of giving birth?’ The following questions explored the women’s views of the counselling they received for childbirth fear, their thoughts and experiences about their birth and finally the feelings regarding an eventual upcoming pregnancy and birth in relation to their fear and the prior counselling.

The average time for the interviews was 30 min with a range between 19 and 47 min. The interviews were transcribed verbatim consecutively by the first author. The data collection was completed after 27 interviews when no new information appeared.

Ethical approval for the study was obtained from the Regional Ethical Review Board in Uppsala (Dnr: 2013/209). All women were informed of the purpose of the interview study, the recording and that all information would be treated confidentially.

2.4. Data analysis

Thematic analysis as described by Braun and Clark\(^2\)\(^3\) was used to analyse the interview data. An inductive data-driven approach was used focusing on the semantic content, meaning the themes are identified within the explicit meanings of the data. The analysis process followed Braun and Clark’s phases of analysis and familiarisation with the data and began during transcription and when an initial understanding appeared. The text was read through again and thereafter initial codes were generated manually through the entire data set and collated into meaningful
groups and patterns. Initial themes were identified and a thematic map was created to find relationships between the themes. The coding and the preliminary themes were then discussed and refined, initially by the first and the last author. Thereafter all authors reviewed the themes and additional refinement was undertaken.

All authors are midwives with clinical experience in counselling for childbirth fear. Throughout the interviews and analysis, the authors paid careful attention to the preunderstanding that inevitably would influence the interpretation of the women’s stories.

3. Results

Of the 27 women, there were 18 first-time mothers and 9 women who were giving birth to their second or third baby. They were aged between 24 and 38 at the time of counselling. The majority, 16 women, had a normal vaginal birth; three had an instrumental vaginal birth; two had a planned caesarean section for medical reasons; and six had an emergency caesarean section. At the time of the interview, between 14 months and 27 months had passed since the birth (Table 1).

A majority of the women stated that they were satisfied with the prior randomisation to the counselling group as they believed that a personal face-to-face dialogue would suit them better than ICBT. Some women mentioned that they hoped that the counselling would provide a sense of calm and preparedness. Only two women expected to get a promise of a caesarean section.

The analysis describes women’s experience of counselling and childbirth fear through pregnancy, labour and after birth. The overarching theme ‘Midwife-led counselling brought positive feelings and improved confidence for birth’ consists of four themes: ‘The importance of the midwife’ and ‘A mutual and strengthening dialogue’ represent the women’s experiences during pregnancy. The third theme, ‘Coping strategies and support enabled a positive birth’, characterises the women’s experience during birth. The fourth theme, ‘Being prepared for a future birth’ signifies the women’s thoughts of how counselling and the birth experience influenced their childbirth fear when thinking of an eventual future pregnancy and birth. The sub-themes are presented within each theme (Fig. 1).

3.1. The importance of the midwife

Most women talked about the importance of the midwife for handling the fear and three women voiced adverse feelings. One woman expressed that she would rather meet someone else for counselling than her antenatal midwife; thus, it felt too private to discuss her issues with her. Two women also found that the antenatal midwife only gave information and did not listen to them.

The theme consists of three sub-themes: ‘The midwife instilled a sense of calm and security’, ‘The midwife listened and acknowledged’ and ‘The midwife’s clinical birthing experience provided credibility’.

3.1.1. The midwife instilled a sense of calm and security

Many women talked about the midwife as crucial to the counselling. They often described her as calm and understanding and they experienced her calmness as an essential part to calm themselves down and feel safe.

So, the midwife I talked to was really calm and matter-of-fact and I felt . . . this is no problem. It’ll be fine. (R1, second baby)

3.1.2. The midwife listened and acknowledged

To be acknowledged by the midwife was a part of why counselling was defined as positive by the women. They felt that they were taken seriously and that the midwife listened and saw the woman as an individual. It normalised their feelings to recognise that other women also felt this way.

I believe it was her acknowledgement [. . . ]. She was able to calm me down and that made me feel safe. But perhaps mostly because there was someone who heard and saw me and acknowledged what I’d been through, you know. (R3, second baby)

3.1.3. The midwife’s clinical birthing experience provided credibility

Another aspect of the importance of the midwife was her expertise in birthing. The women felt that her knowledge and substantive experience made her trustworthy and reliable.

She was accustomed to childbirth, [. . . ] So it was probably pretty natural for her to like ask what it felt like beforehand. That probably helped the most. She could really answer my questions [. . . ] and it actually means more when it’s from someone who’s worked there than when it’s from someone you’ve been in touch with now and then. (R5, first baby)

3.2. A mutual and strengthening dialogue

A majority of the women in the study described the dialogue with the midwife as a contributing factor for strengthening the women’s belief in themselves. Two women found the counselling superficial.

Four sub-themes were identified within this theme: ‘Information and verbalising fear gave confidence’, ‘Tools made fear manageable’, ‘Understand and reconcile previous birth’ and ‘Visiting the labour ward tied it all together’.

3.2.1. Information and verbalising fear gave confidence

A majority of the women repeated the importance of verbalising the fear and to get information about the birth process. They

Table 1  Characteristics of the participating women.

<table>
<thead>
<tr>
<th>Identity code</th>
<th>Parity</th>
<th>Age</th>
<th>FOBS*</th>
<th>Mode of birth</th>
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<td>63</td>
<td>Emergency CS</td>
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</tr>
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<td>27</td>
<td>Multiparous</td>
<td>37</td>
<td>79</td>
<td>Normal vaginal</td>
</tr>
</tbody>
</table>

*a* Fear of Birth Scale.

*b* Caesarean section.
described that the dialogue with the midwife gave answers to their questions and helped them to organise their thoughts, resulting in a better understanding of the causes of their fear. This new knowledge combined with writing down the most important issues in a birth plan, gained their confidence and they felt that the fear decreased.

If you get to put it into words it exits the body and you can ground your thoughts in some way and then you can let it go. (R6, second baby)

But precisely because it was evidence-based instead of emotional, it was more about the brain after these conversations. Otherwise, you would have been stuck in the emotions. (R4, first baby)

3.2.2. Tools made fear manageable
Several women described that they received tools that helped them manage their fear. These tools could be relaxing exercises, breathing techniques, methods for visualising positive scenarios or ways to manage thoughts when worry and anxiety appeared. By having these tools, the women felt more prepared, which affected the fear positively.

Yes, but it, it didn’t totally disappear but I still learned how I should think when I got caught in negative thoughts and freaked myself out. Then I had to turn those thoughts around to make sure I didn’t dig a hole for myself. (R4, first baby)

3.2.3. Understand and reconcile previous birth
For women who expressed a previous negative birth experience, the main focus during the counselling was to understand and process the previous birth. The possibility to talk about their experiences with the midwife, who had knowledge of birthing and could give explanations of the course of birth, provided an opportunity to reconcile and then prepare for the upcoming birth.

Going through the previous birth so that I could kind of see it from the outside [. . . ] Then I felt more at ease and understood why things
turned out the way they did. And then too, I could probably better understand how to handle it, going forward. (R8, second baby)

3.2.4. Visiting the labour ward tied it all together

A common part of the counselling is a visit to the labour ward for the woman to familiarise herself with the premises. Sometimes one of the counselling sessions was held in a labour room. The women described this visit as tough but good and something that defused their negative beliefs. As one woman described it:

Then we got to visit the labour ward and have a look during that third visit when my husband joined me. And it was almost like that kind of made it sink in or . . . made it all fall into place. (R3, first baby)

3.3. Coping strategies and support enabled a positive birth

When women talked about their birth and what influenced the birth experience, they mentioned their own capacity and how they had a sense of control during birth, mostly described as a result of counselling. In addition, they talked about the importance of how they were treated by the staff at the labour ward. Many women felt well cared for and stated that they had good support during labour. In addition, they expressed that the staff were skilled. Four sub-themes were defined within this theme: ‘One’s self-capacity to manage birth’, ‘A sense of control’, ‘The meaning of information and preparation’ and ‘The presence and support of the staff’.

3.3.1. One’s self-capacity to manage birth

There were several descriptions of how women experienced that they had handled the pain and the situation as a whole as well as the fear. Some women remarked that through the breathing techniques they learned and by listening to their own bodies, they felt aware and present and could cope with birth in an acceptable way.

And I was super scared then but I felt . . . . I did not think I’d die that time and I tried to be proactive about it. I was much more active and aware, present in a different way, I felt. (R8, second baby)

3.3.2. A sense of control

Many women described that a contributing factor to being fearful of giving birth was that they were afraid of losing control. Sometimes this was related to a previous negative birth experience. When women talked about how they had or did not have control during birth, there were mainly two aspects that recurred. Firstly, several women were defining a sense of control as the awareness that the midwife had control over the situation, which meant that they could let go of their personal control. Secondly, a sense of control appeared when the women felt they could manage pain with the different techniques they acquired. Only two women had a negative feeling of loss of control.

The only way I could gain control was to be clear about what I wanted them to be in control of. (R9, first baby)

The fact that I could listen to my body and that it was easier to gain, to stay in control obviously if you listen to what the body wants instead of panicking over the pain and resisting. (R6, second baby)

3.3.3. The meaning of information and preparation

An important aspect of having experienced a positive birth was the midwives’ and other staff’s ability to listen and provide continuous information. They were also comforted by the knowledge that the staff was informed from the birth records about the woman’s fear and her needs. The women talked about the importance of being a part of one’s own birth and taking an active part in decision making. When these parts were fulfilled, they had a feeling of affirmation.

It was obvious that they had read my journal and my letter of delivery. They totally knew what I wanted [. . . ] and were very empathetic, great. (R10, second baby)

It was also these important factors that contributed to some women’s negative birth experiences. Some felt that no one cared about their opinion or even asked for it.

It is awful to know that it’s your body everyone is talking about while you’re totally disconnected from it, to be involved in some way. It’s like a really strange feeling. (R11, first baby).

3.3.4. The presence and support of the staff

To feel safe and calm was often linked to the presence of the staff during labour, usually the midwife’s presence and support. In contrast, women stated that the absence of the staff in the labour room made them feel alone and unsecure.

There was a midwife and an assistant nurse, someone was with me at all times, and this made me feel very safe. (R12, first baby).

If they hadn’t been under so much stress they might have been able to . . . perhaps I could’ve received more support and avoided that part (epidural), because I would gladly have done it. So that was too bad. (R13, first baby)

The importance of the partner’s support during labour was mentioned by about half of the women. Some women wished that their partner had been more involved and were clear that the midwife’s support was crucial.

3.4. Being prepared for a future birth

This theme contains women’s perceptions of how counselling and the birth experience influenced their childbirth fear and their thoughts of an eventual future pregnancy and birth. A majority of the women expressed that counselling and the birth experience contributed to a less troublesome level of fear or that they now had the capacity to manage their fear. A few women stated that they had no worries or fears at all after the counselling and birth. This theme consists of three sub-themes: ‘Improved attitude toward giving birth’, ‘The birth experience reduced the fear’ and ‘Tools for a future birth’.

3.4.1. Improved attitude toward giving birth

The information that women received by the counselling midwives is described as crucial for feeling ‘safe in the uncertainty’. The preparedness, and in some cases the processing, gave the women an improved attitude toward the approaching birth and several thought that this preparation was an important part of their experiencing a positive birth. A few women did not think that the counselling affected their birth experience.

You were more prepared that way. And that may have affected that I felt more at ease when things didn’t go as expected. Perhaps a bit more at ease in times of uncertainty. (R8, second baby)

I believe it may have had an impact as I knew beforehand how it might develop on different levels, and that made me feel calmer when I arrived. That I could focus on the pain and that was the reason for me being there, so, yeah, I believe so, absolutely. Then you could relax in a different way. (R14, first baby)

3.4.2. The birth experience reduced the fear

Some women mentioned that it was their experience of a positive birth that mainly contributed to a reduction in childbirth fear and that the experience was the main factor in making them feel confident when thinking of a future birth.

I succeeded in getting through it in a manner that I did not believe I would at all, and that affects everything else, too. That you can handle a task gives you a stronger self-confidence overall. (R7, first baby)
3.4.3. Tools for a future birth

Receiving coping tools for different aspects of the birth, such as fear and pain, made women confident for the future, mostly when confronting an upcoming birth. Additionally, a few women also saw the usefulness for other occasions in life. These women had in common that they did not consider it necessary for any further counselling in a future pregnancy, based on the fact that they had already been given their useful tools.

So I think that I have the tools to cope when I’m there. And I have realised that I do not have to study non-stop, I’m still with it, [...] I can focus on other things now. (R13, first baby)

Finally, a majority of the women had such a positive experience in counselling that they would consider receiving it again in a future pregnancy if needed. However, many felt that they probably would not have that need in a forthcoming pregnancy. In addition, there were a few women who would prefer another type of treatment, for example CBT, which could help them with their main problem such as generalised anxiety.

4. Discussion

In this study which explored the experiences of women who had received midwife-led counselling for childbirth fear, we found that the midwife-led counselling brought a sense of calm and preparedness to the fearful women when facing birth. A new self-confidence influenced the fear and the birth experience was positively affected. In addition, being a part of one’s own birth, e.g., being confirmed, informed and involved in decision-making, were important factors in a positive birth experience. The women expressed that both these factors contributed to a decreased and manageable fear which generated positive thoughts about the future and an eventual forthcoming pregnancy and birth.

A recurring subject from the women who felt that counselling had positively influenced their fear was the midwife’s professionalism, e.g. her ability to listen and make the woman feel safe and confident and her knowledge to give information and strategies to cope with birth. Additionally, they indicated that her personal characteristics were of importance and she was described as calm, factual and a good person. These statements are in line with a review by Nicholls and Webb24 of what makes a good midwife. They describe that having good communication skills, being compassionate, kind, supportive, knowledgeable and skilful contributed to being a good midwife according to childbearing women. The midwife’s communication skills and her compassion were mentioned by the women when they described her ability to listen to their stories, confirm them and give them answers to their questions related to the fear.

The women’s statements that counselling made them more confident when facing birth might be related to an increase in their self-efficacy. Self-efficacy can be described as an individual’s confidence in or her ability to cope with a specific stressful situation.25 Childbirth fear has been associated with low self-efficacy,26 and previous studies12,13 have reported an increased childbirth self-efficacy after intervention for childbirth fear.

Women described that they felt confident during birth when having knowledge, a birth plan and sometimes tools to manage pain and anxiety. In addition, the awareness that the midwife in the labour ward had knowledge of the woman’s fears and her needs through her written birth plan, resulted in a feeling of safety around the birth. A sense of control was also mentioned.

In other words, the women felt empowered. This can be connected to the theory of the good midwife,27 where the authors describe empowerment as a major concept: “Empowerment decreases the woman’s vulnerability, increases her well-being, gives her a stronger ‘voice’ in her situation, gives her a stronger sense of control in the situation in the childbearing process and enables her to empower herself and cope better with the situation which the childbearing process entails”.

The feeling of being safe and calm during birth was linked to the presence and support of the midwife and the assistant nurse. We know from previous studies that the midwife-woman relation is an important aspect for experiencing a positive birth.28,29 Continuous support also increases the likelihood that the birth will proceed normally, which reduces the risk of caesarean section.28 In contrast, studies indicate that a negative birth experience is associated to childbirth fear. A phenomenological study by Nilsson et al.3 found that women with intense fear of childbirth had experienced that even if the midwife was present in the labour room, she did not support the woman. The women felt as if they had no place in the labour room. The feeling resulted in fear, loneliness, and lack of faith in their ability to give birth and diminished trust in maternity care.

Women expressed that the fear in some cases disappeared, but more commonly they described that the fear was still present, but they had strategies that enabled them to cope with it, which led to self-confidence and preparedness for future births. The acquired approaches might have contributed to a more positive feeling when thinking of a future birth even if some of the women still consider themselves as fearful. These findings might clarify previous results20,21 that women with childbirth fear were satisfied with the counselling yet they still were assessed as fearful. In this qualitative study, the women’s narratives might indicate that the preparation and the ability to cope with the fear could be enough for reaching an improved confidence toward birth, even if fear remains. Not all women in the study found counselling helpful for their fear or that it contributed to their birth experience. Women with childbirth fear is a heterogeneous group with a variety of worries and concerns. In addition, previous research found associations between childbirth fear and anxiety, depression and post-traumatic stress disorders.30 It is, therefore, important that treatment for childbirth fear is individually designed and that there is a possibility of other treatment options in addition to counselling. And to our knowledge, there is to date, no evidence of the effect of midwife-led counselling for childbirth fear although women express benefits and positive experiences of counselling.

In addition, there is evidence that counselling for childbirth fear in Sweden differs among organisations in regard to the possibility of offering different treatment options. Additionally, there are differences in midwives’ supplemental education in the area, which might also influence the counselling experience.

4.1. Methodological considerations

When responding to the question of a follow-up interview two months after birth, women with a positive experience might have been more interested in sharing their experiences compared to women with a negative experience. This could have influenced the result. Another limitation is that the offered counselling might differ when antenatal midwives sometimes gives counselling to women with childbirth fear. In addition, conducting telephone interviews could have affected the results when non-verbal messages were absent. On the other hand, telephone interviews have benefits when allowing respondents to talk more freely31 and it is timesaving and allows for more interviews. The time of the interviews could also be questioned. Between one year to just over two years had passed since the birth and the women’s experiences of counselling and birth should have been processed during this time period. Previous reports concerning women’s long-term memories of their birth experiences show that they last up to 20 years after the event.32 In contrast, a study by Waldenström33 indicated that women view the birth more negatively as time
passes. Hildingsson et al. found that the birth experience changed over time with 15% viewing the birth more negatively and 22% viewing it more positively after one year had passed compared to two months after birth.

Trustworthiness is the quality aspect in qualitative research that is based on credibility, transferability, dependability, and conformability. Credibility was demonstrated by the many interviews and the heterogeneous groups regarding age, parity, mode of birth and place of birth. This should have ensured a variety of women’s experiences. In addition, collaborative sessions in the research group during the analysis process further established credibility. Transferability was assured by providing detailed descriptions of the content and the context of the interviews as well as the selection and characteristics of the participants, data collection, and process of analysis and findings. This description provides other researchers the opportunity to assess the relevance of the study. Describing both typical and atypical views in the results also promotes transferability. Dependability was enhanced through the detailed description of the study process through data collection and analysis. Conformability refers to the objectivity and neutrality. The researchers' awareness of their preunderstanding and the use of Braun and Clark’s checklist of criteria for good thematic analysis reinforces the conformability of the study.

5. Conclusion

In this qualitative study women reported that midwife-led counselling improved their confidence for birth by information and knowledge. The women experienced a greater sense of calm and preparedness, which increased the tolerance for the uncertainty related to the birthing process. This, in turn, affected the birth experience positively, and in combination with a feeling of safety, linked to the professional support during birth, the women felt empowered. The positive birth experience strengthened the self-confidence for a future birth and the childbirth fear was described as reduced or manageable.

Ethical approval

Ethical approval for the study was obtained from the Regional Ethical Review Board in Uppsala (Dnr: 2013/209). Date of decision: 2013-08-28.

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