



The effects of antenatal education on fear of childbirth, maternal self-efficacy and post-traumatic stress disorder (PTSD) symptoms following childbirth: an experimental study[☆]



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ABSTRACT

Background: Fear of birth and low childbirth self-efficacy is predictive of post-traumatic stress disorder symptoms following childbirth. The efficacy of antenatal education classes on fear of birth and childbirth self-efficacy has been supported; however, the effectiveness of antenatal classes on post-traumatic stress disorder symptoms after childbirth has received relatively little research attention.

Purpose: This study examined the effects of antenatal education on fear of childbirth, maternal self-efficacy and post-traumatic stress disorder symptoms following childbirth.

Design: Quasi-experimental study.

Methods: The study was conducted in a city located in the Middle Anatolia region of Turkey and data were collected between December 2013 and May 2015. Two groups of women were compared—an antenatal education intervention group ($n = 44$), and a routine prenatal care control group ($n = 46$). The Wijma Delivery Expectancy/Experience Questionnaire, Version A and B, Childbirth Self-efficacy Inventory and Impact of Event Scale–Revised was used to assess fear of childbirth, maternal self-efficacy and PTSD symptoms following childbirth.

Results: Compared to the control group, women who attended antenatal education had greater childbirth self-efficacy, greater perceived support and control in birth, and less fear of birth and post-traumatic stress disorder symptoms following childbirth (all comparisons, $p < 0.05$).

Conclusions: Antenatal education appears to alleviate post-traumatic stress disorder symptoms after childbirth.

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1. Introduction

Antenatal education is instrumental in helping prospective mothers. Prospective mothers often need antenatal education to help them make decisions about birth and during birth, and for developing skills for labor, pain relief, infant and postnatal care, breastfeeding and parenting. Although antenatal education is provided as standard through training programs in developed countries, there is no standard program in developing countries. Therefore, the quality and content of the education vary (Gagnon & Sandall, 2011).

In recent years, there has been increasing research conducted to examine the effect of antenatal education on childbirth worldwide, yet most such research has been conducted in Western countries (Brixval, Axelsen, Andersen, Due, & Koushede, 2014). Several studies found that antenatal education was effective in decreasing birth-related anxiety and fear of childbirth (Byrne, Hauck, Fisher, Bayes, & Schutze, 2014; Miquelutti, Cecatti, & Makuch, 2013; Toohill et al., 2014). Additional studies showed that antenatal education increased maternal knowledge about birth, birth satisfaction, childbirth-related self-efficacy and sense of control in birth (Byrne et al., 2014; Malata, Hauck, Monterosso, & McCaul, 2007; Spinelli, Baglio, Donati, Grandolfo, & Osborn, 2003; Toohill et al., 2014). A recent study conducted in Western Turkey demonstrated that antenatal education was effective in reducing fear of childbirth and increasing maternal self-efficacy, but had no effect on paternal attachment (Sercekus & Başkale, 2016).

Several studies have been undertaken to examine the effects of antenatal education on fear of childbirth and maternal self-efficacy (Byrne et al., 2014; Gagnon & Sandall, 2011; Sercekus & Başkale, 2016). Although fear of birth and low childbirth self-efficacy are

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predictive of post-traumatic stress disorder (PTSD) symptoms following childbirth, the effectiveness of antenatal education on PTSD symptoms following childbirth has received relatively little research attention. As such, this study aimed to examine the effects of antenatal education on fear of childbirth, maternal self-efficacy and PTSD symptoms following childbirth.

2. Background

2.1. PTSD symptoms following childbirth

Childbirth is both a natural and challenging experience that includes positive and negative psychological responses. Women's psychological responses to birth are largely determined by retrospective appraisal of the birth process, and interpretation, thoughts and emotions during and after birth (Ayers, 2007). Births experienced as particularly traumatic might thus have a negative impact on a woman's postnatal psychological well-being. Recently, researchers have increasingly focused on women's psychological trauma and its symptoms following childbirth (Ayers, 2014; Boorman, Devilly, Gamble, Creedy, & Fenwick, 2014). Prevalence estimates of PTSD symptoms following childbirth vary substantially across studies; yet, in a recent review the prevalence of PTSD symptoms following childbirth was found to be 3.17% in community samples and 15.7% in high-risk samples, respectively (Grekin & O'Hara, 2014). Subjective birth experience has been found to have the strongest effect on PTSD symptoms following childbirth (Garthus-Niegel, von Soest, Vollrath, & Eberhard-Gran, 2013). It should also be noted that PTSD symptoms following childbirth are related not only to actual birth trauma but also to other factors can make women more vulnerable or at risk of developing PTSD symptoms following childbirth (Ayers, 2014). Symptoms of PTSD are generally divided into three categories including re-experience/intrusion via nightmares, intrusive thoughts or flashbacks; avoidance and numbing; and increased arousal such as hypervigilance, irritability, difficulty concentrating and other emotional dysregulation. For birth-related PTSD, two clusters of symptoms were identified: (1) re-experiencing and avoidance symptoms; and (2) emotional numbing and arousal symptoms (Ayers, Harris, Sawyer, Parfitt, & Ford, 2009).

2.2. Fear of childbirth and PTSD symptoms following childbirth

The fear of childbirth during pregnancy is a predictive factor for developing PTSD symptoms subsequent to birth (Ayers, 2014). Women with severe fear of childbirth were more likely to describe their birth experiences as involving a sense of not being present in the delivery room, and were more likely to state that they did not receive sufficient support from midwives, and that their faith in their ability to give birth was shaken (Nilsson, Bondas, & Lundgren, 2010). Although fear of childbirth is more likely to be observed in nulliparous women, women with traumatic or difficult birth experiences are around five times more likely to report childbirth fear in a subsequent pregnancy (Storksen, Garthus-Niegel, Vangen, & Eberhard-Gran, 2013). In addition, complications during childbirth may increase postpartum fear of birth, and intense fear during birth may be more predictive than perceived threat of injury or death for postnatal PTSD symptoms following childbirth (Boorman et al., 2014).

2.3. Childbirth related maternal self-efficacy and PTSD symptoms following childbirth

Another risk factor for PTSD following childbirth that has not been widely examined is low self-efficacy. A mother's self-efficacy is affected by her perception of the birth, and confidence in her ability to give birth affects coping mechanisms (Ip, Tang, & Goggins, 2009). High levels of self-efficacy result in greater capability to cope with the stresses of childbirth and to perform required behaviors (Lowe, 1993). According

to Bandura (1989), "Self-efficacy is determined by the belief in what outcome a given behavior will have in a given situation (outcome expectancy) and the belief in one's ability to perform that behavior in the actual situation (self-efficacy expectancy)". In nulliparous women, outcome expectancy and self-efficacy expectancy are positively correlated each other and both variables are negatively correlated with fear of delivery (Salomonsson, Berterö, & Alehagen, 2013). In accordance with the research outlined above, it is proposed that psychological and mental preparation of pregnant women for childbirth in antenatal education might help to reduce fear of childbirth, induce childbirth related maternal self-efficacy and in this way, minimize the risk of experiencing PTSD symptoms following childbirth.

3. Purpose

The main objective of this study was to assess the effects of antenatal education on fear of childbirth, maternal self-efficacy and PTSD symptoms following childbirth.

4. Methods

4.1. Design

A quasi-experimental study was conducted, comparing two groups of women: an antenatal education intervention group, and a usual prenatal care control group.

4.2. Hypotheses

H1. Women who receive antenatal education will have a lower degree of fear of childbirth than those in a control group.

H2. Women who receive antenatal education will have a higher degree of maternal self-efficacy than those in a control group.

H3. Women who receive antenatal education will have a lower degree of PTSD symptoms following childbirth than those in a control group.

4.3. Setting and participants

The study was conducted in a city located in the Middle Anatolia Region of Turkey. Maternity care in this region is provided in family health centers and hospitals. Routine antenatal and postnatal care is provided by midwives, nurses and general practitioners in family health centers. If women require non-routine care, they are referred to obstetricians at the two local hospitals (a government hospital and a private hospital).

Participants in the study were recruited using posted advertisements in the private hospital. To be included in the study, mothers were required to be nulliparous, between 20 and 32 weeks gestation, have no history of pregnancy complications, have their pregnancies be considered non high-risk, and not be attending any other antenatal program. All participants were also required to have graduated from at least primary school and to be able to communicate in Turkish.

The intervention group consisted of women who volunteered to participate in the study under the 'usual care' condition, and met the inclusion criteria. The control group was composed of women who were receiving usual prenatal care at an outpatient maternity clinic of the same private hospital and met the inclusion criteria. In the hospital, usual prenatal care visits take 10–15 minutes, and consist of collecting medical information, a physical examination and ultrasound scan. No antenatal education is offered in these visits, as antenatal education classes are currently not a part of routine care in the region.

Since no prior experimental study has been conducted using the data collection instrument employed in this study, the required sample

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