



ORIGINAL ARTICLE

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The effect of marital adjustment on mother-baby bonding and breastfeeding self-efficacy level

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Abstract

This study was conducted to determine the effect of marital adjustment on mother-baby bonding and breastfeeding self-efficacy. This cross-sectional study is conducted on 510 postpartum women, who delivered a baby in a public hospital in the eastern region of Turkey, between January and June 2019. Data were collected using Personal Information Form, Marital Adjustment Scale (MAS), Mother-Infant Bonding Scale (MIBS) and Breastfeeding Self-Efficacy Scale Short Form (BSES). Data were analyzed by descriptive statistics and t test and Pearson correlation analysis were used in independent groups. The mean age was 29.2 ± 6.67 and it was found that 78.8% of the postpartum women had a desired / planned pregnancy, 48.4% breastfed their baby within the first half hour after birth, and 70.2% gave only breast milk within the first 24 hours after birth. The mean MAS score was 44.29 ± 8.06 ; the mean MIBS score was 22.97 ± 2.58 ; and the mean BSES score was 59.02 ± 9.84 . It was found that postpartum women with an adjusted marriage relationship (59%) had a statistically higher level of mother-infant bonding and breastfeeding self-efficacy compared to postpartum women with non-adjusted marital relationships ($p < 0.05$). It was found that there was a weak positive correlation between the mean MAS score and the mean MIBS score ($r = 0.278$, $p = 0.000$). It was also found that there was a moderate positive correlation between the mean MAS score and the mean BSES score ($r = 0.507$, $p = 0.000$). It was found that postpartum women who had an adjusted marital relationship had higher levels of mother-infant bonding and breastfeeding self-efficacy than those leading a non-adjusted marital relationship. In addition, it was observed that mother-infant bonding and breastfeeding self-efficacy increased as marital adjustment increased in postpartum women.

Keywords: Marital adjustment, mother-baby bonding, breastfeeding self-efficacy

Introduction

Giving birth is a very special event and one of the most beautiful experiences in the lives of expectant mothers and fathers [1]. The postpartum period is a period that requires parents to learn their new roles, develop family sensitivity, create a safe environment for the baby, carry out baby care, communicate with the baby and deal with baby-related problems. This period can be a very positive period for the family, providing satisfaction and strengthening ties, but also can be a period of crisis [2]. During this period, the mother goes through a challenging process requiring adaptation to new roles and responsibilities, as well as the physiological and anatomical changes. In this process, mothers have to learn their new roles, communicate with the baby, care for the baby, and deal with baby-related problems. Many women easily adapt to

physiological, psychological and social changes that occur during pregnancy and after delivery [2]. However, some women may not be able to adapt to this process easily. However, women may not be able to experience a positive postpartum period due to reasons such as low self-esteem of the mother, lack of support systems, fatigue that continues after birth and affects the care of herself and the baby, and marital problems [2].

Marital adjustment is one of the important factors that helps mothers to adapt to this complex process after the delivery and that helps coping with this process [3]. Marital adjustment is explained by the happiness and satisfaction in the marital life as a result of the adjusted partnership of the spouses [3,4]. Therefore, happiness, satisfaction and expectations can be realized with mutual adjustment in marriage [3,4]. Marital adjustment not only positively affects the adaptation process of the woman to the maternal role, but also increases her sensitivity to her baby and facilitates relationships with her relatives [3,5]. The women especially expect support from their spouses in the postpartum period and the satisfaction of this expectation has a positive effect on the physical and mental well-being of the women [6]. Successful adaptation of women to

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motherhood and life changes in the postpartum period also affects the health of the mother and the baby. On the other hand, the lack of adjustment between spouses negatively affects the parenting roles of the mother and father [3]. It can be suggested that if the motherhood role of the woman is negatively affected, bonding and breastfeeding behavior will also be negatively affected.

Mothers should be ensured that they can develop bonding and breastfeeding behavior, in order to help them to adapt to the changing family balances and the new parenting role and to learn the strategies to cope with stress in this transitional process [7]. At this stage, healthcare personnel share the most important responsibility with the spouses and family members [2, 8]. From this point of view, the question of how the care and support that parents need in this period can be provided becomes more important. In this study, it was aimed to determine the effect of marital adjustment on mother-infant bonding and breastfeeding self-efficacy.

Materials and Methods

Study Design and Sample

This cross-sectional study was conducted on 510 postpartum women who gave birth to a baby in the maternity ward of a state hospital in Eastern Turkey, between January and June 2019. In the power analysis, it was calculated that the sample should include as at least 389 postpartum women to represent the universe with a 95% confidence interval with an error level of 0.05. Inclusion criteria for the study; all puerperant women who can communicate verbally, who do not develop any complications in the mother and newborn in the postpartum period and who do not have any diagnosed psychiatric diseases determined as.

Data Collection Tools

Data were obtained by using Personal Information Form, Marriage Adjustment Scale, Mother-Baby Bonding Scale and Breastfeeding Self-Efficacy Scale Short Form.

Personal Introduction Form

The Personal Information Form is created by the researchers and includes questions querying socio-demographic characteristics and some fertility characteristics of the postpartum women. The questions regarding socio-demographic characteristics included the age of, education level, employment status, income level, duration of marriage, obstetric characteristics, birth type, gender of the baby and breastfeeding attitude [9, 10, 11].

Marriage Adjustment Scale (MAS)

The marital adjustment scale is a 15-item scale developed by Locke and Wallace in 1959 [12]. The Turkish validity and reliability study of the scale was conducted by Tutarel-Kışlak (1999), in line with the scoring systems of Hunt (1978) and Freeston and Plechaty (1997). The total score obtained from the scale ranges between 0 and 60. The scores above 43.5 are considered to indicate adjusted marital relations, and the scores below this indicate a non-adjusted marital relationship. In the reliability study of the scale internal consistency coefficient was calculated as 0.84 and split half reliability as 0.84 [1]. In our research, the internal consistency coefficient was 0.86.

Mother-Infant Bonding Scale (MIBS)

MIBS was developed by Taylor et al., in 2005 [13] and adapted to Turkish by Karakulak Aydemir and Alparslan. It is a 4-point Likert scale consisting of 8 items [14]. The MIBS is organized in a way that can be applied from the first day after birth and allows the mother to express her feelings about her baby in a single word. This scale can be applied easily and quickly by the mother and father and indicates the relationship between the bond established between mother and baby and the mother's mood in the first period. The questions in the MIBS are scored between 0 and 3; the lowest total score is 0 and the highest total score is 24. The questions 1, 4, and 6 are expressions of positive emotion and scored as 0,1,2, and 3, while the questions 2,3,5,7 and 8 are expressions of negative emotions and are scored inversely as 3,2,1, and 0. The internal consistency coefficient of the scale was found to be 0.66 for the Turkish validity and reliability study [14]. In this study, the internal consistency coefficient was 0.72.

Breastfeeding Self-Efficacy Scale Short Form (BSES)

BSES was developed by Dennis, in 2003 [15] and consists of 14 items that evaluate breastfeeding self-efficacy. It is a 5-point Likert type scale and the items of the scale are answered as "1 =" not sure at all, 5 = "always sure". The lowest score that can be obtained from the scale is 14, and the highest score is 70; higher score indicates higher breastfeeding self-efficacy. The Turkish validity and reliability study of the scale was conducted by Aluş Tokat, Okumus and Dennis [16]. The internal consistency coefficient of the scale was found 0.86 in the Turkish validity and reliability study. [16]. In this research, the internal consistency coefficient was 0.91.

Data Collection

The data were collected by the researcher in the postpartum ward of the relevant public hospital by face to face interview method. The questions were asked and marked by the researchers. The data were collected by the researcher within the first 72 hours postpartum. The interviews were made on the weekdays and took an average of 10 minutes.

Evaluation of Data

The data were evaluated by using SPSS 25.0 package program. The compliance of the data to normal distribution was evaluated with the Kolmogorov Smirnov test. In statistical evaluation Cronbach's alpha, Pearson correlation and independent groups t test were used Percentage distribution, arithmetic mean, standard deviation and the data were expressed as mean, percentage and standard deviation. A value of $p < 0,005$ was considered statistically significant.

Ethical Regulations

Ethical approval for the study was obtained from the Health Sciences Scientific Research and Publication Ethics Committee of Inonu University (Decision No: 2018 / 18-16). Verbal consent was obtained from all postpartum women before the study was started. The researchers informed the postpartum women that the data obtained from the participants would be published for scientific

purposes, anonymously, and that they could leave the study at any time they wish. Only the postpartum women who were volunteer to participate were included in the study.

Limitations of the Study

The sample of this study is limited to postpartum women hospitalized in the maternity ward of a state hospital in the eastern region of Turkey.

Results

The sociodemographic characteristics of the postpartum women included in the study were given in Table 1. It was determined that the average age of the participants was 29.24 ± 6.67 , 53.3% of them were high school graduates, 62.4% did not work in any job. 67.8% of them stated that their income was moderate, 64.5% lived in the city center, 76.9% had nuclear family structure, and 52.5% had an arranged marriage. When the information about the spouses of the postpartum women is examined, it was determined that the average age was 33.10 ± 7.21 years, 34.3% of them were high school graduates, and 91.3% were employed in a job. It was determined that the mean marriage duration of the participants was 7.63 ± 6.58 years (Table 1).

The obstetric and postpartum characteristics of the postpartum women are given in Table 2. It was found that 72.9% of the postpartum women were multigravida, 78.8% wanted pregnancy, and 68% had a normal birth. In addition, it was determined that 57.1% of the postpartum babies were male, 48.4% breastfed their babies within the first half hour after birth, and 70.2% of the postpartum women fed their babies only with breast milk within the first 24 hours after birth. While 41.0% of women wanted their baby to be male, 50.2% of fathers stated that the gender of the baby did not matter, and 86.1% of women received support from their spouses, during the postpartum period (Table 2).

It was determined that the postpartum women got the lowest 12 and the highest 56 points on the MAS, the lowest 11 and the highest 24 on the MIBS, and the lowest 14 and the highest 70 points on the BSES. The mean total score of MAS was 44.29 ± 8.06 , MIBS was 22.97 ± 2.58 , and BSES was 59.02 ± 9.84 . The distribution of the lowest and highest scores and mean scores that postpartum women got from MAS, MIBS, and BSES are shown in table 3.

The cut-off score of the MAS Scale was 43.5. The postpartum women who scored above the cut-off score can be considered to have an adjusted marriage. We found that, the rate of postpartum women with an adjusted marital relationship was 59% (n = 301) and those with a non-adjusted marital relationship was 41% (n = 209). It was determined that postpartum women who had an adjusted marital relationship had statistically higher MIBS and BSES scores, compared to those with non-adjusted marital relationships ($p < 0.001$). In addition, it was determined that postpartum women with an adjusted marital relationship had a statistically higher BSES scores compared to those with a non-adjusted marital relationship ($p < 0.001$). Comparison of MAS scores individually with MIBS and BSES scores are shown in Table 4.

It was determined that there was a statistically weak significant positive relationship between the mean MAS and MIBS scores; as

the MAS increased, the MIBS increased significantly ($r = 0.278$; $p = 0.000$). It was also determined that there was a weak positive correlation between the mean MIBS and BSES scores; as the MIBS scores increased, BSES scores increased significantly $r = -0.336$; $p < 0.336$). In addition, it was determined that there was a moderately significant positive correlation between the mean MAS and BSES scores; as the MAS score increased, BSES score increased significantly ($r = 0.507$; $p = 0.000$). The relationship between the total mean MAS, MIBS, and BSES scores are shown in Table 5.

Table 1. The Descriptive Characteristics of the Postpartum Women (n=510)

Descriptive Properties	± SS	
Age (years)	29.24 ± 6.67	
Spouse's age (years)	33.10 ± 7.21	
Duration of Marriage (years)	7.63 ± 6.58	
	n	%
Employment Status		
Employed	192	37.6
Unemployed	318	62.4
Educational Status		
Illiterate	14	2.7
Literate	19	3.7
Primary school	93	18.2
Secondary School	114	22.4
High school	170	33.3
University and above	100	19.6
Spouse training status		
Illiterate	2	0.4
Literate	12	2.4
Primary school	84	16.5
Middle school	95	18.6
High school	175	34.3
University and above	142	27.8
Spouse Employment Status		
Employed	475	93.1
Unemployed	35	6.9
Place of Residence		
Province	329	64.5
Town	112	22.0
Village	69	13.5
Income Status		
Good	128	25.1
Moderate	346	67.8
Poor	36	7.1
Family structure		
Nuclear Family	392	76.9
Extended family	116	22.7
Broken Family	2	0.4
Marriage Method		
Arranged	268	52.5
By meeting your own	194	38.0
Through friend	48	9.4
Total	510	100.0

Table 2. Distribution of Obstetric and Postpartum Characteristics of Postpartum Women (n = 510)

	n	%
Number of Pregnancies		
Primigravida	138	27.1
Multigravida	372	72.9
Desired Status of Pregnancy		
Yes	402	78.8
No	97	19.0
Unstable	11	2.2
Form of birth		
Normal birth	347	68.0
Cesarean section	163	32.0
Baby's gender		
Girl	219	42.9
Male	291	57.1
Mother's Baby Gender Preference		
Girl	180	35.3
Male	209	41.0
Not matter	121	23.7
Father's Baby Gender Preference		
Girl	127	24.9
Male	127	24.9
Not matter	256	50.2
Postpartum Spouse Support Asset		
Yes	439	86.1
No	71	13.9
First Breastfeeding Time		
Within the first half hour	247	48.4
Between Half Hour and One Hour	126	24.7
An hour later	119	23.3
Breastfeeding Did Not Happen	18	3.5
Nutrition in the First 24 Hours		
Only Breastfeeding	358	70.2
Formula Only Mama	18	3.5
Both Breast Milk and Formula Mama	134	26.3
Total	510	100.0

Table 3. The Distribution of the Lowest and Highest Scores that the Postpartum Women got from the MAS, MIBS and BSES

	The lowest and highest scores that can be obtained	The lowest and the highest scores obtained	Mean of the scores obtained (Ort.±SS)
Marriage Adjustment Scale	0-58	12-56	44.29±8.06
Mother-Infant Bonding Scale	0-24	11-24	22.97±2.58
Breastfeeding Self-Efficacy Scale	14-70	14-70	59.02±9.84

Table 4. Comparison of MAS scores with MIBS and BSES scores

	Adjusted Marital Relationship (n=301)	Non-adjusted Marital Relationship (n=209)	Test* and p value	
Scales	X±SD	X±SD	t	p
MIBS	23.41±2.15	22.39±2.99	-4.730	0.000
BSES	62.10±7.71	54.57±10.84	-9.166	0.000

*t: Independent-samples t-test p<0.001

Table 5. Relationships Between MAS, MIBS and BSES Scores

Scales	*r	p
MAS - MIBS	0.278	0.000**
MIBS - BSES	0.336	0.000**
MAS - BSES	0.507	0.000**

* Pearson correlation analyze ** p<0.001

Discussion

In this study, we aimed to determine the effect of marital adjustment on mother-infant bonding and breastfeeding self-efficacy. We found that the mean total MAS score of the postpartum women participated in our study was 44.29 ± 8.06 (Table 3). In several previous studies, it has been reported that the mean MAS score ranged between 41.99 ± 9.8 and 47.4 ± 8.2 [17- 21]. The women who scored above 43.5 on the marital adjustment scale were considered to have an adjusted marital relationship [14]. In this study, the rate of postpartum women who have an adjusted marital relationship is 59%. In the literature, the rate of postpartum women with an adjusted marital relationship has been reported to be between 54.5% and 73.6% [17, 18, 21]. The results of our study are similar to the literature.

In our study, the total mean MIBS score of the postpartum women was found to be 22.97 ± 2.58 (Table 3). In the study of Turhal (2019), the mean MIBS score was determined as 22.19 ± 2.63 [22]. In this study, it was determined that as marital adjustment increased, mother-infant bonding increased significantly (Table 5, $r = 0.278$; $p = 0.000$). Similarly, in the study of Mutlu et al. (2018), it was found that as the level of marital adjustment increased, the level of mother-infant bonding increased [23]. In a study conducted by Akkoca (2009) to investigate postpartum mother-baby bonding, it was found that marital non-adjustment negatively affected mother-infant bonding [24]. In the literature, it is stated that the relationship of mothers with their spouses affects their bonding with their babies, mothers who experience marital problems have difficulty in bonding with their children, and a healthy marital relationship is necessary for a healthy mother-baby bonding [25]. In the study conducted by Alan and Ege (2013), it was found that there was a significant relationship between perceived social support and mother-baby bonding in the postpartum period, and maternal bonding increased as the social support that received by the mothers increases [26]. These results support the findings of our study. We also suggest that marital adjustment strengthens the bond between mother and baby.

Breastfeeding is one of the important factors that will enable the mother to establish a deep, lasting and secure bond with her baby. [23, 27]. Breastfeeding self-efficacy refers to a postpartum mother's belief in her breastfeeding ability and requires interactions between the mother and infant [27]. In our study the mean total BSES score of the postpartum women was found to be 59.02 ± 9.84 (Table 3). Given that that the highest value of the scale is 70, we can say that the BSES scores of the mothers in our study were above the average. In the literature, it has been reported that the mean scores of BSES vary between 59.49 ± 8.46 and 38.71 ± 7.37 [28-31]. In our study, we determined that as

marital adjustment increased, breastfeeding self-efficacy increased significantly (Table 5, $r = 0.507$; $p = 0.000$). In the study conducted by Uludağ (2017), it was found that as the level of spousal support increased, the level of breastfeeding self-efficacy increased [32]. Similarly, in the literature, it has been reported that mothers who receive more support from their spouses and experience more marital satisfaction after birth had more breastfeeding self-efficacy and were more likely to start and continue breastfeeding [27]. Given the results of these studies and our study which support the literature, we also suggest that marital adjustment has a positive effect on breastfeeding self-efficacy.

Conclusion

In this study, it was found that women with adjusted marital relationships had statistically higher levels of mother-infant bonding and breastfeeding self-efficacy compared to women with non-adjusted marital relationships. In addition, it was observed that the MIBS and BSES scores as the MAS scores increased. Given these information; we suggest that the pregnant information classes and pregnancy schools should be provided with trainings about pregnancy, delivery and postpartum processes, in order to support marital adjustment, mother-infant bonding and breastfeeding self-efficacy. In this context, midwives and other healthcare professionals should support mothers by counseling and training spouses before the delivery. Spouses should be included in the mother-infant bonding process, and the importance of marital adjustment for both mother and baby should be emphasized during pregnancy follow ups and trainings. New mothers will be able to adapt to their new roles and responsibilities with the positive support of the spouse and family in the postpartum period. It would be appropriate for midwives to continue to provide support to mothers, in the postpartum period and to facilitate interaction between the mother and the baby and starting and continuing breastfeeding.

This research was presented as a summary oral presentation at the 2nd International / 3rd National Postpartum Care Congress (03 - 06 October 2019, Konya/Turkey).

Conflict of interests

The authors declare that they have no competing interests.

Financial Disclosure

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Ethical approval

Ethical approval for the study was obtained from the Health Sciences Scientific Research and Publication Ethics Committee of Inonu University (Decision No: 2018 /18-16).

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