Preparing Expectant Couples for New-Parent Experiences: A Comparison of Two Models of Antenatal Education

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Abstract

This paper describes a pilot antenatal education program intended to better prepare couples for the early weeks of lifestyle changes and parenting. Eight weeks after birth, data were collected by questionnaire from 19 couples who participated in a pilot program and from 14 couples who were enrolled in a routine hospital program. Women in the pilot program were significantly more satisfied with their experience of parenthood. Facilitated gender-specific discussion groups formed a key strategy in the pilot program.

Journal of Perinatal Education, 11(3), 20–27; parenting education, childbirth education, adult education, transition to parenthood.

Introduction

In Australia, approximately 80% of first-time parents attend antenatal/childbirth and parenting education courses (New South Wales Standing Committee on Social Issues, 1998). In the past, the emphasis in antenatal education programs was on preparing women for labor and birth. More recently, programs have incorporated information on infant care and parenting. However, a great variety exists in the approach to antenatal education, with little evaluation of the programs. Where evaluation of childbirth education has occurred, the focus tends to be on labor and birth outcomes.

Review of Literature

Some studies identify positive outcomes of childbirth education, such as an increase in women's knowledge

of labor and birth and a reduced use of medicated pain relief (Hetherington, 1990; Hillier and Slade, 1989; Ledgerman, 1996). Others note a small amount of evidence exists to associate attendance at antenatal programs with a reduction in psychological distress or increased satisfaction with the experience of labor (Nolan, 1997; Spiby, Henderson, Slade, Escott, & Fraser, 1999). Starrock and Johnson (1990) and Nichols (1995) demonstrated no relationship between program attendance and birth outcomes. In addition, Nichols (1995) found no differences between attenders and nonattenders in a parent's sense of competence or ease of transition to parenthood. Two Australian studies (Lumley & Brown, 1993; Redman, Oak, Booth, Jensen, & Saxton, 1991) indicated that, although satisfaction with the programs was high, attendance made no difference to birth outcomes, satisfaction with care, or later emotional well-being of primiparae.

Given these equivocal findings, the value of antenatal education programs has been challenged (Cliff & Deery, 1997; Enkin, 1990; Nolan, 1997; Parr, 1998). A review of parenting education services in New South Wales (NSW Standing Committee on Social Issues, 1998) provided support for antenatal parenting education, but continued to raise concerns about the structure, process, and content of programs. Together with other empirical research (Cliff & Deery, 1997; Freda, Andersen, Damus, & Merkatz, 1993; O'Meara, 1993), this report criticizes programs that continue to present information in a didactic manner (sometimes to large groups) and, thus, do not address the learning needs identified by participants. Male participants of programs have reported a lack of involvement and recognition in groups, often only attending out of duty to their partners (Hallgren, Kihlgren, Forslin, & Norberg, 1999; Russell, James, & Watson, 1988; Smith, 1999). Studies investigating the experience of new parents have found that courses do not prepare women or men for the emotional and psychological aspects of parenthood (Barclay, Donovan, & Genovese, 1996; Brown, Lumley, Small, & Astbury, 1994; Donovan, 1995; Parr, 1998). In spite of the rhetoric that, during pregnancy, women and men are preoccupied only with birth, Parr (1998) reports that couples are in fact more concerned about emotional and relationship issues than practical issues of childbirth and infant care.

With these issues in mind, the midwife/parenting educators at a Sydney metropolitan hospital developed,

implemented, and evaluated a pilot antenatal education program. This paper describes the pilot program and reports on the evaluation, which consisted of a comparison of the outcomes of the pilot program and the routine antenatal education program conducted at the hospital.

The Antenatal Education Programs

Purpose

The purpose of the pilot model of antenatal education was to better prepare women and men for the early weeks of parenting, particularly in relation to the changes in lifestyle, their relationship, and the work of infant care. The belief was that if women and men were better prepared for this experience, they would be more satisfied as parents eight weeks after birth.

The purpose of the pilot was to better prepare women and men for the early weeks of parenting.

Method—Structure, Content, and Process of Program

The routine antenatal education programs conducted at the hospital comprised two early pregnancy sessions around 18-20 weeks gestation, followed by a further six sessions commencing at approximately 28 weeks gestation. Most sessions were mainly didactic and conducted by a midwife for the first hour and a half, followed by a physiotherapist for the last hour. A midwife facilitated the first and last sessions. The midwife and physiotherapist jointly conducted the fourth week of the later pregnancy session. The first two early pregnancy sessions focused on health during pregnancy, the next four sessions focused on birth, and the last two sessions included discussions on parenting and postnatal issues. Groups consisted of 12-15 couples (see Table 1).

The pilot program focused on parenting skills and relationship issues, as well as preparation for birth. Strategies employed in this program were guided by adult learning principles (Knowles, 1984; Nolan, 1997) that emphasize the need for learners to identify their needs and to share and extend their own knowledge and experi-

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Table 1 Process and Content Comparison of Classes

	Routine Class	Pilot Course
Timing of Sessions	<ul style="list-style-type: none">• 2 second trimester sessions• 6 third trimester sessions	<ul style="list-style-type: none">• 2 early second trimester sessions• 2 late second/early third trimester sessions• 2 third trimester classes
Teacher Background	Midwife and physiotherapist	Midwife assisted by male small group facilitator
Approach	Primarily didactic	Adult learning principles
Size	12–15 couples	6–8 couples
Content	<ul style="list-style-type: none">• 2 early sessions on health during pregnancy• 4 sessions on birth• 2 sessions on parenting and postnatal issues	<ul style="list-style-type: none">• 2 early sessions on pregnancy and relationships• 2 mid-sessions on parenting issues and life changes• 2 later classes on birth• 1 agenda-specific discussion session in each set of 2 sessions
Time of Recruitment	Those who called to book classes during second trimester	Invitations to those who called to book classes during the first trimester
Sponsor and/or Funder	Public Hospital Funding—maternity budget	Public Hospital Funding—maternity budget

ences. The pilot program spanned six weeks with two consecutive weeks conducted in early second trimester focusing on pregnancy and relationships. Following a break of approximately six weeks, participants attended sessions for another two consecutive weeks to discuss parenting issues and life changes. They attended again at 30–34 weeks gestation for two consecutive sessions to talk about birth. Groups consisted of 6–8 couples.

A key strategy in the pilot program was providing gender-specific discussion groups that were led separately by female and male facilitators. These groups were conducted three times, one in each segment of the course, and encouraged couples to explore personal issues as individuals, separate from their partners. Kitzinger (1992) and Cliff and Deery (1997) highlight the benefits of providing women with the opportunity to share their hopes and fears with other women in the same situation. Russell and colleagues (1988) also suggest men benefit from separate gender groups. It was considered important that facilitators of the same gender be used so the

participants felt comfortable and relaxed, also providing the opportunity for role modeling (Barclay et al., 1996). The emphasis on adult education principles, parenting, and relationship and lifestyle issues meant that the pilot differed in process and content from the routine antenatal program.

Participants

A convenience sample of 59 first-time parents participated in this evaluation. Twenty-one couples and two unpartnered women participated in the pilot program; 30 couples participating in the routine hospital antenatal education program formed the comparison group. Over a two-month period, all women who had booked into the hospital during the first trimester of pregnancy and who were expecting their first baby were contacted by telephone and asked whether or not they and their partners intended to participate in antenatal classes conducted by the hospital. If so, they were asked to participate in the pilot program and the evaluation. A total of 32 first-time parents were invited to attend the pilot program; 29 couples initially agreed. The comparison group of 30 couples was recruited in the second trimester of pregnancy when they booked into the routine antenatal program.

Ethics approval was obtained from the Ethics Com-

A key strategy in the pilot program was providing gender-specific discussion groups.

mittee of the Area Health Service. Written consent to participate was obtained from both men and women during the first session of the program.

Data Collection and Instruments

Participation involved attendance at all sessions of the antenatal program and completion of a mailed questionnaire at eight weeks postpartum. The questions were the same for women and men, except for the wording of questions that measured birth satisfaction. The postnatal questionnaire collected demographic data, data relating to the type of labor and birth the women experienced, and the use of intervention during labor and birth. Questions similar to those used by Brown et al. (1994) measured satisfaction with the management of labor and birth, the experience of pain, and whether or not they

were given an active say in decision-making during labor. A sample of questions is provided in Table 2.

Participants' satisfaction with parenting was measured using two constructs ("Evaluation" and "Life Change") from the scale, "What Being the Parent of a New Infant is Like—Revised" (WPL-R) (Pridham & Chang, 1989). "Evaluation" comprised 11 items measuring satisfaction in being the parent of a new infant, how well the parent knows the infant, and the extent to which expectations of self as a parent are being met. This subscale has alpha coefficients of .87, .90, and .87 at one week, one month, and three months postpartum, respectively (Pridham & Chang, 1989). The second construct, "Life Change," comprised six items addressing change in a parent's personal life and relationships. This subscale has alpha coefficients of .77, .81, and .81 at one week, one month, and three months postpartum, respectively

Table 2 Sample of Questions Used in the Pilot Program

<p>A. Sample Questions Relating to Labor and Delivery</p> <ol style="list-style-type: none"> 1. My labor was induced. <ul style="list-style-type: none"> • Yes • No 2. My labor was . . . <ul style="list-style-type: none"> • Less than two hours • Between 2–12 hours • Greater than 12 hours 3. My baby was born by . . . <ul style="list-style-type: none"> • Vaginal delivery • Forceps delivery • Emergency cesarean section • Elective cesarean section 4. The midwife/doctor performed an episiotomy <ul style="list-style-type: none"> • Yes • No 5. Medical management of pain: <ul style="list-style-type: none"> • None • Nitrous oxide (gas) • Injection of pethidine • Epidural • General anesthesia 6. The pain relief I received during labor was . . . <ul style="list-style-type: none"> • Very successful • Partly successful • Not at all successful 7. My experience of pain during labor was . . . <ul style="list-style-type: none"> • As expected • Better than expected • Worse than expected • Much worse than expected 	<ol style="list-style-type: none"> 8. Do you feel you were given an active say in making decisions about what happened during your labor? <ul style="list-style-type: none"> • Yes, in all cases • Yes, in most cases • Only sometimes • No, not at all • Uncertain 9. Overall, do you feel your labor and delivery were . . . <ul style="list-style-type: none"> • Managed as you liked • Managed as you liked in some ways and not in others • Not managed as you liked <p>B. The following are a sample of six items from the "Evaluation" and "Life Change" subscales described by Pridham and Chang (1989). Responses were indicated on a 9–point Likert scale with 1 being <i>not at all or very little</i> and 10 being <i>great deal, all of the time, completely satisfying</i>.</p> <ol style="list-style-type: none"> 1. How satisfying has being the parent of a new baby been for you? 2. How much has your life changed since you had your baby? 3. How much do you think that you positively affect your baby's development? 4. How much have the tasks of taking care of a new baby been satisfying to you? 5. On the whole, how stressful is your life, being the parent of a young baby and perhaps having other things to deal with? 6. How much has the baby's growth and development been a source of satisfaction for you? 7. How much has your life changed with members of your family? 8. How much do you feel that having a baby affects what you do and when?
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(Pridham & Chang, 1989). All items were rated on a 9-point Likert scale. See Table 2 for examples.

Analysis

Data were analyzed using descriptive statistics, and chi-square and t-tests were used to evaluate the differences between those who participated in the two programs. Additional information about women and men's experiences in the first eight weeks was gathered from written comments in the postnatal questionnaire. These data were analyzed using content analysis. The first and second authors undertook the categorizing of qualitative data with 90% agreement on all items coded.

Results

Of the 29 couples who initially agreed to participate in the pilot program, six couples did not attend and a further two women were unpartnered and were not included in the analysis, leaving data from 21 couples. All 30 couples in the routine program attended the series of eight sessions. Nineteen women and 18 men in the pilot program returned the postnatal questionnaire—a response rate of 83% and 86%, respectively. In the routine group, 14 women and 14 men returned the questionnaire—a response rate of 47%.

Of those couples completing the study, no significant differences existed between groups on any demographic variable. The average age of all women was 28.9 years (range 21–40 years, $SD = 4$). Table 3 outlines education

and occupations among the women. Prior to the birth, the majority (73%, $n = 24$) of the women were in full-time employment. Australia was the country of birth for 76% ($n = 25$) of the women and 75% ($n = 24$) of the men. The average age of the men was 31 years (range 25–46 years, $SD = 4$ years). Education levels and occupations of the men are also outlined in Table 3. All of the men were engaged in full-time employment.

No significant difference was found in the type of antenatal care chosen by the two groups. When both groups were combined, 21% received all or some of their care at a birth centre, 52% received care through the antenatal clinic sometimes in conjunction with a general practitioner, and 27% had private obstetric care.

At the time of reply to the questionnaire, the average age of the baby was 10.5 weeks ($SD = 3.3$). No significant differences existed between the groups in regard to place of birth or mode of delivery. In total, 67% ($n = 23$) delivered in the delivery suite, 18% ($n = 5$) in the birth centre, and 15% ($n = 5$) had a cesarean section.

Significantly more women in the pilot program (84%) compared to those in the routine program (43%) indicated that their labor and birth was “managed as . . . [they] liked” ($\chi^2 = 5.4, p < .05$). No significant difference existed between groups in regard to women's experience of pain and the type of pain relief used during labor.

Analysis of the WPL-R revealed that women participating in the pilot program were significantly more likely to evaluate their parenting experience more positively than women in the routine program ($x = 89.4$ and 83.6 , respectively; $t(31) = 2.06, p < .05$). A similar trend was

Table 3 Level of Education and Occupational Status for all Women and Men in the Study

Education	Women $n = 33$	Men $n = 32$
Lower Secondary	12%	3%
Upper Secondary	18%	19%
Trade Certificate	9%	39%
Tertiary	61%	39%
Occupation	Women	Men
Home Duties	6%	0%
Trade/Unskilled	0%	3%
Trade/Skilled	3%	31%
Clerical	41%	13%
Technical	3%	6%
Professional	47%	47%

found in the men's evaluation of parenthood (see Table 4), although the difference was not statistically significant. No significant difference was found between the men or the women in the pilot and routine groups to their adjustment to life changes (see Table 4).

Most women and men from both programs indicated on the WPL-R that they were highly satisfied with their experience of parenting (mean > 8, see Table 4). However the open-ended questions elicited ambivalent responses. Eighty percent of women and one-third of the men from both programs found parenting demanding. They identified the following new-parent experiences as the most challenging or frustrating: lack of sleep, difficulty with breastfeeding and settling techniques, and changes in their relationship. Two-thirds of the men from both groups commented that their life had not changed much. None of the women expressed this sentiment.

New-parent experiences as challenging or frustrating: lack of sleep, difficulty with breastfeeding and settling techniques, and changes in their relationship.

The content analysis of the open-ended responses to the questionnaire indicated that 70% of the women and 85% of the men in the pilot program stated they were as prepared as they could have been for the early weeks of parenting, in contrast to only 25% of the women and 40% of the men in the routine group.

Men and women in the pilot program also commented that one of the most helpful aspects of the program was the support received from other participants. The gender-

specific group discussions were appraised positively by both women and men.

Discussion

In implementing and evaluating this pilot model of antenatal education, it was anticipated that both women and men attending the pilot program would be better prepared for the reality of the early weeks of adjusting to lifestyle changes and early parenting experiences. Consequently, they would evaluate their experience of adjusting to parenting more highly and perceive less difficulty with relationships and life changes than those attending the routine programs. The findings demonstrated that the women attending the pilot program rated their early parenting experience slightly more highly (but statistically significant) than those who attended the routine group. According to WPL-R scales by Pridham and Chang (1989), this indicates that these women felt they knew their infant better, were more comfortable in infant care tasks, and perceived themselves more positively as a parent. This higher evaluation of parenting may also impact upon a parent's self-efficacy and parenting ability (Pridham & Chang, 1992).

The scores on the "Evaluation" subscale indicated that, in general, women and men from both programs were satisfied with their experience as a parent in the first 8-10 weeks postpartum. This trend in the statistical analysis, however, was not entirely supported by the open-ended responses in the questionnaire. The women in particular found many aspects of motherhood difficult and distressing and believed they did not receive the support that they needed. These findings are supported by research examining the experience of new mothers (Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997;

Table 4 Statistical Analysis of the WPL-R Scale

	WOMEN						MEN					
	Experimental		Routine		<i>t-value</i>	<i>P</i>	Experimental		Routine		<i>t-value</i>	<i>P</i>
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>			<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>		
WPL-R												
Evaluation of Parenting Experience	89.42	6.59	83.64	9.55	2.06(31)	< .05	83.06	9.00	78.29	8.39	1.53(30)	NS
Life Change	38.00	9.15	37.00	5.52	0.36(31)	NS	37.11	6.44	36.64	6.52	0.20(30)	NS

Brown et al., 1994; Crouch & Manderson, 1993). Importantly, women appeared to evaluate their preparedness for and experience of parenting more highly with satisfaction than the men. This is supported by other work that has examined men's experiences of the early weeks of fatherhood (Jordan, 1990; Lupton & Barclay, 1997).

A significant difference between women in the pilot program and the women in the routine program occurred in relation to their satisfaction with labor management. It is possible that this difference between the women could have influenced their evaluation of parenting or that the varied times of course enrollment represented a relevant difference. It is also possible that the pilot program, incorporating adult education principles, smaller group size, and gender-specific discussion groups, had an impact upon how these women perceived their labor and birth and its management. It is also important to note that this evaluation did not find a significant difference between the women in the two programs in relation to birth intervention and use of pain relief. This is consistent with the many studies that have found birth satisfaction related to perceived control, rather than pain relief. Additionally, no differences were found between participants in relation to the perceived effectiveness of pain relief and perceived involvement in decisions regarding their labor. In the pilot program, approximately five hours were spent on discussing labor and birth, while in the routine program approximately eight hours were spent on preparation for labor and delivery. Similar to other findings (Lumley & Brown, 1993; Nichols, 1995), the reduced number of hours spent in this pilot program on preparation for labor and birth does not appear to have had an impact upon the birth.

Many studies have found birth satisfaction related to perceived control, rather than pain relief.

In presenting the results of this pilot study, the investigators acknowledge a number of limitations. The results of the evaluation may have been compromised by the low response rate to the questionnaires by the routine group. While the response rate in the questionnaire was good in the pilot group, a number of participants re-

cruited to the pilot program did not commence the program and, therefore, were excluded from the results. The small number of participants may also mean that there was insufficient power to demonstrate significant differences. A further limitation of this study is the lack of randomization of participants to groups.

Conclusion

Few studies can be compared with the results of this evaluation. Quasi-experimental studies of the effectiveness of antenatal courses have only compared women and men who attend antenatal courses with those who do not; generally, the dependent variable is obstetric outcomes (Hetherington, 1990; Starrock & Johnson, 1990). Studies that have examined the effect upon parenting outcomes (Lumley & Brown, 1993; Nichols, 1995) have not implemented a new program, but again compared attenders with nonattenders.

Despite the limitations, the significant difference found between groups of women in relation to their evaluation of their parenting experience, and the similar trend noted among the men, should not be overlooked. These findings suggest that, when antenatal education programs are based on adult education principles and employ gender-specific discussion groups that focus on participants' needs, women experience increased satisfaction with their new parenting experiences and are potentially more pleased with their birth experiences. This pilot study provides a basis for a larger, more controlled study.

Women and men described benefits from participating in the gender-specific discussion groups, particularly the greater emphasis on the discussion of relationship issues. Thus, midwives and childbirth/parenting educators are faced with the challenge to become skilled in discussing lifestyle and relationship changes to help couples make a smoother transition to parenthood.

When antenatal education programs are based on adult education principles and employ innovative strategies, women experience increased satisfaction with their birth and new parenting experiences.

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