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Effects of antenatal education on fear of childbirth, maternal self-efficacy and parental attachment

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ARTICLE INFO

Article history:

Received 27 January 2015

Received in revised form

29 May 2015

Accepted 19 November 2015

Keywords:

Antenatal education

Fear of childbirth

Maternal attachment

Paternal attachment

Self-efficacy

ABSTRACT

Objective: to examine the effects of antenatal education on fear of childbirth, maternal self-efficacy, and maternal and paternal attachment.

Design: quasi-experimental study, comparing an antenatal education group and a control group.

Participants: 63 pregnant women and their husbands.

Measurements: demographic data forms, the Wijma Delivery Expectancy/Experience Questionnaire, the Childbirth Self-Efficacy Inventory, the Maternal Attachment Inventory and the Postnatal Paternal–Infant Attachment Questionnaire were used for data collection.

Findings: antenatal education was found to reduce the fear of childbirth and to increase childbirth-related maternal self-efficacy. However, antenatal education was found to have no effect on parental attachment.

Key conclusions: it is recommended that widespread antenatal education programmes should be provided in developing countries, and the content of the education programme about parental attachment should be increased.

Implications for practice: this study found that antenatal education has no influence on maternal and paternal attachment. As such, there is a need to increase the content of the education programme about parental attachment.

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Introduction

Antenatal education is indispensable to the health of pregnant women and their infants in many parts of the world. Although numerous studies have been undertaken regarding the effects of antenatal education, evidence remains insufficient (Gagnon and Sandall, 2011). As such, a large number of interventional studies should be conducted on the effects of antenatal education on childbirth self-efficacy, fear of childbirth, and maternal and paternal attachment.

Antenatal education

Globally, antenatal education has an important place in couples' preparations for pregnancy, childbirth and parenting (Lowdermilk et al., 2012). Although antenatal education is provided as standard through training programmes in developed countries, there is no standard programme in developing countries. As such,

the quality and content of the education varies from one educator to another (Gagnon and Sandall, 2011).

Studies have been conducted on the effects of antenatal education on childbirth and parenthood. Several studies have shown that education reduces anxiety suffered at birth (Ip et al., 2009; Miquelutti et al., 2013). In their pilot study, Byrne et al. (2014) showed that antenatal education reduced the fear of childbirth. Toohill et al. (2014) found that psycho-education by trained midwives was effective in reducing high levels of fear of childbirth. Three studies showed that education increases childbirth-related self-efficacy (Ip et al., 2009; Byrne et al., 2014; Toohill et al., 2014). However, Fabian et al. (2005) determined that education had no effect on the childbirth experience, and Schneider (2001) reported that women receiving antenatal education thought that the education provided was inadequate for childbirth preparation.

It has been found that participation in antenatal classes does not affect parental attachment (Nichols, 1995), and Deave et al. (2008) reported that education in preparation for parenting is inadequate. Leigh et al. (2012) showed that education intended to promote parental attachment, given in the postpartum period, is ineffective. However, other studies have shown the benefits of education for parenting. Toosi et al. (2014) found that relaxation training during the antenatal period increased maternal

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attachment, and [Abasi et al. \(2013\)](#) found that education intended to promote maternal attachment was successful.

As such, while some studies have indicated that education has a positive effect on the childbirth experience and parenthood, others have reported the opposite. In addition, one review study reported that there was insufficient evidence on this issue, and that the effects of general antenatal education for childbirth and parenthood remain largely unknown ([Gagnon and Sandall, 2011](#)). However, a limited number of interventional studies have been undertaken regarding the effects of antenatal education on fear of childbirth, maternal self-efficacy and parental attachment. As such, this study aimed to examine the effects of antenatal education on fear of childbirth, maternal self-efficacy, and maternal and paternal attachment.

Fear of childbirth and maternal self-efficacy

Fear of childbirth is a common problem, and has a negative impact on the childbirth experience ([Saisto and Halmesmaki, 2003](#)). This fear causes birth to take longer ([Adams et al., 2012](#)), and thus the prospective mother suffers labour pain more intensely ([Saisto et al., 2001](#)). Another major problem caused by fear of childbirth is that women ask to have a caesarean section, and the elective caesarean section rate is increasing ([Sydsjö et al., 2012](#); [Raisanen et al., 2014](#)). Fear of childbirth may result in instrumental vaginal birth or emergency caesarean birth ([Sydsjö et al., 2012](#)). It is also known that fear of childbirth has a negative effect on the postpartum period ([Saisto and Halmesmaki, 2003](#)), and is associated with post-traumatic stress disorder ([Andersen et al., 2012](#)) and birth trauma ([Nilsson et al., 2010](#)).

Self-efficacy is a person's belief in his/her own abilities to cope with a particular situation, and it has an important role in the fulfilment of a learned behaviour ([Bandura, 2001](#)). People with high self-efficacy are known to be more satisfied with childbirth ([Berentson-Shaw et al., 2009](#)). Self-efficacy is also associated with levels of anxiety and fear of childbirth. A lower efficacy expectancy (i.e. lower confidence in one's own capability to perform helpful behaviours during labour) was associated with higher anxiety and fear of childbirth ([Beebe et al., 2007](#); [Salomonsson et al., 2013](#)).

Maternal and paternal attachment

Maternal role attachment is the process by which a woman learns mothering behaviours and becomes comfortable with her identity as a mother ([Davidson et al., 2012](#)). It has been considered to be an indicator of adaptation to pregnancy, as well as being positively associated with antenatal health practices ([Lindgren, 2001](#)) and the child's growth and development ([Pisoni et al., 2014](#)). Studies have been undertaken regarding the factors affecting maternal-fetal attachment ([Alhusen, 2008](#); [Yarcheski et al., 2009](#)). The factors associated with higher levels of maternal-fetal attachment included family support, greater psychological well-being, and having an ultrasound performed. Factors such as depression, substance abuse and higher anxiety levels have been found to be associated with lower levels of maternal-fetal attachment ([Alhusen, 2008](#)). [Yarcheski et al. \(2009\)](#) showed that gestational age, self-esteem, planned pregnancy, age, parity, ethnicity, marital status, income and education also affect maternal-fetal attachment.

Becoming a father is a developmental event that marks a new transition for men. It is a period characterised by uncertainty, increased responsibility, disruption of sleep, and an inability to control the time needed to care for the infant and re-establish the couple's relationship ([Lowdermilk et al., 2012](#)). [Yu et al. \(2012\)](#) found that fathers who perceived more marital intimacy and support from their partners were more attached to their infants.

Another study showed that mental well-being is important for father-infant attachment ([Condon et al., 2013](#)).

Methods

Study design

A quasi-experimental study was conducted, comparing women who received antenatal education (experimental group), and women who received routine antenatal care (control group). The use of a quasi-experimental design offers many advantages for researchers, including: the provision of clear evidence of the effectiveness of interventions, the independent variable precedes the dependent variable, the influence of the independent variable can be measured, and a level of control can be introduced that reduces the effect of extraneous variables ([Houser, 2015](#)). The dependent variables in this study were fear of childbirth, self-efficacy and parental attachment, and the independent variable was antenatal education.

Participants

The study was undertaken in a province located in the Aegean region of Turkey. Before the study commenced, the fact that free antenatal education would be given was announced via the Internet. Women and their husbands who volunteered to participate in the study between March 2012 and January 2014, and who met the inclusion criteria, comprised the experimental group. The control group consisted of women and their husbands who received routine antenatal care at an outpatient maternity clinic in a university hospital.

The inclusion criteria were as follows: gestation of 26–28 weeks, minimum education level of primary school graduation, nulliparous, not at high risk in pregnancy, and not attended any other antenatal programme in the antenatal period. Subsequently, inclusion also required giving birth at full term, having a healthy newborn (born at 38–42 weeks of gestation, not of low birth weight and with no disease) and having experienced no postnatal complications (haemorrhage, puerperal infection, mastitis, thromboembolic disease or postpartum psychiatric disorder).

As no previous experimental studies had used the same surveys, the sample size could not be calculated prior to the start of the study. Thus, when the sample size reached eight participants in each group, the sample size was calculated based on the data collected at the time and by using Minitab 14. The total fear of childbirth score was considered to be the primary outcome. The numbers required for each group were calculated using power calculations based on a significance level of 0.05 and assumed mean differences (22.8) and standard deviations (20.73) within the proposed data collection tool. The number for each group was estimated as 15 to achieve a study power of 80%. However, a higher number of participants was included in case of missing participants.

Thirty-five couples were enrolled in the experimental group, and 37 were enrolled in the control group. There were seven (antenatal four, post partum three) absences in the experimental group, and 10 (antenatal five, post partum five) absences in the control group. Among the reasons for absenteeism in the experimental group were refusal of permission to attend from their workplace, medical conditions, premature birth and postnatal complications. In the control group, reasons for being absent were the wish to withdraw from the study, medical conditions, difficulties in terms of access and postnatal complications. In the antenatal period, 31 couples in the experimental group and 32 couples in the control group completed the study. In the

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