

MATERNAL SATISFACTION AS A PRECURSOR TO FULFILLING MOTHERHOOD ROLES

Ayşe Yılmaz Çetin¹, Mehmet Ali Gündoğdu², Zeynep Nur Şahin³

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Abstract

Pregnancy and childbirth constitute profound experiences inherent to the female life cycle. This natural continuum, stretching back to the dawn of humanity, is fraught with critical health implications for women. Numerous studies and health indicators underscore the fundamental nature of pregnancy and childbirth for women's well-being. The childbirth experience straddles the delicate boundary between health and illness, significantly influencing the physical and spiritual dimensions of mothers. Various factors play a pivotal role in ensuring a successful birth with minimal adverse effects on maternal health. In contemporary healthcare assessment, individual satisfaction with services has emerged as a paramount criterion for evaluating the quality of care. The degree of satisfaction experienced by women can offer valuable insights for appraising the quality of healthcare services and identifying areas for improvement.

1.0 Introduction

Pregnancy and childbirth is one of the experiences specific to women (Capık et al., 2014; Pınar et al., 2009). These experiences are natural in the life cycle of women since the beginning of the humankind (Capık et al., 2016; Pınar et al., 2009). However, the most important health problems that affect women's health and life-long quality of health are experienced in this period. Studies and health indicators show that pregnancy and birth are vital needs for women (Balkaya Akdolun, 2002; Celik et al., 2014; Walker & Wilging, 2000). The childbirth experience, which narrows the line between health and illness, affects mothers both physically and spiritually. Various factors are effective in maintaining this period and achieving a successful birth without any adverse effect to health (Pınar et al., 2009). Today, one of the most important and most frequently used criteria in the evaluation of the quality of health care is individual satisfaction of services (Gungor & Beji, 2012). Satisfaction may be instructive in assessing the quality of service in health care as well as identifying and correcting the deficiencies in this area (Ozcan & Aslan, 2015).

The support provided by midwives to women, midwives' respect, modest approach, informative responses towards women, and being accessible all the time that is their professional behavior are important for the satisfaction of women (Kayrakcı & Ozsaker, 2014).

¹ Department of Midwifery, Faculty of Health Science, Fırat University, Elazığ, Turkey

Ozcan and Aslan (Ozcan& Aslan, 2015) have stated that care-related satisfaction is in line with the satisfaction of hospital services, and the satisfaction of individuals from the care services is the most effective factor affecting their satisfaction from the hospital services; and in their study, childbirth satisfaction was found to be lower both in normal and cesarean delivery.

Some periods and experiences in human-life are important more than others. Birth is a process, in which women experience biological, physical, emotional, and social changes needed to adapt to motherhood. Women are exposed to adverse conditions such as failing to protect the privacy and being in an unfamiliar environment, while at the same time trying to cope with the birthing process (Karacam & Akyuz, 2011). In order to cope with the labor and experience a healthy birth process, women need to receive support and feel that they are being considered important. The professional support provided to women may prevent a negative labor experience and may develop a sense of control to help to cope with labor pain (Adams & Bianchi, 2008). Actively assisting women in labor, meeting their emotional needs and demands, providing comfort, improving birth outcomes, increasing self-esteem, ensuring a positive birth experience, and facilitating the transition to motherhood role are among the goals of birth support (Miltner, 2000).

Childbirth satisfaction of women is extremely important in terms of her and baby's health as well as being important for the positive family relationships. A positive childbirth experience leads a mother to perceive her baby positively and easily adapts the motherhood role by feeling positive emotions towards her baby. On the other hand, mother's negative childbirth experience has a negative effect on breastfeeding and baby bonding behavior (Karacam & Akyuz, 2011; Ozcan & Aslan, 2015). This study aims to assess the relationship between childbirth satisfaction and motherhood role.

2. Methods

2.1. Setting

The study was conducted in the postpartum C-section clinics in a maternity hospital in Erzurum, between September 2015 and April 2016. This Maternity Hospital's Department of Obstetrics and Gynecology, which is the subsidiary of the Ministry of Health, has 115 beds capacity. The hospital has 14 obstetricians and a gynecology outpatient-clinic. Approximately 700-800 pregnant women admit to the clinics daily and the number of deliveries is between 25 and 35 daily. In this hospital, women who give a normal birth are discharged in 24 hours after birth and women who have a caesarean section are discharged after 48 hours. Hospital policy do not allow fathers in the clinic either after a cesarean section or normal delivery. After birth, a female is allowed to stay with the mother and her baby. In the postpartum period, women needs are met by midwives and nurses. The hospital conditions are thought to reflect common practices of public hospitals in Turkey.

2.2. Participants

The study population was consisted of mothers who meet the research inclusion criteria and admitted to the postpartum and cesarean delivery units of a maternity hospital in the Province of Erzurum between the dates specified. The study sample size was calculated using the G* Power 3.1.5 program. As a result of the power analysis, the study's power and effect size were found to be 0.99 and 0.71 respectively, and 252 mothers were included for vaginal birth while 257 mothers were included for cesarean birth in the study (total n=509).

Inclusion Criteria for the Study

- Agreed to participate in the research,
- Have a healthy newborn,
- Have no complication developed after birth,
- Open to communication, spiritually and mentally healthy,

- Have a spontaneous pregnancy, ☐ At least primary school graduate.

2.3. Instruments

For the collection of research data, the Personal Information Form prepared by the researcher, Scale for Measuring Maternal Satisfaction and Semantic Differentiation Scale - Myself as Mother were used.

2.3.1. Personal Information Form

The Personal Information Form was prepared by the researchers according to literature (Sirin, 2008; Taskın, 2016). The questionnaire consists of items related to the socio-demographic characteristics, history of pregnancy and birth.

2.3.2. Scale for Measuring Maternal Satisfaction (SMMS)

The Scale for Measuring Maternal Satisfaction, which was developed by Gungor and Beji (Gungor & Beji, 2012), consists of two different scales assessing the childbirth satisfaction of the mother in both the normal and cesarean delivery. The Scale for Measuring Maternal Satisfaction for normal delivery consists of 43 items and 10 subscales. The sub-scales are: perception on the medical team, care during labor, relieving, participation in making decision and giving information, first contact with the baby, postpartum care, hospital room, hospital facilities, respect of privacy, and meeting expectations. The total score is in the range of 43-215. Mothers' level of satisfaction from the care provided in the hospital for the vaginal delivery increases as the total score taken in the scale increases. The cutoff point of Scale for Measuring Maternal Satisfaction for Normal Delivery was determined as 150.5 (≥ 150.5 high level of satisfaction, < 150.5 low-level of satisfaction) (Gungor & Beji, 2012). The Cronbach's Alpha reliability coefficient of the "Scale for Measuring Maternal Satisfaction" was found to be 0.91. Cronbach's Alpha coefficient was 0.89 in this study.

The C-section Scale for Measuring Maternal Satisfaction is a 5-point Likert type scale, consisting of 42 items and 10 sub-scales. The sub-scales are: perception on the medical team, preparation for C-section, relieving, participation in making decision and giving information, first contact with the baby, postpartum care, hospital room, hospital facilities, respect of privacy, and meeting expectations. The total score is in the range of 42-210. Mothers' level of satisfaction from the care provided in the hospital for the C-section increases as the total score taken in the scale increases. The cut-off point of the Scale for Measuring Maternal Satisfaction for Cesarean Delivery was determined as 146.5 (≥ 146.5 high-level of satisfaction, < 146.5 low-level of satisfaction) (Gungor & Beji, 2012). The Cronbach's Alpha reliability coefficient of the "C-Section Scale for Measuring Maternal Satisfaction" was determined as 0.91. Cronbach's Alpha coefficient was 0.88 in this study.

2.3.3. Semantic Differential Scale - Myself as Mother (MMS)

The scale was developed by Walker (Walker et al., 1986) in 1982, and its Turkish validity and reliability study was carried out by Calısır and Basbakkal in 2003 (Calısır & Başbakkal, 2003). The scale measures the evaluated subscales of the "Myself as Mother" concept. It's an 11-item, 7-point Likert type scale consisting of 11 opposite adjective pairs. Higher total scores taken in the scale indicate the positive maternal self-assessment. The lowest and highest scores of the "Myself as Mother" Scale are 11 and 77 respectively. Calısır & Basbakkal have found the Cronbach's Alpha reliability coefficient of the "Semantic Differentiation Scale-Myself as Mother" scale as .73-.74 (Calısır & Basbakkal, 2003). In this research, the Cronbach's Alpha coefficient was 0.77 for normal birth, and 0.77 for cesarean birth.

2.4. Data Collection

Data were collected through face-to-face interviews by researchers after normal delivery during 18 hours for minimum and 24 hours for maximum, while it's collected during 24 hours for minimum and 48 hours for maximum after a C-section delivery, when the mothers' condition have been stabilized. Mothers were informed

about the research before applying the forms. Each interview took approximately 30 minutes of which 5 minutes for the Personal Information Form, and 25 minutes for the scales. Mothers were informed about the Voluntary Approval Form, and their consents were obtained for inclusion in the study.

2.5. Evaluation of Data

SPSS 20.0 statistics software was used coding, statistical analysis and evaluation of the data (IBM Statistics SPSS 20, Network Licensed for 245 Users). Reliability test (Cronbach's Alpha) and descriptive tests were used for statistical analysis of data. The analysis of normality performed for distribution of data showed a normal distribution of data, and parametric tests of t-test and Pearson correlation analysis was used for this.

2.6. Ethical Principles of the Study

The approval of the Erzurum Atatürk University Faculty of Health Sciences Ethical Committee, and permission of the study hospital were obtained before conducting the study.

Since the responses need to be voluntarily in all researches which carried out through questionnaires, participants were informed that they are free to participate, and a special attention was paid to include only the volunteer and women who agreed to participate in the study. Before starting to collect research data, mothers were informed about the research and their questions were answered. 'Informed Consent Policy' was fulfilled by obtaining verbal and written consent of the mothers.

3. Results

The socio-demographic and obstetric characteristics of the mothers, which included in the study are shown in Table 1 respectively.

Table 1. Distribution of socio-demographic and obstetrics characteristics of mothers

Socio-demographic characteristics (s=509)	Normal birth		Caesarean birth	
	n	%	n	%
Education				
Primary school	191	75.8	151	58.7
High school	44	17.5	76	29.6
University	17	6.7	30	11.7
Occupation				
Active	21	8.3	42	16.3
Inactive	231	91.7	215	83.7
Economic status				
Low income	72	28.6	51	19.8
Middle income	159	63.1	185	72.0
High income	21	8.3	21	8.2
The total number of pregnancies				
1	100	39.7	62	24.1
2	62	24.6	74	28.8
3	47	18.7	55	21.4
≥ 4	43	17.1	66	25.7
The state of being planned pregnancy				
Planned	205	81.3	189	73.5
Not planned	47	18.7	68	26.5
Condition getting support in birth and after the birth				
Recieve	247	98.0	248	96.5
Not recieve	5	2.0	9	3.5
Total	252	100	257	100

In the study, SMM Smean score of mothers who have had a normal delivery was 131.96 ± 21.02 , whereas the SMMS mean score of mothers who gave birth with C-section was found to be 141.81 ± 21.32 . The mean MMS score of mothers who have had a normal delivery was 56.03 ± 8.88 , whereas the mean MMS score of the mothers who gave birth with C-section was found to be 62.20 ± 7.32 (Table 2).

Table 2. The minimum and maximum scores taken in SMMS (N-B), SMMS (C-S) and MMS and distribution of mean scores of taken by mothers in the scales

Scales	Lowest and highest ratings can be received	Received the lowest and highest ratings	Received rate average $\bar{X} \pm SS$	Test and p value
SMMS(Normal birth)	43-215	77-186	131.96 ± 21.02	t= -5.24 p=0.001
SMMS(Ceasarean birth)	42-210	71-200	141.81 ± 21.32	
MMS (Normal birth)	11-77	38-74	56.03 ± 8.88	t=-8.56 p=0.001
MMS (Ceasarean birth)	11-77	42-77	62.20 ± 7.32	

According to the cut-off points, 80.6% of mothers who got a normal delivery, and 55.3% of mothers who got a caesarean delivery had low childbirth satisfaction (Table 3).

Table 3. Distribution according to the Cut-Off points of the SMMS (N-B) and SMMS (C-S) scales

Scale cut-off point			
Scales		n	%
SMMS (Normal birth)	<150.5 point	203	80.6
	≥ 150.5 point	49	19.4
	<146.5 point	142	55.3
SMMS (Ceasarean birth)	≥ 146.5 point	115	44.7

In the correlation analysis performed to examine the relationship between MSS and SMMS mean score of mothers who got a normal and caesarean delivery, a moderate correlation was found between MSS and SMMS mean scores of the mothers who got a normal delivery. A positive and weak significant relationship was found between MSS and SMMS mean scores of the mothers who got a caesarean delivery. Adaptation of the motherhood role was found high with increasing of childbirth satisfaction ($p=0.000$, Table 4).

Table 4. The relationship between the mean SMMS (N-B), SMMS (C-S) and MMS scores

Scales		MMS (Normal birth)	MMS (Ceasarean birth)
SMMS (Normal birth)	r p	0.512 0.000	
SMMS (Ceasarean birth)	r p		0.262 0.000

4. Discussion

Birth is one of the most important and special events experienced by woman throughout her life. This special event refers to a process, where notable physical, social, and emotional changes are experienced in the transition to motherhood. In this process, the studies conducted to measure childbirth satisfaction are important in improving health services, and revising the ongoing health policies as well as maximizing maternal and neonatal health, and triggering mother-infant relationship as soon as possible (Bertucci et al., 2012; Ford & Ayers, 2009; Kuo et al., 2010; Mohammad et al., 2014). Woman's childbirth satisfaction affects both herself and her baby

during the early postpartum. A negative birth experience may have a negative impact on mother and baby in long-term, such as the negative thoughts towards the baby, breastfeeding problems, and inability in assuming the motherhood role (Britton, 2006; Goodman et al., 2004; Gungor & Beji, 2012; Harvey et al., 2002; Waldenstrom et al., 2004). In the study, the mean satisfaction score of the mothers who have had a normal delivery was 131.96 ± 21.02 , whereas the SMMS mean score of the mothers who gave birth with C-section was found to be 141.81 ± 21.32 , and the satisfaction in both groups were found to be at lower levels.

More information given more to C-section patients, and their increased participation in decision is thought to be effective in the higher mean score of the C-section group in the satisfaction scale. Informed individuals' levels of satisfaction and confidence towards healthcare professionals were reported to be increased in studies conducted with women of various socio-economic status, cultures and regions in Turkey (Eker & Yurdakul, 2011; Ozcan & Aslan, 2015). Since satisfaction is a multidimensional concept, affected by many factors, different studies on childbirth satisfaction have various obtained different results for vaginal birth and cesarean section birth (Arslan et al., 2012; Goodman et al., 2004; Janssen et al., 2006; Rudman et al., 2007; Smith, 2001; Uzun et al., 2006; Waldenstrom et al., 2000). The studies conducted to measure childbirth satisfaction at normal birth also report lower childbirth satisfaction in those mothers. This result was reported to be associated with reasons such a painful and longer than expected labor, inadequate support of health workers in pain management, too many vaginal examinations, episiotomy applied on a routine basis (Hassan-Bitar & Wick, 2007; Hassan et al., 2012; Mohammad et al., 2011), The routine oxytocin application (Ezeanochie et al., 2013), mandatory lithotomic position in labor (Hassan-Bitar & Wick, 2007; Hassan et al., 2012; Shaban et al., 2011), routinely applied fungal pressure (Shaban et al., 2011), unwanted people in a crowded delivery room, caused lack of opportunity to talk between women and healthcare professionals (Bryanton et al., 2008; Mohammad et al., 2014; Rudman et al., 2007). The results of studies conducted to investigate childbirth satisfaction of women who had a caesarean delivery show that these women had lower childbirth satisfaction (Adıguzel et al., 2013; Bryanton et al., 2008; Mohammad et al., 2014; Rudman et al., 2007; Shorten and Shorten, 2012; Waldenstrom et al., 2004; Yanikkerem et al., 2013).

The other studies also revealed that lower level of satisfaction is affected by factors such as mobilization problem after cesarean, inability to breastfeed, inadequate personal hygiene, and postpartum pain around the incision area (Husslein, 2001; Pınar et al., 2009). The lower level of childbirth satisfaction found in this study both for normal delivery and caesarean delivery is believed to be caused by routine practices mentioned above in the maternity hospitals in Turkey. The higher maternal role score of mothers who have had a cesarean delivery is believed to be due to the lack of labor pain, leading to a higher level of satisfaction. As noted in the literature, a positive birth experience increases the childbirth satisfaction of a mother as well as helping them to feel positive emotions towards the baby and facilitating the transition to the motherhood role (Goodman et al., 2004; Reisz et al., 2015; Sauls, 2004).

Considering the percentage distributions of the scores according to the cut-off points of the childbirth scale, 80.6% of mothers who have had a normal delivery, and 55.3% of the mothers who have had a caesarean delivery was found to have lower childbirth satisfaction. In a study by Ozcan and Arslan, conducted in Turkey, 100% of the mothers who have had a normal birth, 95% of the mothers who have a caesarean delivery were found to be not satisfied with the care given during labor (Ozcan & Aslan, 2015). Most of the mothers do not prefer medical interventions to be made for accelerating or facilitating the delivery, such as oxytocin induction, enema, anatomy, vacuum, fungal pressure, etc., unless there is a risk for herself or baby's health. Therefore, the interventions performed during delivery are thought to affect the satisfaction get from the birth experience. In Turkey, however,

the routine procedures used to accelerate the labor have been reported to be used excessively (Gungor & Beji, 2012; Ozcan & Aslan, 2015). In Jordan, in a study by Mohammad et al. conducted to assess the childbirth satisfaction, 75.6% of mothers was found to be not satisfied with the care provided during labor (Mohammad et al., 2014). Considering the percentile distributions, calculated according to the cut-off points of the scales, it is observed that previous studies are in line with the results of this research. It was stated that childbirth satisfaction in normal delivery is reduced due to the factors such as prolonged duration of labor process in normal delivery, lack of experience of mothers about labor pain especially in their first delivery, experiencing a fear of unknown condition, insufficient support in labor pain management, lack of communication with the staff in the delivery room, unnecessarily routine applications, excessive vaginal examinations, unwanted people in a crowded delivery room, routine application of fundal pressure, which is a very painful intervention, physical conditions of the hospital, delivery room setting, use of shared rooms after delivery, and problems related to other inadequate hospital facilities (Bryanton et al., 2008; Ezeanochie et al., 2013; Hassan Bitar & Wick, 2007; Hassan et al., 2012; Mohammad et al., 2014; Mohammad et al., 2011; Rudman et al., 2007; Shaban et al., 2011). Studies support that the lower level of satisfaction of the mothers who had a C-section delivery is affected by factors such as mobilization problem after cesarean, inability to breastfeed, inadequate personal hygiene, and postpartum pain around the incision area (Adigüzel et al., 2013; Husslein, 2001; Pinar & Pinar, 2009; Shorten and Shorten, 2012; Waldenstrom et al., 2004; Yanikkerem et al., 2013).

In this study, the lower childbirth satisfaction of mothers who had a normal and C-section delivery is believed to be caused by the same reasons given in the literature. A positive significant correlation was found between the childbirth satisfactions mean scores and motherhood-role success scores, which was moderate for normal delivery and weak for C-section. Although the mean satisfaction score of the mothers who have had a normal delivery was lower, considering the correlation between mean scores of motherhood-role success and satisfaction, the correlation was observed to be more significant in the mothers who had a normal delivery. In a study by Pinar et al., mothers who have had a C-section was found to experience more problems, compared to the mothers who had a normal delivery, in the postpartum period, which was effective on the satisfaction and comfort of the mothers (Pinar et al., 2009). It is reported in the literature that a positive birth experience facilitates the transition to motherhood, and helps mothers to feel positive emotions towards the baby, whereas a negative birth experience is stated to affect adaptation to the motherhood role negatively (Goodman et al., 2004; Husslein, 2001; Shorten & Shorten, 2012). In this study, it is also suggested that adaptation to motherhood role is affected positively as the childbirth satisfaction increases in normal and C-section deliveries, and the mothers who have higher childbirth satisfaction were found to behave more elegant, and feel more compassionate, successful, and adequate towards their babies. Mother's positive perception towards the healthcare team, care provided by midwives/nurses during labor, relief provided by healthcare professionals to mothers experiencing fear of labor or surgery, mother's participation in decisions, information given to mothers, early acquaintance with the baby, ensuring a skin-to-skin contact as soon as possible, care provided to the mother in the postpartum period, physical conditions of the hospital room, the hospital's facilities, respect to her privacy, and meeting the mother's expectations are all effective in the childbirth satisfaction, and causes a positive or negative labor experience (Goodman et al., 2004; Janssen et al., 2006; Rudman et al., 2007; Smith, 2001; Uzun et al., 2006; Waldenstrom et al., 2000).

The positive birth experience is stated to be effective in achieving the motherhood role, and perceiving baby positively (Goodman et al., 2004; Sauls, 2004).

5. Conclusions

It was determined that childbirth satisfaction was at lower levels in both the normal and caesarean section delivery, whereas the motherhood role score was found better in delivery by C-section, moderate levels in mothers who have had a normal delivery; and, it was also found that there was a positive and significant correlation between the childbirth satisfaction and motherhood role.

It is especially necessary to reduce the rate of cesarean births, which has increased in Turkey due to fear of childbirth and concerns about experiencing trauma during labor, as well as increasing the rate of normal births, where mothers are supported with minimum medical interventions, and get help to cope with labor pain with nonpharmacologic methods. Encouraging mothers for normal delivery, and increasing their childbirth satisfaction is very important both for the health of the mother and society.

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