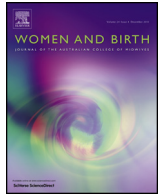




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Original Research - Quantitative

Birth preference in women undergoing treatment for childbirth fear: A randomised controlled trial

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ABSTRACT

Background: Childbirth fear is the most common underlying reason for requesting a caesarean section without medical reason. The aim of this randomised controlled study was to investigate birth preferences in women undergoing treatment for childbirth fear, and to investigate birth experience and satisfaction with the allocated treatment.

Methods: Pregnant women classified with childbirth fear (≥ 60 on the Fear Of Birth Scale) ($n = 258$) were recruited at one university hospital and two regional hospitals over one year. The participants were randomised (1:1) to intervention (Internet-based Cognitive Behaviour Therapy (ICBT)) ($n = 127$) or standard care (face-to-face counselling) ($n = 131$). Data were collected by questionnaires in pregnancy week 20–25 (baseline), week 36 and two months after birth.

Results: Caesarean section preference decreased from 34% to 12% in the ICBT group and from 24% to 20% in the counselling group. Two months after birth, the preference for caesarean increased to 20% in the ICBT group and to 29% in the counselling group, and there was no statistically significant change over time. Women in the ICBT group were less satisfied with the treatment (OR 4.5). The treatment had no impact on or worsened their childbirth fear (OR 5.5). There were no differences between the groups regarding birth experience.

Conclusion: Women's birth preferences 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. A higher percentage were lost to follow-up in ICBT group suggesting a need for further research.

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Statement of significance

Problem or issue

Caesarean section due to childbirth fear is not health promoting and treatment options for childbirth fear is needed.

What is already known

Only a few randomised controlled studies about treatment for childbirth fear and its reduction in caesarean section have been performed and to date, there is no evidence for the best treatment.

What this paper adds

Women's birth preferences fluctuated over the course of pregnancy and after birth regardless of treatment method for childbirth fear. Women felt their fear was reduced and were more satisfied with face-to-face counselling compared to internet-based cognitive behaviour therapy.

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1. Introduction

Childbirth fear is the most common underlying reason for requesting a caesarean section without medical reason. However, caesarean sections are associated with adverse maternal outcome^{1,2} and affects the children's health in both the short- and long term.^{1–3}

Several methods for treating childbirth fear have been studied. To date, there is no evidence for best treatment. Different study designs and varying outcome measures complicate these comparisons. However, in a Norwegian interventional study,⁴ 86% of the women with a request for caesarean section changed their birth preferences after receiving crisis-orientated counselling. Of these women, 69% gave birth vaginally and 31% had a caesarean section for medical reasons.

A feasibility study⁵ using internet-based cognitive behaviour therapy (ICBT) for nulliparous women with childbirth fear reported a significant decrease in childbirth fear and suggested ICBT could treat severe childbirth fear during pregnancy.

A few randomised controlled trials (RCT) have been conducted. Saisto et al.⁶ compared cognitive therapy with standard care (standard information and obstetric check-ups). They found that both methods reduced caesarean sections on request and also reduced birth-related concerns in the intervention group. Rouhe et al.⁷ compared psychoeducative group therapy with standard care (conventional care by community nurses). The intervention group had lower rates of caesarean section and a more positive birth experience. In an Australian study,⁸ individual telephone psycho-education was compared to standard care (usual care by public maternity services). A clinical difference in caesarean section rates was found with significantly fewer women in the study group opting for caesarean section when asked about a future birth.

ICBT is an increasingly popular option for treating psychological disorders. Several RCTs have confirmed the effectiveness of ICBT in treating anxiety and mood disorders. The outcomes are similar to face-to-face treatment.⁹ Guided internet delivered therapy, such as ICBT, combines structured self-help materials via the internet, with an known therapist who provide support, encouragement and therapeutic contact via e-mail.¹⁰ Controlled trials suggest that therapy provided by the internet is effective when a diagnosis is made before the treatment starts, a comprehensive user friendly treatment is provided and there is support and a clear deadline for the duration of the treatment.¹¹

Caesarean section on maternal request is strongly associated with childbirth fear and can affect both women's and the children's health. Thus, it is important to develop treatment methods that can reduce fear and women's request for elective caesarean section. Only a few RCTs with this explicit objective have been performed. There is no evidence for the best treatment of childbirth fear.

The aim of the study was to investigate birth preferences during pregnancy and after birth in women randomised to treatment with ICBT or counselling for childbirth fear. A second goal was to study the birth experience and satisfaction with the allocated treatment.

2. Methods

2.1. Trial design

This study is a two-armed, non-blinded randomised controlled trial with a multi-centre design.

The study is one part of the Uppsala University Psychosocial Care Program (U-CARE)—a governmental funded project using internet-based cognitive therapy for preventing and reducing emotional distress.¹² The program developed an internet platform: the U-CARE portal (www.u-care.se). The portal is used for randomisation, data collection and interventions undertaken

within the U-CARE program.¹² This study was one part of the U-CARE program entitled U-CARE Pregnancy. The trial is registered at ClinicalTrials.gov, ID: NCT02306434.

Ethical approval for the study was obtained from the Regional Ethical Review Board in Uppsala (Dnr: 2013/209).

2.2. Participants

Women in pregnancy week 17–20 with a normal ultrasound screening result, score ≥ 60 on the FOBS—Fear Of Birth Scale indicating childbirth fear were invited to participate. FOBS has been validated within a Swedish and Australian context and showed good internal consistency (Cronbach alpha 0.91), good construct validity and very good known groups validity.¹³ FOBS has also undergone face-validity using think-aloud technic¹⁴ and has been validated against the commonly used instrument W-DEQ.^{13,15} Further inclusion criteria were: mastery of the Swedish language, access to a computer with internet and a mobile phone.

The recruitment was performed during the period of February 2014–February 2015 in three hospitals in Sweden, one university hospital and two regional hospitals with an annual birth rate of 4200, 2600 and 1600 respectively.

The recruitment was done stepwise. Initially, all women who attend their routine ultrasound examination and fulfilled the initial inclusion criteria were asked to fill out the FOBS screening form; 4502 women responded. Of these women, 864 (19.2%) reported childbirth fear, which is defined as a score of ≥ 60 on the FOBS scale.

In the second step, 712 women who were reached by telephone by the research midwives were invited to participate in the study after receiving oral information about the RCT design and the two treatment methods; 258 women consented to participate and were sent a letter with additional information and an informed consent form. After returning the signed consent, the women were given login details to the U-CARE portal. They then completed the baseline questionnaire and were subsequently randomised.

2.3. Interventions

2.3.1. Internet-based cognitive behaviour therapy

Women randomised to ICBT were contacted by one of the two psychologists responsible for the treatment. After the introduction, the participants could access the first treatment module.

The program was based on the three-component theory of emotions as presented by Barlow et al., in the Unified Protocol of Emotional disorders¹⁶ as well as earlier ICBT manuals for anxiety¹⁷ and parts of the third wave of CBT-treatment.¹⁸ The program uses an educative approach where fear is presented as an experience including cognition, behaviour and physical sensations. The participants are taught to identify different aspects of their emotional experience (fear), how to avoid negative emotions and how to use alternative strategies in terms of acceptance, mindfulness and exposure.

There were eight treatment modules in the program exclusively designed for this study that addressed fear. The modules consisted of text material and assignments closely related to the content for each specific module. The participants followed the given order of the modules. When the required assignment was completed for the active module, the psychologist gave the women written feedback via the portal. The next module could then be activated. In addition to this feedback system, women in the intervention group could communicate with their psychologist through the portal at any time for support.

2.3.2. Standard care

All Swedish obstetric clinics offer face-to-face counselling by experienced midwives to women with childbirth fear.¹⁹ According

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