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# Psychological Support for Mothers Victims of Perinatal Death by Caregivers: Case of the Regional Hospital Center (RHC) of Yamoussoukro

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**Abstract**
The loss of a baby during the perinatal period leads to a real grieving process for mothers since they establish an attachment bond with their baby before birth. If relatives and environment bereaved underestimate this particular type of bereavement and its potential impact, this should not be the case for nursing staff. And yet, in African maternities, there are very few psychological support for mothers who are victims of perinatal death. Perinatal bereavement deserves to be analyzed in all its complexity. The aim of this study is to show the importance of psychological support for mothers who are victims of perinatal death in the prevention of negative impact on the mental health of mothers.
Quantitative and qualitative data are collected on a sample of 55 selected mothers through a purposive non-probability sampling strategy.
Quantitative data are processed with SPSS 20 software. Text processing as well as tables and graphs were produced with Word 2016 and Excel 2016 software. The results indicate on the one hand that the psychological support provided by the nursing staff reduces the harmful effects of perinatal bereavement on mothers and on the other hand, the need for the establishment of a support protocol for couples in health facilities.

**Keywords:** perinatal death, bereavement, mothers, psychological support.

**Résumé**
La perte d'un bébé pendant la période périnatale entraîne un vrai processus de deuil pour les mères puisqu'elles établissent un lien d'attachement avec leur bébé avant la naissance. Si les proches et le milieu social des endeuillées sous-estiment ce type de deuil particulier et son impact potentiel, cela ne devrait pas être le cas du personnel soignant. Et pourtant, dans les maternités africaines, il y a très peu d'accompagnement psychologique des mères victimes de décès périnatal. Le deuil périnatal mérite d'être analysé dans toute sa complexité. L'objectif de cette étude est de montrer l'importance de l'accompagnement psychologique des mères victimes de décès périnatal dans la prévention des répercussions négatives sur la santé psychique des mères.

Des données quantitatives et qualitatives sont recueillies sur un échantillon de 55 mères sélectionnées grâce à une stratégie d'échantillonnage non probabiliste par choix raisonné.

Les données quantitatives sont traitées avec le logiciel SPSS 20. Le traitement du texte ainsi que les tableaux et les graphiques ont été réalisés avec les logiciels Word 2016 et Excel 2016.
Les résultats indiquent d'une part que l'accompagnement psychologique fait par le personnel soignant réduit les effets néfastes du deuil périnatal chez les mères et d'autre part, la nécessité de la mise en place d'un protocole d'accompagnement des couples dans les structures sanitaires.
**Mots-clés :** décès périnatal, deuil, mères, soutien psychologique.

## Introduction

The prenatal consultation aims to confirm the pregnancy, to reassure the pregnant woman about the evolution of her pregnancy, to prevent possible complications in order to give birth to a baby alive. However, this process often ends in the death of the child and transforms maternity into a mortuary place. But, these deaths never left the community of the living indifferent. Indeed, among all deaths, that of a very small "innocent", is the most singular (Le Grand-Sébile, 2012). She thus raises a revolt, which reflected in a certain acrimony towards health facilities. It also generates a fatalism, a "crushing" of emotions in the face of reality.
This situation which occurs during the twenty-second week of amenorrhea (WHO, 1977) and the seventh day of including life (WHO 2006) includes stillbirth and early neonatal mortality. It affects nearly five million (5,000,000) children in the world (Liu, 2016) and constitutes a real public health problem despite advances in medicine and obstetrics. This is an unacceptable and revolting drama of counter-nature that the parents and the nursing staff experience daily.

Mothers may need to ask questions, talk, or withdraw into themselves to feel what is happening in their body, to take refuge in their emotions which connect them to their baby (Goulet and Lang, 1996). We thus see appearing in the latter doubts concerning their feminine identity, their capacity to procreate a healthy child (De Broca, 2010). This has many physical, psychological and social consequences such as: loss of self-esteem, suicide attempts, worthlessness, isolation, loss of libido, excessive consumption of alcohol or narcotics (Romano et al, 2011).

Under these conditions, psychological support for mothers can help to mitigate these effects, from confrontation to death and to address existential questions and resonances specific to each individual. This support must necessarily take into account the fact that a new pregnancy can awaken the anxieties linked to the possible dramatic outcome and thus become a source of suffering rather than liberation (Haussaire-Niquet, 2001).

The mission of the medical team being to relieve the suffering of others, the accompaniment that it brings to the mother influences the parents' experience and the grieving process. (Metriller, 2006).

In Canada, perinatal death affects approximately 11,000 families each year. This brought the Canadian government to adopt a perinatal policy in 2008 that sets out several recommendations for increased awareness of perinatal bereavement and support for families (verdon et al., 2008). Ongoing assistance is implemented to help grieving mothers. This assistance consists of: respecting the stillborn, granting him all the rights of a child, to respect the pain of the parents and their right to be a parent and finally, to be at their listening and available to them (Dumoulin and Valat, 1997).

1.6 million newborns die every year in Africa. One million babies during their first month of life and approximately five hundred thousand (500,000 thousand) during the first day of life (WHO, 2005); that is to say a mortality rate of 41.8 for 1000 (Chalumeau, 2006).

The cause of these deaths is sometimes blamed on the mother or attributed to mystical considerations (witchcraft, non-respect of tradition or prohibition). There is no psychological support for mothers who are victims of perinatal death (Douti, 2020). We witness an effective "conspiracy of silence" (Rousseau, 2001). The mother is isolated and avoided by caregivers, the hasty return home, the unthinkable meeting with the child and the rituals skipped funerals. Caregivers thus believe they are protecting parents from great suffering (Dumoulin and Valat, 2001).

In Côte d'Ivoire, there are six hundred and sixty-one thousand (661,000) alive nativities per year with 15% perinatal deaths (WHO, 2015). Thus, to reduce or avoid perinatal mortality, the government with the help of partners has implemented a policy based on targeted free which takes into account the care of pregnant

women and children aged 0 to 5, the sensitization of the population by health personnel on the good practice of care in the health structures and especially in maternity wards.

This high rate puts us in the presence of perinatal mortality which leads us to ask about the way in which the nursing staff accompanies the mothers who are victims of death perinatal on the African continent. In other words, is there a psychological support strategy? How mothers victims of perinatal death react face to the lack of psychological support?

The objective of this study is to show the importance of psychological support for mothers who are victims of perinatal death in the prevention of negative outcomes on their psychological health. It is based on Jean Watson's "caring" theory of human care (1985, 1988). This existential-phenomenological theory has allowed us to have a good comprehension of the phenomenon of perinatal bereavement.
The general hypothesis according to which the psychological support of mothers who are victims of perinatal death contributes to the amelioration of the negative effects of bereavement guided our research.

## I- Material and Methods

### 1.1- Choice of approach

To answer the research question, we will use a mixed approach (qualitative and quantitative). It "is about the use of different approaches, methods or technique in the same study" (hussey and hussey, 1997). That complementary approach enables to go beyond epistemological oppositions in order to build scientific knowledge. Through this approach we want to examine the experience and the realities of women who have been confronted with perinatal bereavement as well as the practices of nursing staff in terms of psychological support for these mothers.

### 1.2- Study area, population and sampling

The field of study is the city of Yamoussoukro. This city is the political capital of Côte d'Ivoire since 1983 and the capital of the district since January 21, 2002. It population is estimated at 362,000 inhabitants (RGPH, 2014) and it is located 248 kilometers north of Abidjan.
The study was conducted at the maternity ward of the Regional Hospital Center (RHC) of Yamoussoukro. It is the main public health structure in the Bélier Region (Yamoussoukro). This center is both the first and the second level of reference of the Commune, apart from the Maternal and Child Protection (MCP) and Urban Health Centers (UHC).

The targeted population is made up of nursing staff working in the maternity hospital of the RHC of Yamoussoukro as well as mothers who experienced perinatal loss (between the 20th week of pregnancies and the 7th day of birth. Medical Terminations of Pregnancy (MTP) are not included.
This will allow us to analyze two situations in order to well understand the adequacy between the needs of mothers and responses provided by staff.

The sample is made up of 55 mothers who have been victims of perinatal death.
The purposive sampling method is used to select participants. Indeed, without seeking exhaustiveness or representativeness, the selection of participants responds mainly to the criteria of diversity, being aged to 18 or over, having experienced a loss perinatal between the 20th week of pregnancy and the 7th day of birth, having experienced this loss between six months and five years prior to data collection and living in the city of Yamoussoukro at the time of the loss.

### 1.3- Data collection tools

Data collection favors the mixed method:
- A questionnaire drawn up from the medical file and addressed to mothers who are victims of perinatal death in the maternity hospital of the RHC. This questionnaire concerns the socio-demographic characteristics, medical history, the course of pregnancy and childbirth.

- An interview with the mothers to complete the data from the questionnaire and have information on the follow-up of the pregnancy, the stay in care rooms (perinatal deaths), the announcement of death and the emotional experience, as well as the psychological support practices received.

To ensure the applicability of our instruments and identify difficulties in time inherent in their use, a pre-survey was carried out with five (05) women victims of perinatal death in the maternity ward of the general hospital of Toumodi. We made sure that the mothers submitted to the pre-surveys had the same characteristics with the population of our study. As the comprehension of the questions did not raise any problem, no change has therefore been made.

### 1.4- Data processing methods

According to Grawitz (2004) “to strip is to classify, to arrange in categories or types the data from the field investigation". Thus, once the data was collected, we made use of electronic counting. So, the quantitative data obtained from of the questionnaire were codified and then processed with the SPSS 20 software which generated tables statistics analyzed on the basis of working hypotheses. Chi-square tests have been essentially carried out to determine the presence of links between the variables of the hypotheses. The processing of the interview as well as the tables and graphs have been carried out with Word 2016 and Excel 2016 software.

## 2- Results

The results of the analysis concern the impact on the one hand, the psychological support of health professionals to announce the death of a newborn and the language used by them and on the other hand, the well-being of mothers.

### 2.1- Socio-demographic characteristics of bereaved mothers

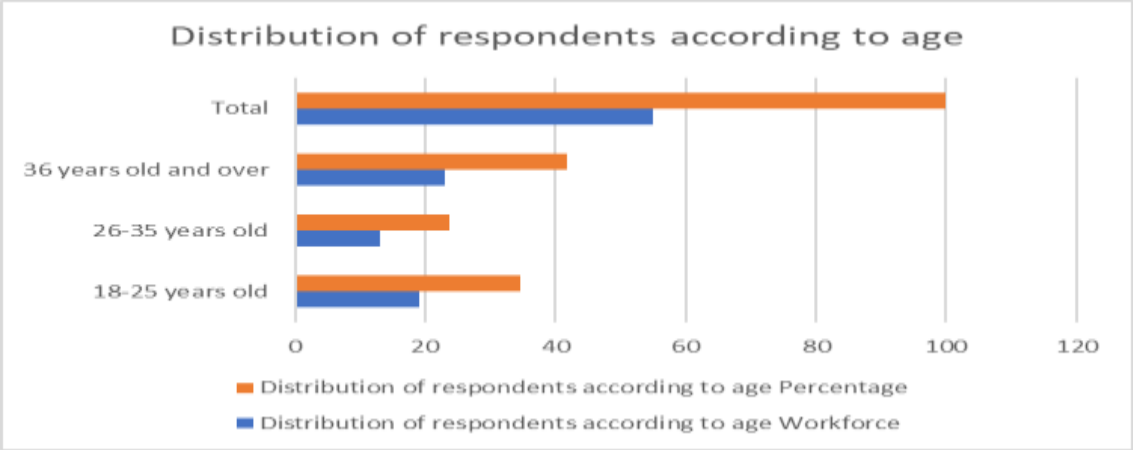


**Figure 1:** Distribution of respondents by age
Source: Study Data (2021)

This figure shows that out of 55 respondents, the age group of 18 to 25 years is 34.54%. That of 26-35 years is 23.64%. The age group of 36 years and over represents 41.82% of respondents. This last age group could represent a risk factor for perinatal death.

### 2.2- Relationship between the psychological support provided by the nursing staff and the well-being to be mothers

**Table I-** Comparison of mothers according to psychological support received

| Psychological support for mothers | | Perinatal bereavement of mothers | | | | | Total |
|---|---|---|---|---|---|---|---|
| | | Feeling of unreality | Sensitivity and irritability exacerbated | Feeling helplessness | Guilt | No problems | |
| | Yes | 3 | 3 | 1 | 2 | 8 | **17** |
| | No | 12 | 6 | 6 | 9 | 5 | **38** |
| | Total | 15 | 9 | 7 | 11 | 13 | **55** |
| | | **42** | | | | **13** | |

Source: study data (2021)

The value of the calculated Chi square ($X^2$ cal) =7.478
The value of the theoretical Chi square ($X^2$ th) = 3.841
Significance S at p.≤ .05; 1 ddf.
Statistical analysis of the data reveals a significant difference of "($X^2$ calculated) = 7.478" compared to "(theoretical $X^2$) = 3.841" read in the table of theoretical values, at the threshold of probability p≤ .05. Indeed, the calculated $X^2$ is higher than the theoretical $X^2$. This result indicates that mothers who benefit from psychological support after a perinatal death have a better life bereavement than those who do not receive psychological support. In other words, our hypothesis 1 is confirmed, namely that the psychological support provided by the nursing staff reduces the harmful effects of perinatal bereavement in mothers.
Analysis of interviews conducted with women who had lost a baby during the perinatal period reveals a total lack of support.
Interview 13: "The midwife was worried, agitated; when the death of my baby was confirmed, I felt responsible because no midwife came to me to comfort me ". They took my temperature and I had a fever (Interview E28).
Interview 27: "The midwife told me that I could have another child. But for me a child does not replace another".
Interview 44: "The midwife told my husband that we should go home because I was fine and that was the main thing."

**2.3- Effects of the language and vocabulary used by health professionals to announce the death of a newborn on the perinatal bereavement of mothers.**

**Table II-** Comparison of mothers according to language and vocabulary used

| Language and vocabulary | | Perinatal bereavement of mothers | | | | | Total |
|---|---|---|---|---|---|---|---|
| | | Feeling of unreality | Sensitivity and irritability exacerbated | Feeling helplessness | Guilt | No problems | |
| | Adapted | 3 | 3 | 2 | 3 | 10 | **21** |
| | Not Adapted | 9 | 7 | 5 | 6 | 7 | **34** |
| | Total | 12 | 10 | 7 | 9 | 17 | **55** |
| | | **38** | | | | **17** | |

Source: study data (2021)

The value of the calculated Chi square ($X^2$ cal) = 4.442
The value of the theoretical Chi square ($X^2$ th) = 3.841
Significance S at p.≤ .05; 1 ddf.

Statistical analysis of the data establishes a significant difference between mothers who believe that the language and vocabulary of health professionals are not appropriate at the time of the announcement of the death and those who affirm that the language and vocabulary of the nursing staff are adapted. Indeed, the calculated $X^2$ is higher than the theoretical $X^2$ at the probability threshold ($P.\leq.05$). Our hypothesis 2 is therefore confirmed, namely that when the language and the vocabulary used by health professionals to announce the death of a newborn are appropriate; this reduces the harmful effects of perinatal bereavement in mothers.

It emerges from the analysis of the interviews that when the death is announced, the words used are very important for patients. Every word is remembered and can be imprinted in their memory. These verbatims evoke the many difficulties encountered by women who weigh on their life.

Interview 2: "He didn't come to stay!" It was announced to me like this as if it were something normal".

Interview 53: "I had no news of my child for two days. When we have started complaining, we were told the doctor would come and explain. He was not very human, cold. Just 30 seconds to tell me that the pregnancy is over".

Interview 28: "The midwife could not hear the baby's heartbeat with her device. Without telling me, thing was wrong when the staff panicked they were called between them. Then the midwife told me not to worry and wait for the doctor."

Altogether, the results of this study revealed that through their distressing grief experience and confusingly, the mothers had developed a cluster of symptoms. However, those who have received psychological support from caregivers managed to cope with this early loss experience. The data analysis also revealed that the experience of psychological support seems to be a favorable experience when it is characterized by the recognition of parental suffering, their access to fair information and encouragement to take a period of convalescence, so as to enable mothers to make sense of their loss.

Interview 6: "The midwife gave me her contact, stating that I could call her at any time, any moment and that I could come back at any time outside of appointments if things are not going well. That was comforting to me."

## 3- Discussion

The results of our study find an explanation with Watson's theory of human care (1999). For this author, the transpersonal caring relationship characterizes a particular type of connection between caregiver and patient, which is based on humanistic values. According to Watson, the purpose of this relationship is to protect, enhance and preserve the dignity of human being, the wholeness and harmony of the cared person (Watson, 2005). Going beyond objective assessment, this type of relationship describes how the caregiver demonstrates an interest in the subjective and deep understanding of the meaning given by the person with regard to their state of health (Watson, 2006). The uniqueness of the caregiver and the cared person as well as the mutuality are therefore fundamental to this relationship, explain Watson (1988).

According to Watson (2001, 2006), the carer and the person cared for unite in research mutual meaning in order to transcend suffering and access a greater harmony.

Our study shows that the age group between 18 and 25 years (36%) and that between the ages of 36 and over (40%) are more exposed to perinatal deaths. Indeed, regarding the first age group, it generally constitutes inexperienced persons often subjected to an unwanted pregnancy. As for the age group of 36 and over, it constitutes multiparous who, although they are experienced, represent an at risk group because of their age. These results are consistent with those of Zeitlin et al (1998) who state that the extremes aged under 20 and over 36 are at greater risk of perinatal death.

The study also shows that the announcement of the perinatal death was done without preparation, psychologically and abruptly. That is to say without any psychological support. Our results join those of Djiba (2017) who deplores the behavior of caregivers when announcing of perinatal death. In addition, the study shows the dissatisfaction of women at the time of the announcement and a lack of listening from the

part of the nursing staff. They denounce a trivialization of their situation through the language and vocabulary used to make the announcement.
Our results agree with those of Gratadour (2017) who returns to the lack of listening to the caregivers during perinatal deaths in its study on support for mothers bereaved.
Our results corroborate those of Métrailler al-Sayegh, (2006) who stipulates that a professional accompaniment is a tool for the prevention of mental disorders and marital conflicts). Mothers who received support from caregivers live better their mourning. Moreover, the work of Caron and Guay (2005), Hurdle, (2001) report that the psychosocial support constitutes a protective factor against perinatal depression. For Webster, Nicholas, Velacott, Cridland, and Fawcett, (2011), access to motherhood is recognized as a period of great psychological vulnerability during which the lack social support can have a significant impact on the level of maternal distress.
The existing literature therefore highlights the key role of social support in the occurrence of perinatal depression.

Although this study provides knowledge on the phenomenon of perinatal bereavement, it nevertheless has limitations that cannot be ignored. These are related to the limited sample size of mothers. Thus, the question of the generalization of the results obtained arises. Consequently, the results are not representative of the reality experienced by all mothers. Another of the present limitations is the difficulty in obtaining testimonials with certain mothers victims of perinatal death because of the sensitivity of the topic. Indeed, interviewing bereaved mothers can reactivate the trauma of death and create inhibitions to protect themselves, which could affect the results.

Despite these limitations, the study allows several areas for improvement. First, it is the reduction of "non-compliance" through work on communication and comprehension. Then, concerning the psychological support of these perinatal deaths, it would be necessary to provide systematically, within the health centers, an interview with a psychologist or other mental health professional. Finally, the announcement of the perinatal death is not formalized, which leads to various practices depending on the sensitivity of the caregiver.

## Conclusion

Perinatal death is an unacceptable tragedy experienced by some mothers as well as the staff caregiver who has to deal with it. The negative impacts of bereavement can lead to consequences on the life of the mother, of the couple and even of society.
It appears from the results obtained that the announcement of the death is mostly badly experienced by the mothers. Indeed, they express their dissatisfaction with the support they received. There is also a strong feeling of loneliness in them.
It is important for caregivers to remember that, face to the incomprehension of their entourage and social pressure, mothers who lose a baby need a psychological support to overcome the difficulty of society's gaze and find a wellness.
The establishment of a systematic psychological consultation for these mothers and/or couples would be a great step forward in taking their needs and concerns into account in a so painful ordeal.

## References

1. Caron Jean and Stéphane Guay. (2005), Soutien social et santé mentale : concept, mesures, recherches récentes et implications pour les cliniciens. Santé mentale au Québec 30.2 15-41.
2. De Broca, Alain. (2010). Deuils et endeuillés (ed. 4). Paris, France : Masson.
3. De Pontfarcy, Charlotte De Farcy (2013). Le vécu d'une fausse-couche chez les femmes : la fausse couche est-elle à considérer comme une situation de deuil périnatal ? Étude qualitative du 20 septembre au 9 octobre 2012. Gynecology and obstetrics, dumas-00866130.
4. Djiba, Aissatou. L'expérience d'un deuil périnatal chez les femmes vivant dans la région du Saguenay-Lac-Saint-Jean. (201)4. Thèse de doctorat. Université du Québec à Chicoutimi.

5. Douti, Pack. (2020). « Si tu ne pousses pas, tu vas tuer ton enfant !» Sages-femmes et mères face aux morts périnatales au Togo. Santé Publique, (S1), 93-104.
6. Dumoulin, Maryse and Valat (2001). Anne-Sylvie. Morts en maternité : devenir des corps, deuil des familles. Études sur la mort, no 1, p. 77-99.
7. Goulet Celine., & Lang, Ariella. (1996). Le deuil des parents qui perdent un enfant pendant la période périnatale. Frontieres, 9(2), 47-51.
8. Gratadour, Louise (2017). Accompagnement du deuil périnatal en Seine-Saint-Denis : le point de vue des femmes de l'audit RéMI. Gynécologie et obstétrique, dumas-01591319f.
9. Grawitz, Madeleine (2004). Méthodes des sciences sociales. Paris, Dalloz.
10. Groupe interinstitutions des Nations Unies pour l'estimation de la mortalité infantile (UN IGME), (2020). A Neglected Tragedy :The global fardeau of mortinaissances, Fonds des Nations Unies pour l'enfance, New York.
11. Haussaire-Niquet, Chantal. (2001). L'enfant interrompu : la mort au creux du ventre. Etudes sur la mort, (1), 155-162.
12. Hurdle, Donna (2001). Soutien social : un facteur essentiel de la santé des femmes et de la promotion de la santé. Santé et travail social 26.2: 72-79.
13. Hussey, Jill and Hussey, Roger. (1997). Business Research. MacMillan Business, London.
14. Institut National de la Statistique (INS). (2014). Recensement Général de la Population et de l'Habitation (RGPH). Données Socio-Démographiques et Économiques des Localités. Résultats Définitifs par Localités, Région des Lacs.
15. Liu Shiliang, Heaman Maureen, Sauve Reg, Liston Robert, Reyes Francesca, Bartholomew Sharon, et Kramer Michael (2007). (Système canadien de surveillance périnatale, Groupe d'étude sur la santé maternelle). An analysis of antenatal hospitalization in Canada, 1991–2003. Matern Child Health Journal, 11(2): 181-7
16. Métrailler al-Sayegh, Jocelyne (2006). Mourir avant de naître: Accompagner le deuil périnatal lors de pertes de grossesse. Culture des soins, 54-56.
17. Organisation Mondiale de la Santé (1977). Classification internationale des maladies. Genève : OMS.
18. Organisation Mondiale de la Santé (2015). Surveillance des décès maternels et riposte : directives techniques : prévention des décès maternels, informations au service de l'action.
19. Organisation Mondiale de la Santé. (2006). Mortalité néonatale et périnatale : estimations nationales, régionales et mondiales. https://apps.who.int/iris/handle/10665/43444.
20. Romano Hélène., Aurore, Amandine, Chollet-Xemard, Charlotte., & Marty, Jacques. (2011). Enjeux psychiques de la mort périnatale en médecine d'urgence préhospitalière. Annales françaises de médecine d'urgence, 1(2), 123-130. doi :10.1007/s13341-011-0032-5.
21. Rousseau, Pierre (2001). Deuil périnatal : transmission intergénérationnelle. Études sur la mort, no 1, p. 117-137.
22. Verdon Chantal, De Montigny Francine, et Vachon, Éric. Les services offerts aux familles lors d'un décès périnatal. L'infirmière clinicienne, 2009, vol. 6, no 2, p. 25-28.
23. Watson, Jean (1985). Nursing: Human science and human care, a theory of nursing. New York: National League for Nursing.
24. Watson, Jean (1988). Nouvelles dimensions de la théorie de la prise en charge humaine. Sciences infirmières trimestrielles, vol. 1, n° 4, p. 175-181.
25. Webster Joan, Nicholas Catherine, Velacott Catherine, Cridland Noelle, Fawcett Lisa (2011). Quality of life and depression following childbirth : impact of social support. Midwifery, 27(5), 745-749.
26. World Health Organization (2005). Donnons sa chance à chaque mère et à chaque enfant, Rapport sur la santé dans le monde : World Health Organization.
27. Zeitlin Jennifer, Combier Evelyne, De Caunes François & Papiernik Emile (1998). Facteurs de risque socio-démographiques de la mortalité périnatale. Une étude de la mortalité périnatale dans le district français de Seine-Saint-Denis, Acta Obstetricia et Gynecologica Scandinavica, 77:8, 826-835, DOI : 10.1080/j.1600-0412.1998.770808.x.