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Does Psychoeducation Encourage Pregnant Women and Positively Influence the Relation between Mother and Baby?

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Abstract

Background: The emotinal instability during pregnancy and the cultural negative feedback about normal vaginal delivery influence the tendency to cesarean section. The myth of vaginal delivery should be replaced with evidence based information which was given by profesional persons. The coordinated educational program and pilates study in hospitals for pregnant women will encourage women during delivery and peurperal period.

Method: This study was designed as case-control for 1292 pregnant women which visit the obstetric clinic of Mersin Sehir Hospital, Turkey. Case group have 421 and control group have 871 patients. The first goal was for defining of fear about vaginal birth, mode of delivery, satisfaction from pregnancy and delivery, lastly flashback after birth. In addition, secondary goal was determining the unnecessary visit of obstetric clinic in postparum period, breastfeeding ratio, planning of next pregnancy and choosing of normal vaginal delivery in future birth.

Result: Obviosly, the midwife intervention encourages women to have happy , satisfied and successfull pregnancy, delivery and peurperium. However the effectiveness of education program shouldn't be measured with the cesarean section ratio and the aim of education shouldn't be forcing of pregnant women to the normal vaginal delivery. It should be encouraged by programme.

Conclusion: The statistical measurements of emotions will be represented with biasis. Besides, the midwife intervention and pilates were seem to be successul programme for pregnant women to neglect the negative effects of delivery without changing of ceaserean numbers.

Keywords: Psychoeducation, Midwife, Pregnancy, Birth, Obstetric clinic, Breast feeding.

Introduction

In Turkey, the increasing cesarean section (C/S) ratio is an universal problem. Especially in south eastearn region and in lower social economics part of Turkey, C/S ratio is rised steadily. Although the epidural vaginal delivery protocol, the lack of practical experience of anesthesia and the over crowded hospitals limit the capability of epidural anesthesia. In contrast to European and American hospitals, the cost of C/S does not differ in Turkey even though in private hospitals from the normal vaginal delivery (NVD). For this reason, the increased elective C/S ratio can't be decereased especially in primary pregnancy. The fearness of vaginal delivery that is emphasized with cultural factors is a nightmare in pregnant women. The satisfaction of pregnancy and the being a maternity or family is not considered. Poor emotional health

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is associated with increasing childbirth fear and risk of depression , birth trauma and inability to interact positively with baby and meet infant development needs and can be stressor in couple relationship [1-11]. By the improving of technology, the social media agrevated this fear with some videos of normal vaginal delivery.

In obstetric clinics at Mersin Sehir Hospital, we try to give education by mid-wive intervention and the opportunity of plates with coach. The aim of this organization to emphasize the nature of vaginal birth and the capability of mother vaginal delivery with less fear , more controlled body and the knowledge about delivery and baby.

This study is a retrospective case-control study among women that visit obstetric clinics in Mersin Sehir Hospital, Turkey. The case and control groups has been choosen randomly. The first goal is the measurement of fear about vaginal birth, and prefered mode of delivery before and after the midwife intervention. The tendency to the C/S because of fearfull pregnant women may be decreased by midwife intervention. The pregnant women with childbirth fear more often prefer a C/S [12-14]. Not only the lowering C/S ratio is our goal, but also the satisfaction of pregnancy, vaginal delivery and lowering flashback are in our first goal. The maternity is a sacred phase of human being and it shouldn't be interrepted with unsatisfied experience in delivery. Secondary goal of our study was the number of visit of obstetric clinic in postparum period. The mother wonders that something is wrong with baby or herself because of unsatisfied delivery. The effective and continuetion of breastfeeding , the programming of future pregnancy in first month and the planning of next pregnancy with normal vaginal delivery are also secondary goals. Infact, unsatisfied delivery causes bad flashback which is the reason of discontinuetion of breastfeeding. The planning next pregnancy in the puerperal period with vaginal delivery is affected with bad experience. Even though the future pregnancy is planned as C/S.

Method

This is retrospective case-control study with sample size of 482 pregnant women in case group and 949 pregnant women in control gruop. All women was in their first pregnancies the 12 women from case group were discontinued the education and 42 women were undergo to the C/S because of fetal disstress or cephalopelvik disproportion. 8 women from case group were unreachable after the delivery. In the control group, 23 women were excluded because of cholestasis and preeclampsia, 43 patients were lost during pregnancy or postpartum period. 12 women refused the filling of WDEQ-A questionaire. To summrise; the pregnant women between 16-40 years old first pregnancy was included to study. Those women were integreted in midwife intervention in 3 sessions and 3-6 times pilates sessions with coach in obstetric clinics of Mersin Sehir Hospital.

Data collection and measurements

The completion of questionaire about demographic characteristics was asked to women. The WDEQ-A was used to measure the antenatal childbirth fear [15]. Women scoring high childbirth fear (>66) were randomised to the case and control group [16]. The other midwife intervention was done after 1 month of delivery in case and control groups.

Statistic analysis

The study was a retrospective case-control study among patients in the obstetric clinics, at Mersin Sehir Hospital. The data was analyzed with SPSS (Statistical Package for Social Sciences) for Windows 22.0 programme. The analysis of data was delineated in numbers and percentages. The relation between the group variations was analyzed ki-square test.

Findings

The tables from Table 1-8.

Result

It has been estimated that 6-10% of all pregnant women suffer from severe fear of childbirth. The estimated child birth fear is 6-10% of all pregnancy which is common among the nulliparous as in parous [17-20]. This study is the measurements of subjective findings. The absence of recall and the analysis of emotion will cause the biasis in some degree. But the bad experience during the pregnancy and delivery may effect the whole women's life. We try to standardized the education programme for pregnant women to increase the normal vaginal delivery (NVD) numbers, be satisfied from pregnancy and NVD, to reduce the unnecessary reccurent visit of obstetric clinics, to encourage breast feeding, to support families for their future pregnacy.

The study determined that the educational programme may encourage the pregnant women in the delivery room (Table 1). Instead , the cesarean ratio didn't changed especially in planned pregnancy (Table 2). Especially in planned pregnancy, delivery route was choosen as cesarean section even in educated pregnant women. Besides, the midwife intervention satisfied women from pregnancy period and NVD (Tables 3 and 4). Women felt the being mother during delvery by comparing with control groups. The nightmare or flashback recall during one month of peurperium was decreased by midwife intervention (Table 5). For this reason, the traumatic part of the delivery and pregnancy was regreded by the educational programme.

Table 1: The comparision of normal vaginal delivery ratio between groups.

	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Normal vaginal delivery	308	%73,2	444	%51,0	752	%58,2	X^2=57,412 p=0,000
Cesarean section	113	%26,8	427	%49,0	540	%41,8	
Total	421	%100,0	871	%100,0	1292	%100,0	
The normal vaginal delivery ratio as we expected was higher in case group (%73,2) than the control (%51,0) statistically (X^2=57,412; p=0,000<0.05).							

Table 2: The prefering c/s in planned pregnancy.

Prefering C/S in Planned Pregnancy	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Prefering C/S	113	%26,8	49	%5,6	162	%12,5	X^2=116,483 p=0,000
Prefering NVD	308	%73,2	822	%94,4	1130	%87,5	
Total	421	%100,0	871	%100,0	1292	%100,0	
The cesarean section option in the planned future pregnancy was suprisingly higher in case group (%26,8) than the control group (%5,6), (X^2=116,483; p=0,000<0.05).							

Table 3: The satisfaction from the pregnancy in case and control groups.

Satisfaction from the Pregnancy	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Satisfaction	371	%88,1	548	%62,9	919	%71,1	X^2=87,820 p=0,000
Non-satsifaction	50	%11,9	323	%37,1	373	%28,9	
Total	421	%100,0	871	%100,0	1292	%100,0	
By the midwife intervention and pregnancy and pilates coach educational program the satisfaction from the pregnancy among the pregnant women was statistically higher in case (%88,1) than the control group (%62,9), (X^2=87,820; p=0,000<0.05).							

Table 4: The satisfaction from normal vaginal delivery.

Satisfaction from Delivery	Groups							X^2/p
	Case		Control		Total			
	n	%	n	%	n	%		
Satisfaction	274	%65,1	304	%34,9	578	%44,7		X^2=104,567 p=0,000
Non- satisfaction	147	%34,9	567	%65,1	714	%55,3		
Total	421	%100,0	871	%100,0	1292	%100,0		
The similar result was found in the stasifaction from the normal vaginal delivery. The ratio was higher in case group (%65,1) than the control group (%34,9), (X^2=104,567; p=0,000<0.05) statistically.								

Table 5: The flashback of normal vaginal delivery.

Flashback	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Flashback	206	%48,9	775	%89,0	981	%75,9	X^2=249,043 p=0,000
No flashback	215	%51,1	96	%11,0	311	%24,1	
Total	421	%100,0	871	%100,0	1292	%100,0	
The normal vaginal delivery flashback was statistically measured and the ratio was lower in case group(%48,9) than the control (%89,0), (X^2=249,043; p=0,000<0.05).							

Table 6: The recurrent visit of obstetric clinic.

Recurrent Visit Of Obstetric Clinic	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Recurrent visit	164	%39,0	566	%65,0	730	%56,5	X^2=78,232 p=0,000
Planned visit	257	%61,0	305	%35,0	562	%43,5	
Total	421	%100,0	871	%100,0	1292	%100,0	
The unnecessary reccurrent visit of obstetric clinic was lower in case (%39,0) than the control group (%65,0) by statistical importance(X^2=78,232; p=0,000<0.05).							

Table 7: The ratio of breast feeding.

Breast Feeding	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Breast feeding	400	%95,0	714	%82,0	1114	%86,2	X^2=40,609 p=0,000
No breast feeding	21	%5,0	157	%18,0	178	%13,8	
Total	421	%100,0	871	%100,0	1292	%100,0	
The ratio of breast feeding was higher in case group (%95,0), although the percentage was %82,0 in control group. The statistical importance was determined between groups (X^2=40,609; p=0,000<0.05).							

Table 8: The planning future pregnancy.

Planning Future Pregnancy	Groups						X^2/p
	Case		Control		Total		
	n	%	n	%	n	%	
Planning	135	%32,1	148	%17,0	283	%21,9	X^2=37,703 p=0,000
Non-planning	286	%67,9	723	%83,0	1009	%78,1	
Total	421	%100,0	871	%100,0	1292	%100,0	
In the case, the planning of future pregnancy was (%32,1) more than the control group (%17,0), (X^2=37,703; p=0,000<0.05).							

In the control group, the reccurent unnecessary obstetric clinic visit was detected because of questions about delivery and baby (Table 6). In those visit the emotionally unsatisfied, scarred and doubtfull mother's was observed. By means of midwife intervention, those traumatic factors was elected and happy mothers with happy babies were created. The emotional satisfaction effects the breast feeding positively, in the educated pregnant women the future plan and the happiness of being mother was showed by the high ratio of planning next pregnancy in contrast to control group (Tables 7 and 8). Interestingly, the C/S ratio was not affected by the education, it was certain that , even though midwife intervention did not positively rised the desire of normal vaginal delivery (Table 2).

Surely, the case group did'nt want to undergo NVD in next pregnancy. The reason of this may be, although the education, traumatic pain of delivery which wasn't decreased by the midwife intervention. Besides the positive effect of educational programme, the reality of normal vaginal delivery may have negatif consequences.

Conclusion

Midwife intervention should be profesionally given to all pregnant women to encourage women for healthy mothers and babies but the C/S rate shouldn't be designed by the educational programme.

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