

The Influence of Supportive Interventions On Decision Self-Efficacy and Decision Conflict in Mothers with Previous Cesarean Section to Choose Mode of Delivery: A Randomized Clinical Trial

Roghayeh Pakdaman (MSc)¹, Mahboobeh Firoozi (PhD)^{2*}, Mansoureh Mirzadeh (PhD)³, Kataneh Kazemi (PhD)⁴, Jamshid Jamali (PhD)⁴

¹ MSc Counseling in Midwifery, Student Research Committee, Mashhad University of Medical Sciences, Mashhad, Iran

² Assistant Professor, Nursing and Midwifery Care Research Center, Mashhad University of Medical Sciences, Mashhad, Iran

³ Assistant Professor, Child & Adolescent Psychiatrist Dr. Shahinfar Medical Faculty-Islamic Azad university of Mashed, Mashhad, Iran

⁴ Assistant Professor, Department of Obstetrics and Gynecology, School of Medicine, North Khorasan University of Medical Sciences, Bojnurd, Iran

⁵ Assistant Professor, Department of Biostatistics, School of Health, Mashhad University of Medical Sciences, Mashhad, Iran

ARTICLE INFO	ABSTRACT
<p><i>Article type:</i> Original article</p>	<p>Background & aim: Vaginal birth after cesarean section is a strategy which is recommended to reduce repeat cesarean section. Concerns about its complications can cause crisis in decision making. Therefore, this study was performed to investigate the effect of supportive interventions on decision self-efficacy and decision conflict in mothers with previous cesarean section to choose mode of delivery.</p> <p>Methods: This randomized clinical trial was carried out on 60 pregnant women with a history of previous cesarean section and gestational age of 28-30 weeks, who referred to the health centers in Bojnourd, Iran in 2020. The participants were randomly divided to intervention and control groups. Supportive interventions in the intervention group included in-person supportive counseling approach via three 45-minutes sessions per week, telegram channel, educational pamphlet and telephone. Data was collected in both groups before and four weeks after intervention by valid and reliable decision self-efficacy and decision conflict questionnaires. The analysis of data was done by SPSS software (version 25) using independent t-test, paired t-test and Mann-Whitney.</p> <p>Results: There was a statistically significant difference in mean scores of decision self-efficacy ($P=0.005$) and decision conflict ($P=0.010$) in the intervention group four weeks after supportive interventions. While, the difference in mean scores of these variables was not significant in the control group.</p> <p>Conclusion: Supportive interventions could help to improve the decision self-efficacy and decrease decision conflicts in mothers with previous cesarean section to choose vaginal birth after cesarean section. It can be recommended as an effective strategy to promote natural birth.</p>
<p><i>Article History:</i> Received: 10-Jan-2022 Accepted: 15-Apr-2022</p>	
<p><i>Key words:</i> Counseling Decision Support Decision Conflict Self-Efficacy Vaginal Birth After Cesarean</p>	

► Please cite this paper as:

Pakdaman R, Firoozi M, Mirzadeh M, Kazemi K, Jamali J. The Influence of Supportive Interventions On Decision Self-Efficacy and Decision Conflict in Mothers with Previous Cesarean Section to Choose Mode of Delivery: A Randomized Clinical Trial. Journal of Midwifery and Reproductive Health. 2020; 10(2): 3220-3228. DOI: 10.22038/jmrh.2022.62778.1793

Introduction

Nowadays, excessively increasing rate of cesarean section (CS) has become one of the major problems in maternal health care(1). Previous C-section is the most common cause of high rate of caesarean sections in most parts of the world and Iran (2, 3). According to the

guidelines of the Ministry of Health and Medical Education in Iran, Vaginal Birth After Cesarean (VBAC), as a suitable alternative for Repeat Cesarean Section (RCS) (4), reduces maternal complications in current and subsequent pregnancies and reduces cesarean section rate

* Corresponding author: Mahboobeh Firoozi, Assistant Professor, Nursing and Midwifery Care Research Center, Mashhad University of Medical Sciences, Mashhad, Iran Tel: 00985138591511; Email: firoozim@mums.ac.ir

at national level (5-7). VBAC can be performed following the mother's request and her choice and participation in decision-making process (7). Women's decisions about VBAC are affected by lack of awareness of vaginal birth after cesarean section (8), uncertainty about the outcome of childbirth, fear of unpleasant experiences, lack of access to a physician whose agree with this decision, the insistence of others for the mode of delivery (subjective norms) (9), lack of self-confidence, negative attitude to vaginal delivery, lack of self-efficacy in decision-making process (10). Decision-making process refers to choosing one of several solutions and weighing the pros and cons on a particular issue, that ambiguity and incompatibility in this process is called decisional conflict. Some of the most important factors of decisional conflict include the existence of benefits and risks that cause doubt in decision making and the variable factors that can make a difficult decision, including decreased awareness, uncertain personal values, unrealistic expectations, social pressures, lack of support and reduced self-confidence (11). Therefore, pregnant women should be encouraged to consider all choices about a particular topic and evaluate their performance, experiences and personal values (12); this needs self-efficacy (13). Self-efficacy is the most important prerequisite to predict behavior in stressful situations, and its promotion is an important strategy for active participation in behavior change (13, 14). Decision-making self-efficacy refers to a person's self-confidence in the ability to make decisions in a way leading to desired outcomes.

Concerns about the complications of VBAC in previous cesarean section mothers lead to experience crisis and conflict in decision-making; therefore they need help in making decisions (10, 14). Supportive counseling is considered as one of the appropriate interventions to help mothers in this field. A process that facilitates behavior change, strengthens coping and decision-making skills (3, 15). One of the main goals of supportive counseling is to help healthy people who are in a crisis or temporary state of turmoil to better adapt to stressful situations in all types of counseling methods available (8, 16). Supportive counseling is a client-centered

approach aimed to increase clients' self-esteem, performance, and adaptability skills.

The overall goal of supportive counseling is to maximize the adaptive capacity of client (8). Rostampoor et al. in their study concluded that supportive counseling helps to promote self-care behavior in patients with gestational diabetes and can be used as an effective method to reduce the adverse consequences of gestational diabetes (17). Glavin et al. reported that supportive counseling reduced maternal depression during the postpartum period (18). Shepherd et al. concluded that face-to-face supportive counseling reduced decision-making conflict and increased treatment self-efficacy in patients with colorectal cancer (19).

Based on the results of a qualitative study, decision making barriers have been reported as one of the individual barriers to vaginal birth after cesarean section and its low rate in Iran (20). So, this study was designed to promote VBAC as a suitable alternative to repeat C-section, to evaluate the importance of decision self-efficacy and reducing decision conflict in choice behavior. Due to the lack of access to a study with a supportive counseling approach in previous cesarean section mothers, this study was performed to investigate the effect of supportive interventions on decision self-efficacy and decision conflict in mothers with previous cesarean section to choose mode of delivery.

Materials and Methods

This randomized clinical trial (IRCT20200614047768N1) was performed using a Pre-test/Post-test control group design, after approval by the ethics committee of Mashhad University of Medical Sciences, Mashhad, Iran, under code of IRNURSE.REC.1399.018 in 2020.

Inclusion criteria included history of one previous cesarean section, gestational age of 28-30 weeks, ability to read and write, more than 6 months' interval between prior cesarean and first day of the last menstrual period in the current pregnancy, childbirth fear score less than 85 from Vijima questionnaire version A, body mass index (BMI) of 18.5-29.9 kg/m², pregnancy without infertility treatment, no mental or medical illness, no indication for cesarean section in the current pregnancy. The

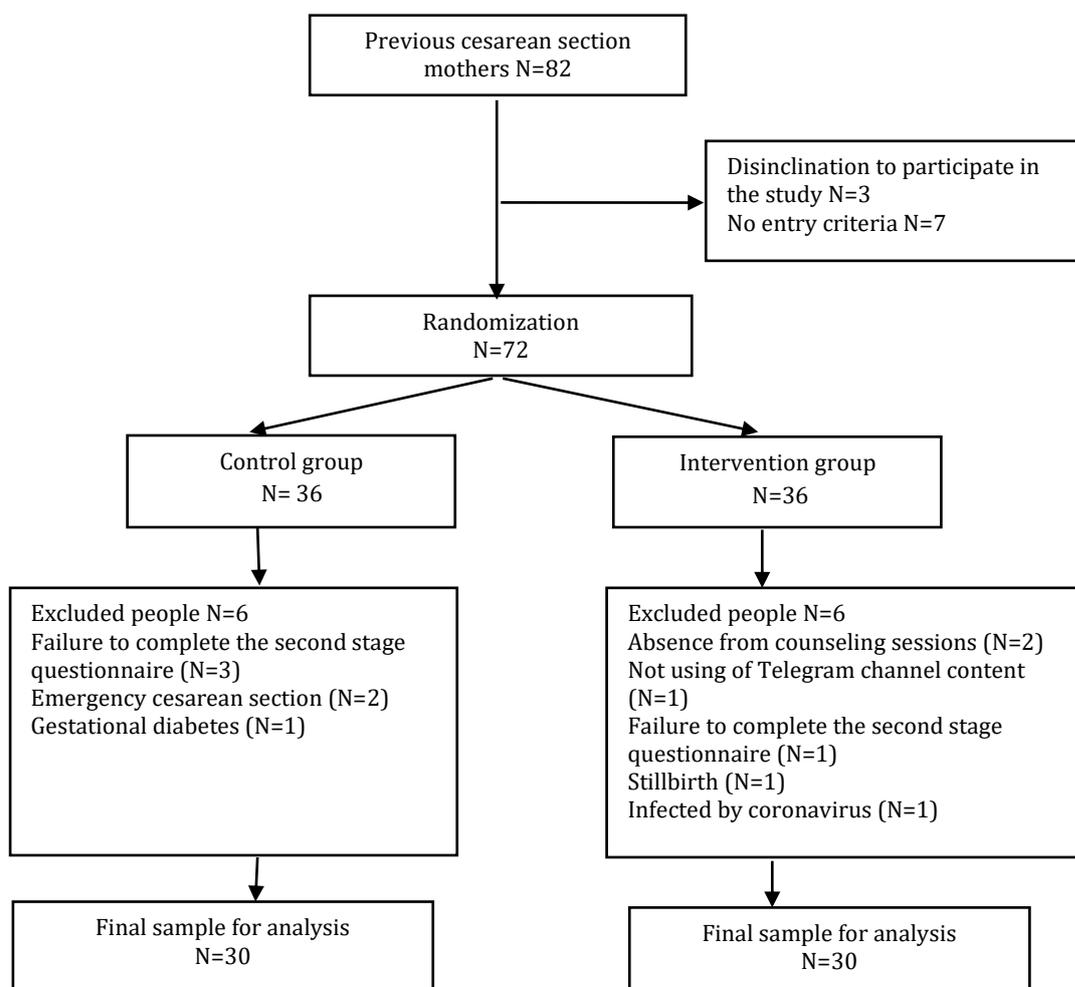
subjects were excluded from the study if they did not attend at least one of the counseling sessions, did not participate in the post-test measurements, had pregnancy termination before the end of research period, and failed to receive telegram channel content and pamphlets during study period.

The sample size for each group was estimated 36 peoples based on pilot study with 10 people at each group in the same population, considering 5% error and 80% power with drop-out rate of 20%. Sampling was done by multi-stage method among the comprehensive health centers in Bojnourd.

At first, two comprehensive health centers were randomly selected from all of health

centers of Bojnourd and then, from each center, two affiliated centers were selected according to the total number of clients and the physical space available for counseling. Each center was randomly allocated to a group to prevent interaction and dissemination of information between two groups. Since the enough samples were not obtained from these places, the nearest center to each of those was selected and sampling continued. Convenience sampling was done inside each center. After obtaining written consent and ensuring the confidentiality of information, demographic, decision self-efficacy and decisional conflict questionnaires were completed.

Figure 1. CONSORT Flowchart



The Decision Making Self-Efficacy Questionnaire includes 11 short phrases about a person's confidence in making informed decisions. All questions of this questionnaire were answered based on 5-6 version of Decision Making Self-Efficacy Questionnaire was performed based on the Brisselsen model using back translation method for validity, and then the validity of the modified final version was approved by faculty members of nursing and midwifery school and experts in content validity. Also, its reliability was confirmed using intraclass correlation coefficient (ICC) ($I_c = 0.84$). The decisional conflict scale (DCS) was used to measure uncertainty in choosing the type of delivery among pregnant women. The scale includes 16 questions with a 5-point Likert scale that each phrase is scored from one to five. Total average of this scale, above 2.5, is the highest level of conflict in decision making and the average of two or less is considered as non-conflict in decision making and implementation of decisions. The validity and reliability of decisional conflict scale (DCS) has been confirmed by Tohil (2014) with Cronbach's alpha coefficient (0.78) (8). In the present study, its validity was determined by content validity method by faculty members and its reliability was determined by intra-cluster correlation coefficient, it was 0.86.

For the experimental group, supportive interventions were performed by the researcher in three 45-minute sessions of In-Person counseling weekly through supportive counseling approach based on these steps: explanation, guidance, reassurance, encouragement and emotion discharge (9).

The first session was held to discuss the mother's experience of previous cesarean section and its indication, then counseling was conducted based on supportive counseling steps including: explanation (right to choose mode of delivery, mechanism of vaginal delivery, complications of repeated cesarean section. Then, pamphlet was delivered and message channel link was presented at the end of session. Supportive counseling can be performed based on the needs of individuals with an integrated approach, so during the intervention, the focus was on the mother's need to support the choice of birth mode. The second session was held

based on reassurance (benefits of vaginal birth for mother and baby, comparison of advantages and disadvantages of VBAC, success rate of VBAC and guidance methods of labor analgesia, relaxation techniques in labor, different positions in labor and birth, accompanying support, helping to remove barriers to choose from their point of view). In third session, counseling was performed based on emotion discharge and encouragement and guidance of the mother with a focus on increasing the self-efficacy of the mother for choosing in a conscious manner, including encouragement (experience of mothers with a history of VBAC, presentation of statistics, success rate of VBAC) and leave for emotional discharge (listening to clients talk about feelings, beliefs, experiences, expectations about childbirth). At the end of third session, phone number was provided to the research unit to resolve any questions or ambiguities if needed by calling or sending text messages. Also, based on mother request or the discretion of the researcher, refer to gynecologist who's agreed with vaginal birth after cesarean was predicted.

The control group received integrated maternal health care according to the booklet. Decision self-efficacy questionnaire and Decisional Conflict Scale (DCS) were completed by the research units in two groups before and one month after the intervention. Data were analyzed by SPSS software (version 25) and Kolmogorov-Smirnov test, independent t-test, paired t-test, chi-square and Fisher precision. In all tests, $P < 0.05$ was considered statistically significant.

Results

At the beginning of the study, 72 women entered the study and 12 subjects excluded during the study (flowchart). Data was gathered from 60 women at the end of study. The homogeneity of the study variables was investigated accordingly (Tables 1-a and 1-b).

According to the results of independent t-test, before the intervention, there was a significant difference in the mean scores of decision self-efficacy between the intervention (48.5 ± 17.7) and control (61.89 ± 9.1) groups ($p = 0.009$). Therefore, the changes have been reported in both groups (Tables 2).

There was no significant difference in the mean score of decision conflict between the two groups before the intervention ($P = 0.762$), but after the intervention, the mean score of

Table 1-a. Demographic characteristics of the participants

Quantitative variable	Supportive counseling	Control	P-value
	N= 30	N = 30	
	Mean±SD	Mean±SD	
Age (year)	29.53±3.79	28.93±5.45	*P=0.825
Gestational age (week)	28.03±1.13	28.60±1.45	*P=0.124
Body mass index (kg/m ²)	24.87±2.69	25.93±3.00	*P=0.124
Number of gravidity	2.37±0.72	2.47±1.11	*P=0.861
Birth weight (gr)	3024±478.9	3225±448.3	**P=0.861
Number of children	1.07±0.37	1.17±0.53	P=0.313
Number of abortions	0.3±0.53	0.33±1.06	*P=0.26

* Mann-Whitney test ** Independent t-test

Table 1-b. Characteristics of the participants

Qualitative variable	Supportive counseling	Control	P-value
	N= 30	N= 30	
	N (%)	N (%)	
Occupation			
Housewife	27(90)	26(86.7)	*p>0.999
Working	3(10)	4(13.3)	
Educational level			
Reading and writing literacy	0(0)	3(10)	
Primary education	5(16.7)	4(13.3)	
Middle education	3(10)	1(3.3)	*P=0.474
Secondary education	10(33.3)	9(30)	
University degree	12(40)	13(43.3)	
Type of pregnancy			
Planned	21(70)	11(36.7)	**P=0.010
Unplanned	9(30)	19(63.3)	
History of infertility			
Yes	1(3.3)	2(6.7)	*p>0.999
No	29(96.7)	28(93.3)	
History of vaginal birth			
Yes	1(3.3)	3(10)	*P=0.612
No	29(96.7)	27(90)	
Satisfaction with the previous C-section			
Yes	27(90)	24(80)	*P=0.472
No	3(10)	6(20)	
Partner advice			
Normal delivery	0(0)	5(16.6)	
Repeated cesarean section	22(73.3)	25(83.3)	*P=0.475
Vaginal birth after cesarean section	6(20)	5(19.7)	
No comments	2(6.7)	0(0)	
Participation in childbirth preparation classes			**P=0.176
Yes	13(43.3)	8(26.7)	
No	17(56.7)	22(73.3)	
Family income			**P=0.771
Below sufficient	9(30)	7(23.3)	
Sufficient	21(70)	23(76.7)	

* Fischer's exact test **Chi-Square

Table 2. The mean scores of decision self-efficacy in the two groups one-month post-intervention

Variables	Supportive counseling N= 30 Mean±SD	Control N = 30 Mean±SD	P-value
Decision self-efficacy			
Pre-intervention	48.5±17.7	61.89±9.1	**P=0.009
One month post-intervention	75.47±9.7	60.7±19.9	*P=0.005
Mean changes	26.8±20.6	-1.14±4.5	***P<0.001
P-value	*P<0.001	*P=0.206	

***Mann-Whitny test **Independent t-test *Willcoxon test

decision self-efficacy and decision conflict between the two groups was significant ($P = 0.005$) and ($P = 0.010$), respectively.

Table 3 showed the results of the mean scores of decision self-efficacy before and after the intervention. Table 4 showed the results on decision conflict scores before and after the intervention (Tables 3).

Table 3. The mean scores of conflict self-efficacy in the two groups one-month post-intervention

Variables	Supportive counseling N= 30 Mean±SD	Control N = 30 Mean±SD	P-value
Conflict self-efficacy			
pre-intervention	2.54±0.65	2.05±0.66	**P=0.726
One month post-intervention	1.96±0.39	2.006±0.66	**P=0.010
P-value	*P<0.001	*P=0.163	

Paired t test **Independent t-test

Discussion

Despite the recommendation of Iran's ministry of health to propose VBAC to qualified candidates as well as evidence based on high success rate of VBAC (72-75%) (10), but its rate in Iran is very low (0.8%); it seems that the health care system has not accepted this necessity (23), as a result, previous cesarean section mothers have not gain the necessary self-efficacy in choosing the mode of delivery after cesarean and in this situation, decision conflict becomes more pronounced. According to the results of the current study, four weeks after the intervention, decision self-efficacy to choose vaginal childbirth in women with previous cesarean section increased in the intervention group and decision conflict significantly reduced compared to the control group. Moghaddam Tabrizi et al. (2016) in their study aimed to determine the effect of natural childbirth preparation classes on self-efficacy in adapting to delivery of pregnant mothers (24) concluded that natural childbirth preparation classes have a significant effect on promoting

self-efficacy and adaptation to labor in pregnant women. Improving self-efficacy in performing the desired behavior is considered as the similarity of the present study with the study of Tabrizi.

Miller et al. (2017) who examined the interaction between the informing role of health care providers and the position of women in decision-making in delivery preferences and choosing mode of delivery after cesarean, concluded that women who were exposed to incomplete and biased information in favor of repeat cesarean section and risk assessment of VBAC are less likely to prefer vaginal birth after cesarean compared to people who receive complete and non-recipient information and definitive risk assessment. In the present study, counseling was performed by the researcher based on positive communication, empathetic support and neutrality and its effect on the decision self-efficacy in choosing VBAC was evaluated, which is consistent with the results of Miller's study (25).

Also, according to the study of Hamidzadeh et al. (2012) aimed to determine the effect of

computer training on the self-efficacy of pregnant women in adaptation to childbirth, a significant increase in the level of self-efficacy was observed in pregnant women after the computer training program (26). One of the dimensions of support in the present study was the use of Telegram channel. The results of the present study showed that the use of technology is an effective tool to increase women's self-efficacy. According to the results of other studies, there is a significant relationship between decision self-efficacy and choose of VBAC (27), also, self-efficacy is a key element in women's desire for natural childbirth and her choice as the preferred method of childbirth (28). Hadizadeh et al. (2021) assessed the effect of shared decision making on the mode of delivery and decisional conflict and regret in pregnant women with previous cesarean section. They demonstrated that shared decision making counseling sessions increase awareness, value clarity, as well as decision support. Therefore, it can reduce decisional conflict and regret, as well as increase the rate of VBAC (29). Since they had similar approach in counseling, their findings were consistent with the findings of the present study. Reduction of conflict in decision making and similarity of the content presented in the intervention group has been one of the similar aspects of these interventions.

Horey et al. (2013) in their study concluded the interventions such as: computer based information and educational booklet about the benefits of planned vaginal birth after cesarean, providing an educational program by an experienced nurse and providing decision support by health professionals responsible for a woman's care, had a significant effect on reducing decision conflict. Due to the similar interventions in the present study, similar results with Horey's research and Ghoreyshi et al. (2022) can be justified (30, 31).

One of the strengths of this study was using various strategies to support mothers in birth mode counseling by midwives especially during prenatal care during coronavirus crises. This crisis could have a significant effect on the willingness of mothers to perform cesarean delivery due to short length of labor. This concurrence was one of the limitations of this

study which influence the decision conflict and self-efficacy of mothers.

Conclusion

Mothers with previous cesarean section need help to improve their decision self-efficacy and decrease decision conflicts in choosing vaginal birth after cesarean section; supportive interventions can be recommended as an effective strategy for this necessity. The health care system in each country must design and implement these interventions.

Acknowledgements

Authors would like to thank the Vice Chancellor for Research of Mashhad University of Medical Sciences that provided financial support for the project. Also, the professors of the School of Nursing and Midwifery and the staff of Health Centers in Mashhad and mothers who helped us in this study are appreciated.

Conflicts of interest

Authors declared no conflicts of interest.

References

1. Villar J, Valladares E, Wojdyla D, Zavaleta N, Carroli G, Velazco A, et al. Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. *The Lancet*. 2006; 367(9525): 1819-1829.
2. Quinlivan JA, Petersen RW, Nichols CN. Patient Preference the Leading Indication for Elective Caesarean Section in Public Patients—Results of a 2-Year Prospective Audit in a Teaching Hospital. *Obstetrical & Gynecological Survey*. 2000; 55(1): 19.
3. Ghadimi M, Rasouli M, Motahar S, Lajevardi Z, Imani A, Chobsaz A, et al. Affecting factors the choice of delivery and attitude of pregnant women admitted to the civil hospitals, the Social Security Organization in 2013. *Journal of Sabzevar University of Medical Sciences*. 2014; 21(2): 310-319.
4. Hoseini Haji SZ, Firoozi M, Asghari Pour N, Shakeri MT. Impact of Motivational Interviewing on Women's Knowledge, Attitude and Intention to Choose Vaginal Birth after Caesarean Section: A Randomized Clinical Trial. *Journal of Midwifery and Reproductive Health*. 2020; 8(1): 2115-2125.
5. Yang Q, Wen S, Oppenheimer L, Chen X, Black D, Gao J, et al. Association of caesarean delivery for first birth with placenta praevia and placental abruption in second pregnancy. An

- International Journal of Obstetrics & Gynaecology. 2007; 114(5): 609-613.
6. Flenady V, Middleton P, Smith GC, Duke W, Erwich JJ, Khong TY, et al. Stillbirths: the way forward in high-income countries. *The Lancet*. 2011; 377(9778): 1703-1717.
 7. Crowther CA, Dodd JM, Hiller JE, Haslam RR, Robinson JS, Group BACS. Planned vaginal birth or elective repeat caesarean: patient preference restricted cohort with nested randomised trial. *PLoS Med*. 2012; 9(3): e1001192.
 8. Folsom S, Esplin MS, Edmunds S, Metz TD, Jackson GM, Porter TF, et al. Patient counseling and preferences for elective repeat cesarean delivery. *American Journal of Perinatology Reports*. 2016; 6(2): e226.
 9. Black M, Entwistle VA, Bhattacharya S, Gillies K. Vaginal birth after caesarean section: why is uptake so low? Insights from a meta-ethnographic synthesis of women's accounts of their birth choices. *BMJ open*. 2016; 6(1): e008881.
 10. Chen S-W, Hutchinson AM, Nagle C, Bucknall TK. Women's decision-making processes and the influences on their mode of birth following a previous caesarean section in Taiwan: a qualitative study. *BMC pregnancy and childbirth*. 2018; 18(1): 1-13.
 11. O'Connor A, Jacobsen M. Decisional Conflict: Assessing and Supporting Patient Experiencing Uncertainty About Decisions Affecting their Health. University of Ottawa. 1998. <https://doi.org/10.1111/j.1552-6909.2002.tb00083.x>
 12. Vanstone M, Kinsella EA, Nisker J. Information-sharing to promote informed choice in prenatal screening in the spirit of the SOGC clinical practice guideline: a proposal for an alternative model. *Journal of Obstetrics and Gynaecology Canada*. 2012; 34(3): 269-275.
 13. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*. 1977; 84(2): 191.
 14. Say R, Robson S, Thomson R. Helping pregnant women make better decisions: a systematic review of the benefits of patient decision aids in obstetrics. *BMJ open*. 2011; 1(2) :e000261. doi:10.1136/bmjopen-2011-000261.
 15. Ghazaie M, Davoodi I, Neysi A, Mehrabizadeh Honarmand M, Bassak Nejad S. The effectiveness of cognitive-behavioral therapy on fear of childbirth, fear of pain, self-efficacy of childbirth and tendency to caesarean in nulliparous women. *The Iranian Journal of Obstetrics, Gynecology and Infertility*. 2016; 19(31): 1-12.
 16. Winston A, Rosenthal RN, Pinsker H. Introduction to supportive psychotherapy: American Psychiatric Publishing, Inc.; 2014; 43.
 17. Rostampour S, Erfanian AF, Kordi M, Shakeri MT, Akhlaghi F, ASGHARI NSM. The effect of couples 'supportive counseling on self-care behavior in women with insulin-treated gestational diabetes: A randomized clinical trial. *HAYAT* 2020; 26 (1): 58-71.
 18. Glavin K, Smith L, Sørnum R, Ellefsen B. Supportive counselling by public health nurses for women with postpartum depression. *Journal of Advanced Nursing*. 2010; 66(6): 1317-1327.
 19. Shepherd SC, Hacking B, Wallace LM, Murdoch SE, Belkora J. Randomised controlled trial of a repeated consultation support intervention for patients with colorectal cancer. *Psycho-oncology*. 2019; 28(4): 702-709.
 20. Firoozi M, Tara F, Ahanchian MR, Roudsari RL. Health care system barriers to vaginal birth after caesarean section: a qualitative study. *Iranian Journal of Nursing and Midwifery Research*. 2020; 25(3): 202.
 21. AM O'Connor, User Manual - Decision Self-Efficacy Scale. © 1995 [Updated 2002]. Available from www.ohri.ca/decisionaid.
 22. Bunn H, O'Connor A. Validation of client decision-making instruments in the context of psychiatry. *Canadian Journal of Nursing Research Archive*. 1996; 13-28.
 23. Firoozi M, Tara F, Ahanchian MR, Roudsari RL. Clinician's and women's perceptions of individual barriers to vaginal birth after caesarean in Iran: A qualitative inquiry. *Caspian Journal of Internal Medicine*. 2020; 11(3): 259.
 24. Alipour P, Alizadeh S, Moghaddam TF, Sayadi H. The effect of antenatal preparation classes on self-efficacy coping with childbirth in pregnant women referring to fatemeh polyclinic, and other health care centers in urmia in 2015. *Nursing and Midwifery Journal*. 2017; 14(10): 859-866.
 25. Miller YD, Holdaway W. How communication about risk and role affects women's decisions about birth after caesarean. *Patient education and counseling*. 2019; 102(1): 68-76.
 26. Hamzekhani M, Hamidzadeh A, Vasegh RSF, Montazeri A. Effect of computerized educational program on self-efficacy of pregnant women to cope with childbirth. *knowledge and Health*. 2014; 9(1):13-20.
 27. Scaffidi RM, Posmontier B, Bloch JR, Wittmann-Price R. The relationship between personal knowledge and decision self-efficacy in choosing trial of labor after caesarean.

- Journal of Midwifery & Women's Health. 2014; 59(3): 246-253.
28. Taheri Z, Mazaheri MA, Khorsandi M, Hassanzadeh A, Amiri M. Effect of educational intervention on self-efficacy for choosing delivery method among pregnant women in 2013. *International Journal of Preventive Medicine*. 2014; 5(10): 1247.
29. Hadizadeh-Talasaz F, Ghoreyshi F, Mohammadzadeh F, Rahmani R. Effect of shared decision making on mode of delivery and decisional conflict and regret in pregnant women with previous cesarean section: a randomized clinical trial. *BMC Pregnancy and Childbirth*. 2021; 21(1): 1-10.
30. Horey D, Kealy M, Davey MA, Small R, Crowther CA. Interventions for supporting pregnant women's decision-making about mode of birth after a caesarean. *Cochrane Database of Systematic Reviews*. 2013; 7.
31. Ghorayshi F, Hadizadeh Talasaz F, Rahmani R, Ahmadi H, Mohammadzadeh F. The Effect of Shared Decision Making on Anxiety and Satisfaction of Decision about Mode of Delivery in Pregnant Women with A History of Previous Cesarean Section: A Randomized Clinical Trial. *Journal of Midwifery and Reproductive Health*. 2022; 10(2): 1-10.