

*Published by the Nigerian Psychological Association*



## Stigma, Locus of Control and Self-Concept as Predictors of State Anxiety among Women who underwent Caesarean Operation

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### Abstract

*This research investigated stigma, locus of control and self-concept as predictors of state anxiety among caesarean women, one hundred excepted mothers awaiting to undergo caesarean operation were selected as participant from University Of Nigeria Teaching Hospital Ituku/Ozalla, Enugu State, with the aid of purposive sampling techniques from. Three instruments which include; Three instruments which include; State Anxiety, Nicholson McBride Resilience Questionnaire (NMRQ), Locus of Control Behaviour Scale and Tennessee Self Concept Scale were used for data collection, a cross sectional survey design was adopted as the research design while a multiple hierarchical Regressions with the aid of S.P.S.S version (23) was applied to analysis the data, result shows that none of the predictor variables predicted state anxiety among caesarean women. With value of stigma sig. = .960, locus of control sig. = .438 and self-concept sig. = .823. Also stigma, locus of control and self-concept did not jointly predict state anxiety among caesarean women with sig. f-change=.884, all at  $p < .05$ . The findings indicated that stigmatization, locus of control and self-concept are not predictors of state anxiety among caesarean women. Therefore, hospital management, gynecologists and all stakeholders should develop a program that will easy expecting mothers awaiting caesarean operation the fear of the unknown.*

Received: 2<sup>nd</sup> August, 2022  
Revised: 31<sup>st</sup> August, 2022  
Accepted: 9<sup>th</sup> October, 2022

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**Keywords:** *Caesarean, Women, Hospital, Locus of Control, Management, State Anxiety, Stigma, Self-Concept.*

## Introduction

A Caesarean section, is a type of surgery used to deliver a baby, a procedure where the baby is surgically removed through an incision in the mother's abdomen and then a second incision in the uterus (PLife 2021). According to new research from the World Health Organization (WHO), caesarean section use continues to rise globally, now accounting for more than 1 in 5 (21%) of all childbirths, this number is set to continue increasing over the coming decade, with nearly a third (29%) of all births likely to take place by caesarean section by 2030 (WHO 2021). While a caesarean section can be an essential and lifesaving surgery, it can put women and babies at unnecessary risk of short- and long-term health problems if performed when there is not medical need (WHO 2021). Caesarean sections are absolutely critical to save lives in situations where vaginal deliveries would pose risks, so all health systems must ensure timely access for all women when needed. Caesarean sections can be essential in situations such as prolonged or obstructed labour, fetal distress, or because the baby is presenting in an abnormal position. However, as with all surgeries, they can have risks. These include the potential for heavy bleeding or infection, slower recovery times after childbirth, delays in establishing breastfeeding and skin-to-skin contact, and increased likelihood of complications in future pregnancies (WHO 2021).

There are significant discrepancies in a woman's access to caesarean sections, depending on where in the world she lives. In the least developed countries, about 8% of women gave birth by caesarean section with only 5% in sub-Saharan Africa, indicating a concerning lack of access to this lifesaving surgery (WHO 2021). Conversely, in Latin America and the Caribbean, rates are as high as 4 in 10 (43%) of all births. In five countries (Dominican Republic, Brazil, Cyprus, Egypt and Turkey), caesarean sections now outnumber vaginal deliveries. Worldwide caesarean section rates have risen from around 7% in 1990 to 21% today, and are projected to continue increasing over this current decade. If this trend continues, by 2030 the highest rates are likely to be in Eastern Asia (63%), Latin America and the Caribbean (54%), Western Asia (50%), Northern Africa (48%) Southern Europe (47%) and Australia and New Zealand (45%), the research suggests (WHO 2021). Schaal, Fehm, Wolf, Gielen, Hagenbeck, Heil, Fleisch, and Hepp (2020) postulated that around 30% of births are through caesarean section and repetition rates for receiving a caesarean section are high, and went further to state that Women experiencing their first caesarean section displayed significantly higher anxiety levels compared to women with a repeated caesarean section.

For most women, pregnancy is an inevitable and important period in their lives, which involves a series of physical and psychological changes (Huizink, Mulder, Robles De Medina, Visser, & Buitelaar 2004 as cited in Sun, Huang, Hu, Yan, Xu, Zhu, et al. 2019). These changes may cause great emotional fluctuations especially in primiparous women. Pregnancy-specific anxiety, consisting of pregnancy-related worries and fears, is the most common emotional problem in pregnancy (Westerneng, Witteveen, Warmelink, Spelten, Honig & de Cock, 2017).

American Psychological Association (APA) (2021) defined Anxiety as an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure. While Saviola, Pappaianni, Monti, Grecucci, Jovicich and Pisapia (2020) defined anxiety as a mental state characterized by an intense sense of tension, worry or apprehension, relative to something adverse that might happen in the future. Anxiety is a state of fear in patients that arises from the prediction of a threatening event (Mostafayi, Imani, Zandi, & Jongi 2021). Anxiety is related to the specific behaviours of fight-or-flight responses, defensive behaviour or escape (Heeren, 2020). It's normal to feel anxious, worried or fearful in certain situations. These feelings are our bodies natural 'fight or flight response' to a perceived dangerous or risky situation, however if continuous feelings of anxiety impact your ability to carry out life as normal, you could have an anxiety disorder (Mental Health UK 2021). Anxiety is the body's physical response to a threat or perceived threat. It causes a pounding heart, rapid breathing, butterflies in the stomach and a burst of energy as well as

mental responses such as excessive fears, worries or obsessive thinking (healthdirect, 2021). Everyone experiences anxiety from time to time, it helps the individual to avoid danger by giving him/her energy and alertness to escape, but for some people, anxious feelings don't go away, they can see situations as much worse than they really are, and their anxiety affects their ability to concentrate, sleep and carry out ordinary tasks, these feelings can be caused by anxiety disorders (Healthdirect, 2021).

Researchers differentiate aspects of anxiety into state and trait, respectively defined as a more transient reaction to an adverse situation, and as a more stable personality attribute in experiencing events (Saviola, Pappaianni, Monti, Grecucci, Jovicich & Pisapia 2020). State anxiety is defined as a temporary reaction to adverse events (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs 1983 as cited in Saviola, Pappaianni, Monti, Grecucci, Jovicich & Pisapia 2020). State anxiety is a more transient intense emotional state, associated with a temporary increased sympathetic nervous system activity, but with no specific pathological conditions (Saviola, Pappaianni, Monti, Grecucci, Jovicich & Pisapia 2020).

Mozes (2021) postulated that state anxiety results from a situational belief that one is under threat or facing danger — and, therefore, varies as situations change. Gentile says state anxiety is triggered by external factors unrelated to a personality-driven predisposition toward anxiety. Anxiety symptoms can include: Nervousness, tension and restlessness, looming sense of panic or doom, increased pulse, hyperventilation, sweating, trembling, weakness or fatigue, trouble concentrating, difficulty sleeping, GI problems, uncontrolled worry (Mozes, 2021). Urge to avoid anxiety-inducing things. Pregnancy-specific anxiety has gradually been considered as a potential determinant that may affect women's preference for CS.

Mostafayi, Imani, Zandi, and Jongi (2021) stated that anxiety is common in surgical candidates and also Caesarean section (C-section) is one of the most prevalent surgeries among women. Caesarean candidates experience higher levels of anxiety than patients ready for surgery (Bansal & Joon2021). The preoperative stages in the surgery day and lack of control over being in an unfamiliar situation and feeling danger cause anxiety, and consequently, instability in patients (Mostafayi, Imani, Zandi, & Jongi, 2021). Feelings of helplessness and low self-esteem, stress, and anxiety have been reported frequently among C-section women (Bastani, Begloo & Haghani, 2021). Drzymalski, Lumbreras-Marquez, Tsen, Camann, Farber (2020) stated that previous research has shown that 30.9% of mothers will experience anxiety during pregnancy.

The main reasons for preoperative anxiety are doubts about the success of surgery and fear of the threats that surgery can entail. The effects of prenatal anxiety include enhanced levels of cortisol, anti-inflammatory cytokines, and less breastfeeding. Its effects on infants also include preterm delivery (Ali, Altun, Oguz, Ilhan, Demircan & Koltka, 2014). Anxiety also causes symptoms such as increased blood pressure, heart rate, and respiration in mother by stimulation of the autonomic nervous system (Sahin, Gulec, SaracAhrazoglu, & Tetiker, 2016). Many variables can cause anxiety, but this research is looking at stigma, locus of control and self-concept as predictor of state anxiety among caesarean women. anxiety.org (2017) proposed that individuals with anxiety disorders are often considered unpredictable, neurotic, or weak and need to just toughen up. The consequences of stigma are severe. The stigmatization of anxiety causes a person to have diminished self-worth and confidence, and to feel socially disconnected from peers (anxiety.org2017).

Stigma involves negative attitudes or discrimination against someone based on a distinguishing characteristic such as a mental illness, health condition, or disability (Jenev, 2020). Stigma is a mark of disgrace or shame associated with a quality or circumstance, a negative attitude toward those who have mental health or other problems. Individuals with anxiety disorders are often considered unpredictable, neurotic, or weak and need to just toughen up (Arick, 2017). World Health Organisation (2021) defines stigma as a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society. Jenev (2020)

stated that social stigmas can also be related to other characteristics including gender, sexuality, race, religion, and culture. The consequences of stigma are severe (Arick, 2017). Beyondblue (2021) theorised that stigma is divided into three which are, Structural: expectations within a society, cultural norms and institutional practices (including laws, regulations and policies) that constrain the opportunities, resources, and wellbeing for stigmatised groups. Social: negative social norms which predispose individuals in a social group to fear, reject and discriminate against people who are different. Social stigma can operate at two levels: (1) Actual Social Stigma: the actual stigmatising attitudes people hold, and (2) Perceived Social Stigma: how somebody thinks everyone else thinks about people who are different (e.g. how stigmatising do I think others are about people with anxiety?). Self: Negative self-talk which could lead to denial of symptoms, rejection of treatment and self-isolation from potentially valuable social supports. Another variable of interest is locus of control.

According to Psychology today (2021) stated that people with an external locus of control are also more likely to experience anxiety since they believe that they are not in control of their lives. This is not to say, however, that an internal locus of control is good and an external locus of control is bad. There is a research which states that anxiety in partnering is not always negatively related to self-concept (Djajasaputra1 & Basaria, 2021).

Self-concept refers to a person's self-perception. Thus self-concept is the way one thinks of one's self (Onukwufor, 2012 as cited in Onukwufor & Ugwu, 2017). According to Brehm, Kassin and Fein (2005) as cited in Onukwufor and Ugwu (2017) Self-concept refers to the sum total of beliefs that people have about themselves. Onukwufor and Ugwu (2017) proposed that self-concept is seen as the beliefs a person has about himself. Self-concept is how you perceive your behaviour, abilities, and unique characteristics (Bailey 2003 as cited in Kendra, 2021). Self-concept tends to be more malleable when you're younger and still going through the process of self-discovery and identity formation, as one age and learn who he/she is and what's important to them, these self-perceptions become much more detailed and organized (Kendra, 2021). Huitt (2011) as cited in Onukwufor and Ugwu (2017) saw self-concept as the basis for all motivated behaviour. Onukwufor and Ugwu (2017) stated that people develop and maintain their self-concepts through the process of taking action and then reflecting on what they have done and what others tell them about what they have done. There are certain factors that determine self-concept, these include social identity: this refers to the social groups we identify with such as our nation, state, town, religion and club (Onukwufor & Ugwu, 2017).

Rotter in one of the write-up defined locus of control as the degree of control to which individuals believe they have over the outcome of certain situations (Mali, 2013). A person who believe that he or she has control over his/her life events is said to have an internal locus of control while the one who believes that he or she is controlled by luck, chance, fate or powerful others (heath professionals, family, friends) is said to have an external locus of control. According to Baharuddin (2015), locus of control was one of the variables of personality which was defined as the individual's belief in the ability to control his/her own destiny. Someone who has a locus of control will have self- confidence to succeed. Based on Hermawan et al. (2016), locus of control was a personality variable associated with general expectations of a person whether someone will be able to control events in life or not. This concept is based on the degree to which people perceive the eventuality that certain outcomes will result from specific reasons or actions (Wang et al., 2010).

Cognitive theory of anxiety is adopted as the theoretical framework because it help individuals develop more realistic and rational appraisals of themselves and the situations they encounter. The way individual process things cognitively leads to anxiety, the cognitive process matters in the individual day to day activities. The cognitive theory helped to anchored the four variables together, once an individual possess negative thought towards a particular stimulus it might trigger negative responses, because the thought of the negative stimuli

might invoke fear and anxiousness, which might lead to anxiety. Also the knowledge one has about him/her determine the level of self-concept. The amount and the way the individual process information or the cognitive believe about a particular idea determine if the person will exhibit stigma or not. Also, locus of control is a cognitive thing. The way one perceived, processes and interpret information determine the locus of control one expressed.

### **Purpose of the study**

The following purpose motivated this study:

To determine whether sigma will significantly predict preoperative anxiety before caesarean surgery

To determine whether locus of control will significantly predict preoperative anxiety before caesarean surgery

To determine whether self-concept will significantly predict preoperative anxiety before caesarean surgery

### **Method**

#### **Participants**

One Hundred (100) participants comprise mainly of pregnant women scheduled for caesarean delivery in the hospital were selected with aid of purposive sampling techniques University of Nigeria Teaching Hospital, Ituku/Ozalla. Inclusive criterion: All pregnant women (elective and emergency) scheduled to deliver through caesarean section, ability to understand or communicate in English; however non literate mothers will be assisted in the interpretation of the test materials by the researcher and certified nurse midwives serving as interpreters. Not mentally retarded. Not under treatment for significant mental illness. Age range between 18 to 48years

Exclusion criteria includes:- Unwillingness to participate, all those who birthed through the natural or vagina route. Participants diagnosed with anxiety, depression and personality disorders on pharmaco-psychological medications, respondents who delivered still birth

#### **Instruments**

Four sets of instruments were used for the study; namely

- State Anxiety (Spielberger 1972)
- Locus of Control Behaviour Scale (Craig, Franklin & Andrews, 1984)
- Tennessee Self Concept Scale (Fitts, 1965)

#### **State Anxiety (Spielberger1972)**

The State – Trait Anxiety Inventory (STAI)Spielberger (1972) STAI – State (Y – 2 form) subscale of the STAI consists of 20 items Likert type response format with total possible score between 20 – 80. This particular subscale is designed to measure a dimension of anxiety namely the state anxiety, which according to its authors defined state anxiety as a ‘transitory state or condition of an organism characterized by subjective, consciously perceived feeling of apprehension and tension, which are accompanied by or associated with activation of the autonomic nervous system (Spielberger, Gorsuch & Lushene, 1983). The subscale requires the testee to indicate options describing how they feel today or present time. It has been found to reflect changes in the stressfulness of various stimulus situations, indicating that it measures the subjective experiential component of STAI i.e. A- State.

Psychometric properties of STAI – State test was provided by Omoluabi (1987) for the Nigerian samples. The norms reported among the Nigerian populace are the mean score for male (M) and female (F) n = 100 which yielded 34.54. In this study, this norm will be adopted and serves as the cut off point for interpreting scores obtained as higher than the norm indicates a typical manifestation of anxiety. Jegede (1979) revalidated the STAI on Nigerian subjects and found it to be cultural-free with reliability of 0.77 and internal consistency co-efficient as high as 0.98. Awaritefe and Kadiri (1981) have also validated the instrument on

Nigerian subject. STAI has been used in various studies among Nigerian sample (Adetayo & Akinade, 2019; Ogbolu & Omidiji, 2018; Akinsulore, Owojuyigbe, Faponle & Fatoye, 2015).

The researcher carried out a pilot with excepted mothers whom were selected with the aid of purposive sampling techniques from Enugu State Teaching Hospital, Department of gynecology, Parklane Enugu State, which yielded a Cronbach alpha of .939

#### **Locus of Control Behaviour Scale (Craig, Franklin & Andrews, 1984)**

The researcher carried out a pilot with excepted mothers whom were selected with the aid of purposive sampling techniques from Enugu State Teaching Hospital, Department of gynecology, Parklane Enugu State, which yielded a Cronbach alpha of .940

#### **Tennessee Self Concept Scale (Fitts, 1965)**

The Tennessee Self Concept Scale (TSCS) (Fitts, 1965) is a 5 point Likert scale comprises of 100 self – descriptive statement to which the respondent indicate their level of agreement or disagreement on agreed. The TSCS is made up two dimensions namely, internal and external dimensions. Internal dimension measures what the individual sees when he or she evaluates the self from within in 3 domains like Identity, behavior and self-satisfaction while the external dimension reflects what the individual sees when he or she evaluates the self from outside on a subscale that includes 5 domains: - Physical, Personal, Family, Moral-ethical and Social self. Findings from Nigerian samples have shown TSCS to be valid and reliable instrument for measuring self-concept of literate Nigerian subjects. Among its psychometric properties, test-retest reliability coefficient of .80 have been reported and coefficient of concurrent validity with many MMPI scale ranging from .50 to .60 were reported (Oladimeji, 2005) In a study to establish concurrent validity of TSCS among Nigerian subject, a validity coefficient of .50 had been reported between TSCS and Self Confidence scale of Adjective Checklist (Ikiddeh (1987).Nigerian users of TSCS: - Ezeilo, (2018); Popoola and Ilugbo, (2010); Ayinde, (2011). The researcher carried out a pilot with excepted mothers whom were selected with the aid of purposive sampling techniques from Enugu State Teaching Hospital, Department of gynecology, Parklane Enugu State, which yielded a Cronbach alpha of .955

#### **Procedure**

Ethical letter was obtained from the ethical committee Psychology Department along with identification from the H.O.D of Psychology, which was attached along with an application letter to conduct the study were summited to University of Nigeria Teaching Hospital Research and Ethics committee for the proper identification to carrying out the study. Informed consent also obtained from selected participants prior to the administration of the test materials. The consent form clearly stated what is required of the participants, the length of the study, and the importance of their role in the study. One hundred participants scheduled for elective or planned caesarean deliveries while in the antenatal wards and labour room reception as part of the initial admission protocols were selected with the aid of purposive sampling techniques for this research work. Also, participants for emergency caesarean section were also selected. One and thirty copies of questionnaire were send out, one hundred and fifteen were return, of which nine bears multiple names and six were not properly responded to, which total the while responded ones to be one hundred, which were used for the analysis.

#### **Design/Statistics**

A cross-sectional survey design was adopted based on coverage of a wide range of the population. Thus, hierarchical Regressions with the aid of S.P.S.S version (23), was applied as a statistic to analyze the data in order to test the hypothesis.

**Results**

**Table I:** descriptive table

s/n	mean	S/D	1	2	3	4
1.	State anxiety		54.34	8.21	1	
2.	Stigma		32.85	6.88	-.01	1
3.	Locus of control		5.42	1.46	.08	-.08 1
4.	Self-concept		263.12	56.59	.02	-.02 -.04 1

The result in table I above indicate that none of the variables are related. The result shows that state anxiety and stigma, stigma and locus of control, stigma and self-concept and locus of control and self-concept have negative interaction. It means that when one of the variables is going up the other one will be going down. This shows that the above variables cannot be present together among caesarean section patients.

**Table II:** regression analysis of caesarean patients

s/n	$\beta$	t	sig.
1.	Stigma		-.005 -.050 .960
2.	Locus of control		.082 .779 .438
3.	Self-concept		.022 .210 .823
		r	.089
		r <sup>2</sup>	.007
	adj r		-.026
		f-change	.217
		sig. f-change	.884

Dependent variable = State anxiety, at P< .05\*

Table II above shows that stigma did not predict state anxiety among caesarean section women, so the first hypothesis tested which stated that ‘stigma will not significantly predict state anxiety’ was confirmed, hence accepted. It was accepted because stigma sig, value of .960 is higher than the threshold of at p< .05.

From same table II, locus of control did not predict state anxiety, hence the second hypothesis tested which stated that ‘locus of control will not significantly predict state anxiety’ was confirmed, and was accepted. The hypothesis was accepted because locus of control sig. of .438 was above the threshold of at p< .05.

Finally, table II above displayed that self-concept did not predict state anxiety, hence the third hypothesis tested which stated that ‘self-concept will not predict state anxiety’ was confirmed, and also accepted. It was accepted because sig. value of self-concept of .823 was exceeded the limit at  $p < .05$ .

Table II above shows that the predictor variables are not related with the dependent variable f state anxiety at  $r = .09$ , also stigma, locus of control and self-concept contributed 0% to the variance of state anxiety among caesarean women. Final the sig. f-change value of .884 exceeded the threshold of at  $p < .05$ , hence the fourth hypothesis tested which stated that ‘stigma, locus of control and self-concept will not jointly predict state anxiety among caesarean women’ was not confirmed, and was accepted.

### **Summary of result**

Stigma did not significantly predict state anxiety among caesarean section women

Locus of control did not significantly predict state anxiety among caesarean section women

Self-concept did not predict did not significantly predict state anxiety among caesarean section women

Stigma, locus of control and self-concept did not jointly predict state anxiety among caesarean section women.

### **Discussion**

The first hypothesis tested which stated that “stigma will significantly predict state anxiety among caesarean women” was not confirmed, hence accepted. The result obtained disagreed with earlier literatures that postulate that stigma can lead to anxiety. Just like Wang (2017) stated that stigma can contribute to an individual's worsening anxiety and become an obstacle to their seeking treatment, and went further to elaborate that Stigma is a mark of disgrace or shame associated with a quality or circumstance, a negative attitude toward those who have mental health or other problems. The research proved stigma is not strong predictor of state anxiety among caesarean women, which indicated that pregnant women don't see anything wrong in caesarean section as such they don't feel ashamed or being scared of stigmatization delivery their baby through operation. The result displayed that pregnant women don't read negative meaning into any means of them giving birth; all they care about is for them to deliver safely, because the risk of death for caesarean sections is 13 per 100,000 vs. for vaginal birth 3.5 per 100,000 in the developed world (American College of Obstetricians and Gynecologists 2014).

This implies that undergoing caesarean section is a problem to women; they perceived it as a safe route for both themselves and their unborn child. So many factors might have contributed to stigma not predicting state anxiety among caesarean women, may be the fear of death and the anxiety to see their unborn baby might have over shadow the fear of stigma. Also, the pains, stress, anxiety, hormonal imbalance and other pregnancy related issue and uncertainty might have cause stigma not to have predicted state anxiety among caesarean women.

The second hypothesis tested which stated that ‘locus of control will not significantly predict state anxiety among caesarean women’ was confirmed, hence accepted. The result obtained was not in agreement with some earlier literatures which postulated that one of the dimension of locus of is a major predictor of a state anxiety, because when one start to blame the outside environment as the cause of its problem, on the spot anxiety will crib in. because the fear of the unknown will be so much high that it might bring about anxiousness which can end up as state anxiety. The result shows that centre of believe or the persons believe does not in any way affect their choice of down going caesarean section, because what the expected is thinking of is the her personal and baby safety. Pregnant women can undo any procedure as far as it can bring about her safe delivery and her baby being alive saves and sound.



The result implies that locus of control is not a primary cause of anxiety among pregnant women undergoing or that have undergone caesarean section, the series of physical and psychological changes according to Huizink, Mulder, Robles de Medina, Visser, and Buitelaar (2004) might have contributed to it. These changes may cause great emotional fluctuations especially in primiparous women. Pregnancy-specific anxiety, consisting of pregnancy-related worries and fears, is the most common emotional problem in pregnancy (Westerneng, Witteveen, Warmelink, Spelten, Honig, & de Cock 2017). Locus of control might be predictor in other participants out the one used by the researcher, but in this work locus of control did not predict state anxiety among caesarean women. It shows that locus of control cannot cause state anxiety among CS women.

The findings indicated that locus of control cannot predict state anxiety among expecting mothers, because the thought to come out alive and eagerness to see their baby might have over shadowed the external fears and anxiety.

The third hypothesis tested which stated that 'self-concept will significantly predict state anxiety among caesarean women' was confirmed, hence accepted. This result shows that self-concept is not part of expecting mothers' problem.

The fourth hypothesis tested which stated that 'stigma, locus of control and self-concept will not jointly predict state anxiety among caesarean women' was not confirmed, hence the stated was accepted. The result obtained indicated that the three independent variables are not major problems of pregnant women or expected mothers, rather the series of physical and psychological changes according to Huizink, Mulder, Robles de Medina, Visser, and Buitelaar (2004) might have contributed to it. These changes may cause great emotional fluctuations especially in primiparous women. Pregnancy-specific anxiety, consisting of pregnancy-related worries and fears, is the most common emotional problem in pregnancy (Westerneng, Witteveen, Warmelink, Spelten, Honig, & de Cock 2017). It shows that the predictor variables are not primary concern of pregnant women view about caesarean, maybe fear of the unknown, anxiousness to meet/see/tough the expecting baby.

### **Implication of the finding**

The result agree with the theoretical framework of cognitive theory of anxiety which stated that it help individuals develop more realistic and rational appraisals of themselves and the situations they encounter. It implies that the major of pregnant women or expecting mothers is to deliver safely and for their baby to be safe and sound.

The findings created a new literature and empirical evidences on some of the predictor variables, because there was lack of literature backing some of the predictor variables.

The findings indicated that stigmatization, locus of control and self-concept are not predictors of state anxiety among caesarean women. Therefore, hospital management, gynecologist and all stake hold should

### **Limitation**

Many factors militated against this work; one of such is the sampling site, using only University of Nigeria Teaching Hospital reduces the numbers of participants. The numbers of participants would have increase assuming other hospitals were considered.

Secondly, selecting only women undergoing caesarean section also reduces the number. More participants would have participated assuming none caesarean women were sample also.

The nature of the participants selected makes them to be difficult to get to. It would have be much easier to get across to caesarean women if they were psychological stable.

### Suggestion for further study

Future researcher should considered sampling participants from more than one hospital so as to increase the numbers of participants. Pregnant women in general should be sampled, rather than selecting only women who had caesarean operations. Finally, researchers should find a way to get across to the participants when they are psychologically balance.

### Conclusion

The researcher investigated stigma, locus of control and self-concept as predictors of state anxiety among caesarean women, hundred participants were selected from UNTH Enugu with the aid of purposive sampling techniques, and the result shows that the predictor variables did not predict state anxiety among caesarean section. which indicated that stigma, locus of control and self-concept are not strong predictors of state anxiety among caesarean section women, therefore hospital, gynaecologist and the general public should look outside the predictors variable when trying to solve caesarean section state anxiety among pregnant women.

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