Received: 24 March 2020 | Revised: 16 November 2020 | Accepted: 17 November 2020

DOI: 10.1111/jep.13523

ORIGINAL PAPER

Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

WILEY

The effect of empathy training given to midwives on the empathic communication skills of midwives and the birth satisfaction of mothers giving birth with the help of these midwives: A quasi-experimental study

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Abstract

Rationale, aims, and objectives: Empathic attitudes and behaviours of midwives directly affect obstetric outcomes. The study aims to examine the effect of empathy training on the empathic communication skills of midwives and the childbirth satisfaction of primiparous mothers.

Methods: This quasi-experimental study has two sample groups including midwives working in the delivery unit (n = 15) and mothers giving birth with the help of these midwives (n = 134). Empathy training was given to the midwives through a 32-hour program involving didactic narrative, creative drama, and psychodrama techniques. A "Descriptive Information Form," and the "Empathic Communication Skills" and "Empathic Tendencies" scales were used to collect data from the midwives, and another "Descriptive Information Form" and the "Scale for Measuring Maternal Satisfaction in Normal Birth" were used for the maternal data.

Results: Empathic communication skills and empathic tendencies of the midwives were found to be higher right after and 8 weeks after the training than before the training (P = .001, P = .040, respectively). The total score and sub-dimensions of the maternal satisfaction scale (ie, midwifery care, respect for privacy, meeting expectations, postpartum care) were found to be higher in mothers giving birth after the midwives' empathy training than those giving birth before (P < .001). A higher level of maternal birth satisfaction was seen in mothers giving birth right after the training (94%) than those giving birth before training (3%).

Conclusion: The empathy training improved both the empathy skills of midwives, and translated to improved maternal satisfaction with birth among their mothers. It is recommended to increase the number of follow-ups to evaluate the long-term effect of empathy training.

KEYWORDS

birth satisfaction, birth unit, empathy, experimental study, midwives, vaginal birth

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1 | INTRODUCTION

Empathy is most commonly defined as the ability to put oneself in someone else's shoes to understand his/her feelings, experiences, concerns, and perspectives along with the ability to express them.[1,2] A good level of empathic skill of a midwife has been shown to prevent occupational burnout, facilitate job satisfaction and understanding others' feelings, increase the sensitivity of helping in the nursing profession,[3,4] strengthen the midwife-mother relationship,[5] provide humanization of childbirth, and prevent excessive medicalization of birth.[6] The emphatic approach also enhances the quality of birth satisfaction through the care, compassion, respect, and presence of the midwife.[3,7,8] A brief definition of "Childbirth satisfaction" is fulfilling the expectations of a woman at birth.[9,10] Mothers whose expectations are unmet by the midwives and who are exposed to their negative attitudes and behaviours have decreased birth satisfaction and increased fear of birth.[7,8]

Several studies investigating the empathic skills of midwives and maternal satisfaction in birth experience suggest that midwives' communication scores are insufficient,[11-13] the mothers are dissatisfied with their birth experience due to their midwives' negative attitudes and behaviours,[14-16] and the level of vaginal birth satisfaction is low.[9,11,17] Mother-friendly hospital practices[18] and childbirth preparation training[19] are some of the practices that aim to improve maternal satisfaction and perception of positive birth at birth. In the literature, it is emphasized that there is a positive relationship between satisfaction with the midwife who assists birth and maternal satisfaction at birth.[8,11,20] Many studies show that qualified midwifery services are effective in reducing medical interventions at birth, coping with labour pain, shortening labour time, starting first breastfeeding, experiencing positive birth, reducing hospital costs, etc.[5,21,22]

There is a paucity in the literature investigating the emphatic skills of midwives working in the birth unit.[11] In previous empathy training programs for midwives and midwifery students, the didactic expression technique was generally used, but no empathy training including both drama and psychodrama techniques to our knowledge has been carried out so far. The number of follow-up studies that monitor the effectiveness of the training after empathy training is also very limited.[23] As far as we have examined the literature, we have yet to come across a study that examines the effect of empathy training given to midwives in terms of both midwives and mothers who are assisted by these midwives.

This study that was planned based on such a need aims to examine the effect of empathy training on the empathic communication skills of midwives and the birth satisfaction of mothers who received care from these midwives. It covers "the first of empathy training program" prepared for midwives working in maternity units in Turkey. Unlike what is reported in the existing literature, the duration of empathy training in this study (32 hours) was longer than many training programs,[13,23-26] and it was based on developing empathy skills in cognitive and affective dimensions using three empathy training techniques (didactic expression, creative drama, and psychodrama) that activate multiple senses such as seeing, hearing, touching, and feeling. Besides, it provides an opportunity to evaluate the clinical services holistically, as "midwives providing care service in a maternity unit, and mothers receiving care from these midwives" are evaluated together. In addition, this study is thought to contribute to the improvement of intrapartum care quality with the empathetic ability of the midwife, and to the policy of WHO to encourage vaginal birth and provide a positive birth experience.[27] With all these features, this study is believed to fill the gap in the literature and to shed light on future studies.

2 | METHODS

2.1 | Design

This quasi-experimental study aims to comparatively examine the effect of empathy training on empathic communication skill score of caregiver midwives. It also endeavours to examine the impact on the birth satisfaction of mothers who receive care from these midwives according to their status of assisting the delivery before and after the empathy training. In this study, there is only one group of midwives working in the maternity unit and two groups of mothers who gave birth before and after the empathy training of midwives.

We first measured the empathic communication skills of each midwife (first stage) and the birth satisfaction of mothers who gave vaginal delivery with the help of these midwives (second stage). Then, we gave 32-hour empathy training to the midwives (third stage). Right after the empathy training, we re-measured the empathic communication skills of midwives (fourth stage). Next, we measured the birth satisfaction of mothers who gave birth with the help of midwives who received empathy training (fifth stage). Finally, we remeasured the empathic skills of the midwives (8 weeks after the empathy training) (sixth stage).

The empathic skills scores of each midwife were measured three times; before the training, right after and 8 weeks after the training, and were evaluated by comparing the mean scores obtained before and immediately after the training. We compared the mean scores of two independent groups, the mothers who gave birth before the empathy training of the midwives and the mothers who gave birth immediately after the training. Below is some descriptive information about the empathy training program (ETP) we provided to midwives. Please see Appendix for the ETP program details (see Appendix).

2.2 | Empathy training program

The entire 32-hour ETP given to midwives actively working in the maternity unit in our study was prepared by the researcher. The ETP consisted of eight sessions each of which lasted 4 hours. Each session has a different goal, such as empathic listening or empathic reaction skills. We performed ETP in the groups divided into a minimum of 3, a maximum of 10 people due to midwives' shift hours. In ETP, we used three techniques together: creative drama, psychodrama, and didactic

narration. As is known, psychodrama and creative drama are among the techniques used to promote empathic skills in the individual.[25,28,29] We used three techniques together and planned the duration of the training as 32 hours at ETP to improve the affective and cognitive empathy of midwives and to increase the effectiveness of empathy training, by activating nurses' multiple senses such as seeing, hearing, touching, and feeling. For example, the mirror technique helped us to hold a mirror to us in recognizing ourselves and others and looking at ourselves from outside; the role switching technique enabled us to understand and feel the feelings and thoughts of that person by embracing the role of someone else, and didactic narrative technique helped to raise awareness about the importance of knowing ourselves and understanding others' feelings and thoughts in maternity services. With the games and techniques we used in psychodrama and creative drama training, such as role-playing, mirroring, matching, role changing, inner voice, we aimed to improve the ability of midwives to understand the emotions and thoughts of that person by taking the role of another person (eg, the role of the giving birth mother).[28]

A researcher in the study made the presentation of creative drama and didactic expression techniques in the ETP program. The researcher had completed creative drama training with professional instructors before starting this study (196 hours in total). In the didactic narrative technique, we theoretically explained the subjects such as self-knowledge, empathy, communication, feelings of mothers at birth with an oral presentation. For the psychodrama techniques in ETP, we purchased a 10-hour of service from a psychologist and psychodramatist who has a psychodrama study in the obstetric field.[29] We completed the empathy, empathic listening, empathetic responsiveness issues using psychodrama techniques.

TABLE 1 Distribution of socio-demographic, vocational and communication characteristics of midwives (N = 15)

Characteristics	Mean ± SD	(Min-Max)
Age	38.40 ± 4.96	27-45
Number of Children	2.13 ± 0.74	1-3
Years of Working Experience	18.53 ± 6.53	5-26
Years of Working Experience in Birth Unit	8.20 ± 6.68	1-19
	Number (n)	**Percent (%)**
Marital Status		
Married	15	100.0
Education		
High School	3	20.0
Associate's Degree	6	40.0
Bachelors' Degree	6	40.0
Working Hours in Birth Unit		
Day Shift Only (between 08:00 AM and 16:00 PM)	1	12.5
Mixed (both day shift or night shift[a])	14	87.5
Having a previous empathy training		
Yes[b]	10	66.7
No	5	33.3
Total	15	100.0

[a]Night shift: Between 16:00 PM and 08:00 AM time.
[b]They received this training as a 1-hour presentation from the institution they worked at.

2.3 | Setting and sample

We carried out the study in the birth unit of a state hospital in the north of Turkey. Fifteen midwives work in this maternity unit, and all of them participated in the study voluntarily. The distribution of socio-demographic, vocational, and communication characteristics of midwives are given in Table 1.

The population of the study also consisted of all the mothers who gave birth vaginally while assisted by the participant midwives during the study period. Based on the power analysis of the sample, two independent groups with a 95% confidence interval, alpha $P = .05$, 80% power, and medium effect size were created for independent samples *t*-test. A total of 134 primiparous women were included in the sample; 67 of them gave birth before midwives' empathy training (BMET), and 67 gave birth right after the empathy training (RAMET).

Inclusion criteria were to be a volunteer to participate in the study, to be a primary school graduate, to be primiparous, to be in the 38th to 41st gestational week, to have a normal or low-risk pregnancy, to have a single fetus, to be in the latent phase of the first stage of birth (cervical dilation between 1 and 3 cm), to have a vaginal birth with the help of a midwife, and to have a living newborn. In the pilot study, it was determined that intravenous synthetic oxytocin and an episiotomy were applied to nearly all the primiparous mothers. Therefore, all the primiparous mothers within the scope of the study were applied at least 1 hour of induction and episiotomy. It was ensured that women were assisted by the same midwife/midwives during labour and childbirth.

Those who gave birth with physicians, and had a known psychiatric condition were not included in the study, so the data of 37 mothers were excluded (Figure 1). We also excluded the mothers who gave birth during the midwives' empathy training (2 months) from the study. The duration of data collection was extended until 67 mothers were reached in power analysis. The primiparous mothers were included in the study because nulliparous mothers need more empathetic midwifery care in the birth process depending on the lack of birth experience[7,12] and the primary caesarean birth rate is high in Turkey (53%).[30]

2.4 | Data collection

We collected the data for this study using three forms for midwives and two forms for mothers. The forms for the midwives are described below.

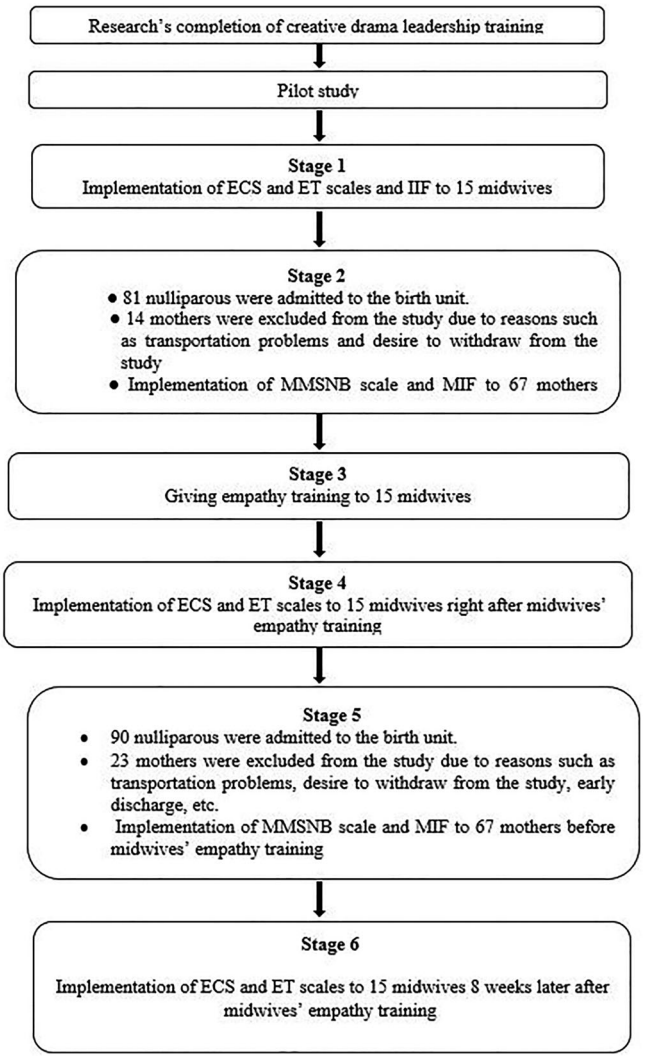


FIGURE 1 Flowchart of the study

2.4.1 | The descriptive information form (DIF)

Created by the researchers after reviewing the relevant literature,[1,11,21] the form consists of 12 questions about socio-demographic, vocational, and empathic skills data on midwives.

2.4.2 | The empathic communication skill scale (ECSS)

Developed by Dökmen (1988) in Turkey, the ECSS measures affective and cognitive components of empathy with verbal response dimensions of communication using the repeated measure test approach. The stages of empathy development in Dökmen's classification are "You, I, and they." "You" step is the highest quality step of empathic response, which includes understanding what the other person (you) thinks and feels regarding your problem. This step involves understanding and feeling the other person cognitively and emotionally. The "I" level is a medium-quality level of empathic response. It shows what you are thinking and feeling in the face of the other person's problem. The "they" step is the least empathic response. The person using this step evaluates the problem according to the values of society.[31] The scale has been shown to be valid and reliable (REF). The lowest and highest scores to be obtained in the ECSS are 62 and 219, respectively. Higher scores refer to higher levels of empathic communication skills.[31]

2.4.3 | The empathic tendency scale (ETS)

Created by Dökmen in 1988, the ETS is a 20-item self-report scale including a 5-point Likert-type design that measures the potential of an individual to establish empathic relationships in daily life. This scale has also been shown to be reliable and valid (against the Edwards Personal Preference Schedule Intraception subscale) Empathic tendency scores in the scale range between 20 and 100. Higher scores indicate higher empathic tendencies.[31]

We collected the data of the mothers with the following two forms.

2.4.4 | The descriptive information form (DIF)

The form was prepared by the researchers using the relevant literature. It consists of questions about socio-demographic and obstetric characteristics of mothers and medical interventions at birth.[7,11,23,26]

2.4.5 | The scale for measuring maternal satisfaction in normal birth (MMSNB)

The MMSNB, developed by Güngör and Beji (2012), consists of 43 items and 10 subscales (perception of health professionals, midwifery care, comforting, etc.) (Table 4). The total raw score is between 43 and 215. As the total score obtained from the scale increases, the birth satisfaction levels of mothers in normal birth increase. The Cronbach's α coefficient is 0.91 for the total mean score and 0.67 to 0.89 for the subscales.[9] The maternal data in the study were collected in their rooms between 20 and 24 hours after birth when the mother felt most comfortable in terms of breastfeeding, sleeping, etc., before leaving the hospital.

2.5 | ETHICS STATEMENT

To conduct the research, ethical committee approval and the institutional permission were obtained from the state hospital where the study was carried out (No: 5.1./23/2012.). The midwives and mothers were informed about the purpose of the research and the way it would be conducted before data collection, and they all gave their oral and written consent prior to their inclusion in the study.

TABLE 2 Comparison of empathic communication skill and empathic tendency mean scores according to when midwives' received empathy training (N = 15)

	The training period of midwives'		The Training period of midwives'	
	Before MET[a] pretest	Right after MET[a] post test	Right after MET[a] post test	8 weeks later after METa follow test
Scales	Mean ± SD[b]	Mean ± SD[b]	Mean ± SD[b]	Mean ± SD[b]
Empathic Communication Skill	133.88 ± 16.24 (min:119-max:168)	184.80 ± 18.43 (min:143-max:205)	184.80 ± 18.43 (min:143-max:205)	175.00 ± 20.81 (min:136-max:204)
Test and *P* value	Wilcoxon = −3.416 *P* = .001		Wilcoxon = −2.358 *P* = .018[c]	
Empathic Tendency	73.06 ± 4.33 (min:69-max:81)	77.00 ± 7.72 (min:65-max:98)	77.00 ± 7.72 (min:65-max:98)	76.66 ± 5.23 (min:73-max:90)
Test and *P* value	Wilcoxon = −2.049 *P* = .040[c]		Wilcoxon = −.028 *P* = .977	

[a]MET: Midwives' Empathy Training.
[b]SD: Standard Deviation.
[c]P < .05.

2.6 | Data analysis

The data analysis was performed using the Statistical Package for the Social Sciences (SPSS) package 21. For each numeric variable, the mean, maximum, minimum, median, and SD were calculated. Categorical variables were described in terms of absolute (n) or relative frequencies (%). The data were evaluated in terms of normality, extreme value after they had been entered into the database. All analyses were performed at a 95% confidence interval, and $P < .05$ was accepted as statistically significant.

The primary outcome of our study was the change in empathy skill scores of midwives. In this study, the ECS and ET scores of midwives were compared in two groups; before and after training; and right after training and 8 weeks after training. In the statistical evaluation, the Wilcoxon test was applied because the number of midwives was 15.[31]

The secondary outcome of the study was the satisfaction scores of the mothers who gave birth before and after the empathy training of midwives. Prior to the statistical analysis, whether the MMSNB mean scores of the mothers complied with the normal distribution or not was assessed using the Kolmogorov-Smirnov analysis. The data were not appropriate for the normal distribution. The MMSNB total and subdimension mean scores of the mothers were found by comparing two independent groups as mothers giving birth BMET and RAMET. Since maternal data did not show normal distribution, the statistical comparison was performed with the Mann Whitney *U* test. Besides, the Chi-square test was used for the comparisons of the socio-demographic (age, education, etc.) and obstetric characteristics (such as the use of analgesia) of mothers in two independent groups.[32]

3 | RESULTS

The results are presented in two groups in the study: results for the midwives and mothers.

3.1 | Results for the midwives

The mean ECS and ET scores of the midwives increased right after the training compared to before training ($P = .010$, $P = .040$, respectively). The mean ECS score decreased 8 weeks after the training compared to that right after the training ($P = .018$), and no statistically significant difference was found in the ET mean score ($P = .997$) (Table 2).

3.2 | Results for the mothers

In the study, the results for the mothers were evaluated in two independent groups: the mothers giving birth before midwives' empathy training (BMET) and right after empathy training (RAMET). The distribution of mothers was homogeneous between the groups in terms of socio-demographic and obstetric characteristics such as age, education, occupation, family type, place of residence, amount of prenatal care, number of caregiver midwives, analgesia applied during labour ($P = .360, .614, .411, .848, .351, .338, .120, .119$ respectively). Most of the mothers in both groups were housewives, middle school/high school graduates, had a nuclear family structure and had planned pregnancies (n = 133) (Table 3).

The total mean score and the mean scores for all 10 subscales of MMSNB of the mothers giving birth RAMET was determined to be higher than those giving birth BMET ($P < .001$) (Table 4).

The comparison according to the cut-off score for the MMSNB in two groups revealed a high level of maternal satisfaction in those giving birth right after midwives' training (94%) than those giving birth training (3%) (Figure 2).

4 | DISCUSSION

In this study, after the empathy training given to midwives, the mean empathic skill score of midwives and the mean maternal satisfaction

TABLE 3 Comparison of socio-demographic and obstetric characteristics of mothers giving birth before and after midwives empathy training (N = 134)

Mother's characteristics	Mothers giving birth BMET[a] (n = 67)		Mothers giving birth RAMET[b] (n = 67)		Test and *P* value
	n	%	n	%	
Age					
19 ≤	12	17.9	7	10.4	χ = 2.043[c] *P* = .360[e]
20-29	45	67.2	52	77.7	
30 ≤	10	14.9	8	11.9	
Educational level					
Primary school	17	25.4	16	23.9	χ^2 = 1.803[c] *P* = .614[e]
Secondary school	24	35.8	18	26.9	
High school	18	26.9	24	35.8	
University	8	12.9	9	14.4	
Employment status					
House wife	61	91.0	58	86.6	χ^2 = 0.676[c] *P* = .411[e]
Employed	6	9.0	9	13.4	
Family size					
Nuclear family	47	70.9	49	73.1	χ^2 = 0.701[c] *P* = .848[e]
Extended family	20	29.1	18	26.9	
Place of residence					
Village	10	14.9	6	9.0	χ^2 = 1.214[c] *P* = .542[e]
Country	21	31.3	24	35.8	
City centre	36	53.8	37	55.2	
Income perception					
Bad[d]	4	6.0	1	2.7	χ^2 = 2.094[c] *P* = .351[e]
Medium	57	85.0	58	86.4	
Good	6	9.0	8	10.9	
Pregnancy status[d]					
Planned	66	98.5	67	100.0	- -
Unplanned	1	1.5	-	-	
Analgesia administration during labour					
Applied	22	32.8	14	20.9	χ^2 = 2.431[c] *P* = .119[e]
Not applied	45	67.2	53	79.1	
The number of midwives assisting during labour					
One	11	16.4	16	23.4	χ^2 = 4.236[c] *P* = .120[e]
Two	45	67.2	47	70.6	
Three	11	16.4	4	6.0	
Total	67	100.0	67	100.0	

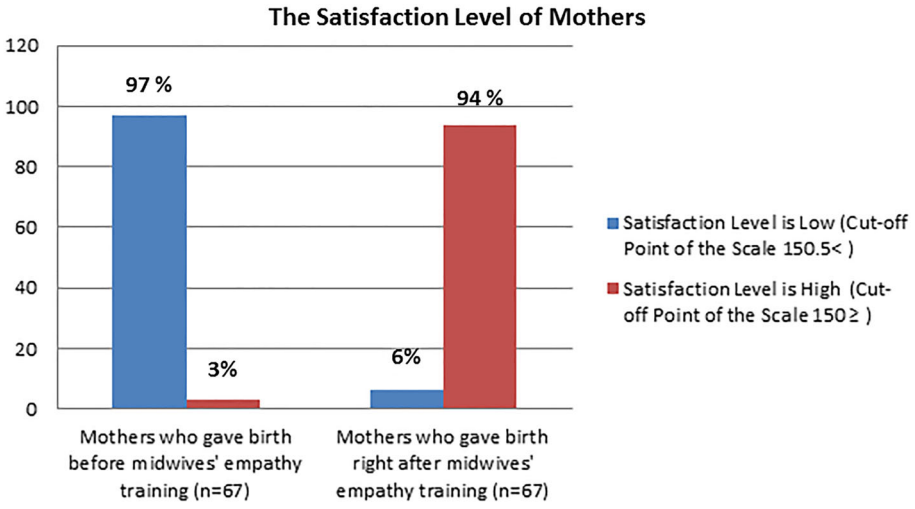
[a]BMET: Before Midwives' Empathy Training.
[b]RAMET: Right after Midwives' Empathy Training.
[c]Chi Square test.
[d]The statistical evaluation was not done.
[e]p>.05.

TABLE 4 Comparison of maternal satisfaction mean scores of mothers giving birth before and after midwives' empathy training (N = 134)

Subscale of MMSNB[a]	The mothers giving birth BMET[b] (n = 67)			The mothers giving birth RAMET[c] (n = 67)			Test and *P* value	
	Min-Max	Mean ± SD[d]	Median	Min-Max	Mean ± SD[d]	Median	MU[e]	*P*[f]
Perception of health professionals	6-20	12.52 ± 3.25	12.00	10-20	18.17 ± 2.20	19.00	362.000	.000
Nursing/midwifery care in labour	2-10	5.74 ± 5.62	4.00	4-10	8.92 ± 1.55	9.00	456.000	.000
Comforting	4-17	10.29 ± 3.68	10.00	5-20	17.86 ± 3.27	19.00	286.000	.000
Information and involvement in decision making	8-36	14.49 ± 4.83	13.00	14-39	30.01 ± 4.99	31.00	141.000	.000
Meeting baby	3-15	10.79 ± 3.48	11.00	3-15	14.29 ± 1.78	15.00	709.000	.000
Postpartum care	7-25	16.22 ± 4.12	16.00	18-30	25.82 ± 3.84	26.00	244.000	.000
Hospital room	5-20	12.08 ± 3.66	12.00	10-20	18.47 ± 2.30	19.00	341.000	.000
Respect for privacy	8-20	14.95 ± 2.32	15.00	2-20	18.92 ± 1.77	20.00	379.000	.000
Meeting expectations	5-23	11.74 ± 3.93	12.00	12-25	20.61 ± 3.30	22.00	241.000	.000
Hospital facilities	3-12	7.56 ± 2.01	7.00	5-15	11.89 ± 1.88	12.00	295.000	.000
Total score for MMSNB	67-164	116.43 ± 21.62	116.00	134-207	185.01 ± 16.54	189.00	65.000	.000

[f]$P < .001$.
[a]MMSNB: Mother Maternal Satisfaction at Normal Birth.
[b]BMET: Before Midwives' Empathy Training.
[c]RAMET: Right after Midwives' Empathy Training.
[d]SD: Standard Deviation.
[e]MU: Mann Whitney U Test.

FIGURE 2 The level of maternal satisfaction



score at the birth of mothers who gave vaginal delivery with the help of these midwives increased compared to those before the training. In the literature, no study to our knowledge has examined the effect of empathy training given to midwives working in the birth unit on their empathic skills and maternal satisfaction at birth.

4.1 | Midwives' empathic skills

In this study, after the empathy training, the mean ECS and ET scores of the midwives increased compared to those before training ($P < .05$). The studies with nurses by Kahriman et al (2016)[25] and Ançel (2006)[24] showed that the empathic skill score increased after empathy training. The finding of the study is consistent with the literature. On the other hand, in the 2-day and 8-hour empathy training given to midwifery students by Alhassan (2019)[13] and by Tafazoli et al (2018)[23] respectively, no change was found in the empathic skills of these students after the training. It is thought that this difference may be due to different training techniques, duration of education, socio-demographic and professional characteristics of trainees, measurement tools, etc.

In our study, a 38% increase was seen in empathic skill score right after the 32-hour midwives' empathy training (Percentage increase formula ECS: right after training score-pre-training score/pre-training

score ×100, Table 2). Çalım and Saruhan (2019)[11] found that a total of 13.5 hours of interpersonal communication training for midwives working in the maternity unit increased empathic communication skill score of midwives after the training by 22%. It is thought that the reason why the increase in the empathic skill score of midwives in our study was higher than the study mentioned above and other studies in which the same scale was used may be due to the positive effect of the "combined use" of three techniques (didactic narration, psychodrama, and creative drama) in empathy education and the duration of the training which was 12 to 20 longer than the other relevant studies.

One of the significant features of the empathy training of midwives in this study is the re-evaluation of the empathic skills of midwives 8 weeks after the training. Eight weeks after the training, a decrease was detected in the mean ECS and ET scores of midwives compared to those right after the training. While the decrease between the ECS mean score was statistically significant, the decrease in the ET mean scores was not found to be statistically significant. Like our study, Kahriman et al (2016)[25] and Çalım and Saruhan (2019)[11] reported no change in ET scores of nurses and midwives after the empathy and communication training. Ronsmans et al (2001) found that interpersonal communication and counselling skills of midwives gradually decreased 3 and 16 months after the training.[33] These outcomes of the studies reveal that the empathic tendency does not change easily, and the effect of the training decreases over time. Therefore, this training should be repeated at regular intervals to ensure the behavioural change in midwives.

On the other hand, it should not be forgotten that the high empathic skills of midwives and other personnel may lead to compassion fatigue, secondary stress and compassion fatigue over time.[34,35] Çankaya et al (2020)[36] argued that the high empathic approach of some midwives who witnessed traumatic births caused secondary trauma. Therefore, the psychosocial health of midwives with high empathic skills should be protected.

4.2 | Maternal satisfaction at birth

In this study, the total score of the maternal satisfaction scale at normal birth (MNSNB), the mean score of 10 sub-dimensions of the MNSNB scale (respect for privacy, comforting, etc.), the level of maternal satisfaction at birth in the mothers giving birth RAMET were found to be "higher" than those giving birth BMET. Similarly, in the study of Çalım and Saruhan (2019),[11] the total score of the maternal satisfaction scale at normal birth (MNSNB) and the mean score of eight sub-dimensions of the MNSNB scale of primiparous mothers who gave birth with the help of midwives after "interpersonal communication training" given to midwives working in the maternity unit were higher than those who gave birth before midwife empathy training. In parallel with this finding of our study, some studies in the literature suggested that the birth experiences of the mothers who received emotional support and continuous care from their midwives and who evaluated their interpersonal relationship with midwives as positive also had the positive birth experience.[5,10,20-22,37] On the other hand, unlike the study of Çalım and Saruhan, the total mean score increase of the MNSNB scale, the rate of maternal satisfaction being at a "high" level, the increase in "hospital room and hospital facilities" sub-dimensions of the MNSNB scale scores for mothers who gave birth after midwives' empathy training were found to be higher than those who gave birth before training in our study.

Although not statistically significant (P = .119), the use of analgesia in the intrapartum period was also found to be lower in RAMET mothers than BMET mothers in this study. These findings of our study suggest that the 32-hour empathy training given to midwives with multiple methods may have contributed to the increase in the empathic communication skill score in midwives and thus to the increase of the maternal satisfaction score at birth through increased quality of midwifery care. It is thought that the reasons for the increase in the quality of midwifery care are the provision of self-information to nurses, the increase of interpersonal communication skills of midwives, the decrease in analgesia needs of mothers as midwives understand their emotions by adopting their maternal role and relax them, meeting the expectations of mothers, and contributing to the mothers' positive perception of the hospital room and hospital facilities.[5,10,21,37,38] On the other hand, another point that should be taken into account in the evaluation of maternal satisfaction at birth is the socio-demographic characteristics of midwives and mothers, and the infrastructure facilities of the centre where the birth takes place.[10,11,39]

4.3 | Limitations of the study

The limitations of the study are as follows; follow-up study was only performed for the midwives, not for the mothers because the hospital was located far from the city centre, and only primiparous mothers who gave birth with a midwife were included in the study. Therefore, whether the perceptions of birth satisfaction of the mothers in the study within the first 24 hours after birth will change in the later periods after birth is unknown. The study was carried out at a single centre, which may limit generalizability of results.

5 | CONCLUSION

The results of this study should be evaluated from two different perspectives: midwives and mothers giving birth with the help of these midwives. Empathy training given to midwives has an impact on increasing their empathic skills score, and the birth satisfaction score of the mothers assisted by these midwives with improved empathic skills increased (in terms of midwifery care, respect for privacy, meeting expectations, comforting, etc.). In line with the results of the study, midwife participation in ETP may translate to improved quality of care for mothers cared for by a midwife. For a long-term behavioural change in midwives, ETP may need to be repeated at regular intervals and updated with multi-education techniques. Besides, further studies should be performed with a larger population, with multiparous mothers using mixed-method and follow-up studies.

ACKNOWLEDGEMENTS

This study is a PhD thesis. We would like to thank the midwives and mothers who shared their time and experiences with us by participating in our research, hospital administrators who allowed us to make interview with the mothers. The project has also some other research outcomes conducted for different purpose apart from this one. This study was financially supported by Scientific and Technological Research Council of Turkey, TÜBİTAK as project with number 113S672.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTIONS

Songül Aktaş and Türkan Pasinlioğlu: Study conception, Songül Aktaş: Creation and application of empathy training program Songül Aktaş: Data collection, Songül Aktaş and Türkan Pasinlioğlu: Study design, Songül Aktaş and Türkan Pasinlioğlu: Data analysis, drafting the manuscript, Songül Aktaş and Türkan Pasinlioğlu: Critical revisions for intellectual content, supervision.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions: The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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How to cite this article: Aktas S, Pasinlioğlu T. The effect of empathy training given to midwives on the empathic communication skills of midwives and the birth satisfaction of mothers giving birth with the help of these midwives: A quasi-experimental study. *J Eval Clin Pract*. 2020;1–10. https://doi.org/10.1111/jep.13523

APPENDIX: AN ETP SESSION EXAMPLE (4 HOURS)

Objectives

Effective Listening and Improving Empathic Response Skills.

Subjects

- Developing effective empathy
- Types of Listening
- Effective Listening Skills

Listening using acceptance techniques.
Listening using communication-maintaining techniques.
To share your personal feelings by establishing eye contact when there is nothing left to say during your listening (on condition that not being long)

- Inactive Empathic Response Steps
- Providing Information About Empathic Response Steps

They, I and You step.
They Step.
Approach that Asserts Others People's Thoughts.
(eg, What do people around me say if I cannot give vaginal birth?)
I Step.
Negative Criticism/Judgement Approach.
(eg, You behave like a child)
Giving Advice Approach.
(eg, When you have pain, do not shout!)
Diagnosing Behaviours Approach.
(eg, You worry too much about pushing)
Asking Questions/ Examining Approach.
(eg, Why do not you apply the pushing techniques that I showed you?)
Saying that I also have that/Talking about Your Problem.
(eg, I have also experienced many problems during my birth…)
You Step.
Repeating.
(eg, You are saying that you have a lot of pain)
Supporting.
(eg, It is not easy to deal with this pain, of course, you are so right)
Paying attention to the problem.
(How long have you had this problem?)
Understanding Deep Emotions.
(eg, I think that you have suffered a lot and feel exhausted now due to long duration of delivery)

- Importance of Giving Empathic Response in Midwifery
- Presentation Methods for Subjects
  Didactic lecture: Presentation as a verbal.
  Games: Three boxes game, role-playing, improvisation.

Techniques: Matching, mirror, and role-switching techniques.
A saying: The desire to be understood is as violent as the desire to be loved (Anonymous).