Психологическая наука и образование
2023. Т. 28. № 2. С. 70—82
DOI: https://doi.org/10.17759/pse.2023280206
ISSN: 1814-2052
ISSN: 2311-7273 (online)

Psychological Science and Education
2023. Vol. 28, no. 2, pp. 70—82
DOI: https://doi.org/10.17759/pse.2023280206
ISSN: 1814-2052
ISSN: 2311-7273 (online)

Childbirth Education and Support During Labour: Association with Birth Satisfaction

Anna D. Suarez
Lomonosov Moscow State University, Moscow, Russia
ORCID: https://orcid.org/0000-0001-5935-2498, e-mail: anna.suarez.fig@gmail.com

Liubov A. Shraibman
Interregional Nonprofit Organization for Advocating for Practical, Informational, and Psychological Support for Families in Pregnancy, Labor & Birth, & Postpartum “Association of Professional Doulas” (INO “APD”), Novosibirsk, Russia
E-mail: doula.nsk@gmail.com

Vera A. Yakupova
Lomonosov Moscow State University, Moscow, Russia
ORCID: https://orcid.org/0000-0002-9472-8283, e-mail: vera.a.romanova@gmail.com

Antenatal education is a common practice with disputable effects on women’s psychological and physical wellbeing. By contrast, there are hundreds of studies that confirm benefits of continuous support during labour, however, women have much less chances to have such support. The purpose of this study was to compare the effectiveness of antenatal education and individual labour support in the context of childbirth experience (the mode of birth and obstetric violence) and its psychological perception (birth satisfaction and physical wellbeing of women after childbirth) in Russia. The study was conducted in February—March 2021 and included mothers of infants aged 0—13 months (N=1645). We found that antenatal education had no direct association with the mode of birth, women’s physical wellbeing after childbirth and birth satisfaction (p>0,70). Women who gave birth without individual labour support were less satisfied with their birth experience, more likely to experience obstetric violence, and more often gave birth via caesarean section (p<0,001). Thus, labour support is a safe way to improve childbirth experience and maternal quality of life in general.

Keywords: labor and birth, childbirth education, labour support, doula, emotional support, obstetric violence, birth satisfaction.

Funding. The reported study was funded by Russian Science Foundation (RSF), project number 22-18-00356 (“PTSD and postpartum depression in mothers as a risk factor for the emotional and cognitive development of the child”).

Acknowledgements. The authors are grateful to Anna A. Kharchenko for assistance in data collection and to all participants of this study.

For citation: Suarez A.D., Shraibman L.A., Yakupova V.A. Childbirth Education and Support During Labour: Association with Birth Satisfaction. *Psikhologicheskaya nauka i obrazovanie = Psychological Science and Education*, 2023. Vol. 28, no. 2, pp. 70—82. DOI: https://doi.org/10.17759/pse.2023280206 (In Russ.).

CC BY-NC

Подготовка к родам и сопровождение: связь с опытом родов

Суарэз А.Д.
ФГБОУ ВО «Московский государственный университет имени М.В. Ломоносова» (ФГБОУ ВО МГУ), г. Москва, Российская Федерация
ORCID: https://orcid.org/0000-0001-5935-2498, e-mail: anna.suarez.fig@gmail.com

Шрайбман Л.А.
Межрегиональная общественная организация содействия практической, информационной и психологической поддержке семьи в беременности, родах и послеродовой период «Ассоциация профессиональных доул» (Ассоциация профессиональных доул), г. Новосибирск, Российская Федерация
E-mail: doula.nsk@gmail.com

Якупова В.А.
ФГБОУ ВО «Московский государственный университет имени М.В. Ломоносова» (ФГБОУ ВО МГУ), г. Москва, Российская Федерация
ORCID: https://orcid.org/0000-0002-9472-8283, e-mail: vera.a.romanova@gmail.com

Представлены материалы исследования эффективности подготовки к родам и индивидуального сопровождения родов в России. Обращается внимание на то, что подготовка к родам — распространенная практика со спорной эффективностью для психологического и физического благополучия женщин. Отмечается, что преимущества непрерывной поддержки в родах показаны в сотнях исследований, но ее реальная возможность значимо ниже. Целью проведенного авторами исследования было сравнение эффективности подготовки к родам и индивидуального сопровождения родов в контексте опыта родов (способа родов и опыта акушерского насилия) и его психологического восприятия (степени удовлетворенности родами и самочувствия женщин после родов) в России. Для этого в феврале—марте 2021 г. матери младенцев в возрасте 0—13 месяцев (N=1645) приняли участие в исследовании. Полученные результаты указывают на то, что подготовка к родам не имеет связи со способом родов, самочувствием женщины после родов и со степенью удовлетворенности опытом родов ($p>0,70$). Женщины, которые рожали без поддержки, были менее удовлетворены своими родами, чаще сталкивались с акушерским насилием, их роды чаще проходили путем кесарева сечения, было худшее самочувствие после родов ($p<0,001$). Таким образом, поддержка женщин во время родов — это безопасный способ улучшения опыта родов и качества жизни матерей в целом.

Ключевые слова: роды, подготовка к родам, сопровождение родов, доула, психологическое сопровождение родов, акушерское насилие, удовлетворенность родами.

Финансирование. Исследование выполнено при финансовой поддержке Российского научного фонда (РНФ) в рамках научного проекта № 22-18-00356 «ПТСР и послеродовая депрессия у матерей как фактор риска для эмоционально-когнитивного развития ребенка».

Благодарности. Авторы хотят выразить благодарность Анне Харченко за ее вклад в сбор данных и всем женщинам, принявшим участие в нашем исследовании.

Для цитаты: *Суарэз А.Д., Шрайбман Л.А., Якупова В.А.* Подготовка к родам и сопровождение: связь с опытом родов // Психологическая наука и образование. 2023. Том 28. № 2. С. 70—82. DOI: https://doi.org/10.17759/pse.2023280206

Introduction

Antenatal education is a common practice, however, its effects on childbirth outcomes remain disputable due to a great variety of educational programs and heterogeneity of their content, as well as researchers' confirmation bias [18]. For example, two studies published in 2021 show contradictory results: in one of them women who had attended antenatal education had statistically higher rates of vaginal births [17], while the other study did not find any correlation between antenatal education and the mode of birth [33]. Moreover, antenatal education can decrease the risk of obstetric violence, i.e. physical, sexualized and/or verbal abuse, intimidation, coercion, humiliation, and/or assault committed by medical staff during childbirth [35]. However, studies report mixed results: for example, in Italy not having attended an antenatal education class was one of the factors most associated with obstetric violence [31], while women who attended such classes in Spain experienced obstetric violence more frequently [28].

Nevertheless, some studies report that antenatal education can improve long-term psychosocial outcomes due to lower rates of birth dissatisfaction that, in turn, often leads to postpartum depression and posttraumatic stress disorder [19; 14; 20]. Another way of how antenatal education may impact birth satisfaction is by reducing discrepancies between birth expectations during pregnancy and actual birth experience [22; 23].

Childbirth education courses started to emerge in Russia and post-Soviet countries in 1980-s and represented closed communities of parents with shared values where one or several experienced mothers (often without any medical/obstetrical background) assumed a role of a childbirth educator to prepare other members to childbirth [6]. As time passed by and in response to changing demands of pregnant women, these courses transformed into qualified antenatal schools and centers that follow Code of Ethics for Childbirth Educators [6].

Meanwhile, there are few studies in Russia that would explore the impact of antenatal education on birth outcomes. K.A. Silayev in his dissertation showed that antenatal education can reduces rates of cesarean births (CBs) and obstetric complications (such as hypotonic labor) and improve maternal and perinatal outcomes [4]. Similar results were reported in a study on antenatal preparation of pregnant woman to VBAC: such comprehensive antenatal education helped more mothers decide to try VBAC and increased the success rate of VBACs [11].

By contrast, there are hundreds of studies that confirmed benefits of continuous support during labor for tens of thousands of women. In 2003 Hodnett et al. published the first Cochrane review[1] on continuous support for women during childbirth, with the latest revision published by Bohren et al. in 2017 [15]. The authors reviewed data of 26 studies and came to a conclusion that continuous support during labor had numerous benefits, including higher rates of spontaneous vaginal births, lower rates of instrumental vaginal births and CBs and

[1] Cochrane Reviews are systematic reviews of research in health care and health policy published in the Cochrane Database of Systematic Reviews https://russia.cochrane.org/ru

less need in pharmacologic management of pain [15]. Mothers who had a support person who only focused on providing their comfort were more satisfied with their childbirth experience and more rarely suffered from symptoms of postpartum depression. Labour support was most effective when provided by a companion who was neither part of the hospital staff nor the woman's social network prior to her pregnancy and labor [24]. Based on all these benefits from a presence of a support person during labour and the lack of any side effects, the American College of Obstetricians and Gynecologists (ACOG) and World Health Organization (WHO) recommend that all women are provided with continuous labour support by a companion of choice [12; 36]. The emotional component of doula support during labour includes non-judgmental reflection of a labouring woman's emotions, reassurance, encouragement, breathing techniques for alleviating anxiety, and providing information on the process of childbirth [21; 29].

The presence of a birth partner in Russia has only become a legal right in 2012 [16]. However, small maternity care hospitals can still restrict a birth partner's presence during labor due to absence of individual wards. It is even more difficult for any other person, such as doula or private midwife, to get access to a maternity care hospital and provide support during labour. Most maternity care hospitals allow individual support by a doula/midwife only under a paid contract but not during labour under state compulsory health insurance. Moreover, maternity care hospitals may restrict doula access to the unit as there is no law in Russia that would ensure a woman's right to have a doula during labour [5]. Therefore, women in Russia face an acute problem of inaccessibility of continuous labour support, despite the fact that there are studies on Russian samples that already confirmed positive effects of labour support such as lower rates of CBs, medical interventions, and obstetric violence [37].

Thus, the aim of this study is to examine the associations between antenatal education and individual labour support with the following factors of childbirth: the mode of birth, obstetric violence, birth satisfaction, and women's physical wellbeing after childbirth in Russia.

Methods

2.1 Procedure and participants

In February — March 2021 women were invited to take part in the study via specialized online and offline communities and antenatal education classes. The survey was conducted online using 'Testograph' platform. The inclusion criteria were respondent's age of 18 years and over, ability to read and write in Russian, and having given birth no longer than 14 months prior to the study. A total of 1,645 mothers of infants aged 0—13 months ($M = 6.93$) met these criteria and completed the online survey.

The study was approved by the Ethical Committee of the Russian Psychological Society, Lomonosov Moscow State University. All participants were offered to sign an informed consent via the online 'Testograph' platform. The study was conducted in accordance with the WMA Declaration of Helsinki.

2.2 Demographic, pregnancy and childbirth experience questionnaire

2.2.1 Demographic characteristics

The participants specified their age at the time of childbirth, education (basic school education/vocational education/higher education), marital status (married/cohabiting with a partner/single), and the place of childbirth (Moscow and capital region/Other city in Russia with population >1 million/Other city in Russia with population <1 million/Post-Soviet States/Other).

2.2.2 Obstetric and medical characteristics

The survey included questions regarding childbirth experience: the respondents provided information regarding gestational age at the time of birth (in weeks), time since birth (in months), parity, and mode of birth (vaginal/CB). We also collected information about the type of the childbirth healthcare plan (childbirth in a maternity care hospital under state compulsory health insurance/ childbirth in a maternity care hospital with a paid contract/home birth).

In addition, the participants reported whether they had experienced obstetric violence during childbirth. If they had faced any, we asked the women to specify the type of obstetric violence (medical interventions without patient's consent and approval/verbal aggression /physical aggression (such as immobilization, forbiddance to drink)/threats and accusations/Kristeller maneuver/pain relief denial/ignoring the needs of the birthing woman).

The participants also rated how they felt physically after childbirth on a scale from 1 to 10, where 1 is very bad and 10 is excellent.

2.2.3 Individual labour support and antenatal education

Further we collected information about the sources of support during labour (none/ partner/doula or private midwife/partner+doula or private midwife) and antenatal education type (none/self-education/ educational courses/mixed educational strategies, where participants chose several sources for childbirth preparation). We also asked the participants whether their labour support plan prepared during pregnancy was actually fulfilled during birth.

2.3 Birth Satisfaction Scale Revised Indicator

We used the Russian version of the Birth Satisfaction Scale Revised Indicator (BSS-RI) [27] to assess the levels of birth satisfaction. It is a short 6-item self-report questionnaire to assess birth satisfaction where the subscales represent the level of stress and anxiety, feeling of control, and caregivers' support. A 3-point Likert scale is used for each question (range 0—2, where 0 means "no", 1 means "partly" and 2 means "yes"). Minimum score is 0, maximum score is 12. The Cronbach's α in this study was 0.805.

2.4 Statistical analysis

We explored the association between the type of support during labour and type of antenatal education and birth experience factors specified in metric variables (birth satisfaction, the number of types of obstetric violence and physical wellbeing after childbirth) using ANOVA.

Pearson Chi-square tests were performed to explore the association between the type of support during labour and type of antenatal education and birth experience factors specified in qualitative variables (the mode of birth and experience of obstetric violence).

We analyzed obstetric violence both as a qualitative variable (the fact of experienced obstetric violence) and as a metric variable — the total number of types of obstetric violence a woman experienced during childbirth.

All statistical procedures were adjusted for covariates (maternal age at the time childbirth, time since birth, gestational age at the time birth) and random factors (the place of childbirth, education, marital status).

The statistical analysis was performed using IBM SPSS 25 software.

Results

The main characteristics of the sample are presented in Table 1 in the following OSF repository: https://osf.io/

trvh4. As you can see, the majority of the participants are officially married (94%), have higher education (91.8%), and gave birth in big cities in Russia with population >1 million (60.2%). The majority of the participants were primiparous (59%), gave birth in a maternity care hospital under state compulsory health insurance (62%) and had vaginal births (69%). 58% of the participants reported that their labour support plan could not be fulfilled due to COVID-19 restrictions. More than a quarter of the women (27.7%) experienced minimum one type of obstetric violence, most often in form of verbal aggression and rudeness (15.6%). Two thirds of the participants reported that they used some type of antenatal education (75.1%), most often — self-education (45.2%). The overall majority of the participants (73%) gave birth without individual labour support.

3.1 Association between the type of antenatal education and birth experience

We identified four types of antenatal education: none, self-education, educational courses and mixed educational strategies (where a woman used several types at the same time). We also analyzed presence or lack of antenatal education in general. We did not find any significant association between birth satisfaction and type of antenatal education (F=0.151 (3; 10, 263), p=0.70). No significant association was found between presence of antenatal education and the mode of birth (Pearson Chi-Square=3.201, (3), p=0.074). We also did not find any statistically significant association between the type of antenatal education and women's physical wellbeing after childbirth (F=10.192 (3; 7, 637), p=0.72).

The results show a statistically significant association between the number of types of obstetric violence a woman experienced during birth and antenatal education (F=12.438 (3; ,654), p<0.001). The lowest mean number of types of obstetric violence was in the group of women who did not have any antenatal education (Table 2).

3.2 Association between individual labour support and birth experience

After the data processing, we identified four types of labour support: none; partner; partner + private midwife or doula; private midwife or doula (Table 3). We found significant differences in the level of birth satisfaction depending on

Table 2

Mean values of the main variables depending on the type of antenatal education

Type of antenatal education	Birth satisfaction (within 0—12 range) Mean/Standard deviation	Obstetric violence (within 0—4 range) Mean/Standard deviation	Wellbeing after childbirth (within 0—10 range) Mean/Standard deviation
None	7.83 / 3.18	0.24 / 0.59	6.27 / 2.74
Self-education	7.48 / 3.25	0.43 /0.83	6.33 / 2.80
Educational courses	7.78 / 3.05	0.45 / 0.84	6.44 / 2.78
Mixed educational strategies	7.59 / 3.37	0.67 / 1.03	6.58 / 2.72

the type of labour support (F=13.094, (3; 9.819), p<0.001). The lowest mean values of birth satisfaction were observed in the group of women who gave birth without labour support (Table 3). There were significantly higher rates of obstetric violence experienced by women who gave birth without labour support (PearsonChi-Square=21.483, (3), p<0.001). There were also significant differences in the number of types of obstetric violence a woman experienced during birth depending on the group (F=9.910 (3; ,648), p<0.001): the highest mean number of types of obstetric violence was found in the group of women who gave birth without labour support (Table 3).

We found a statistically significant association between labour support and the mode of birth (PearsonChi-Square=25.731, (3), p<0.001). The rate of CBs was higher among women who gave birth without labour support (PearsonChi-Square=4.484 (3), p=0.034).

The ratings made by a woman on her physical wellbeing after childbirth also correlated with the type of labour support (F=6.534, (3; 7.560), p<0.001): the highest mean rating was seen in the group of women who were supported by a private midwife or doula (Table 3).

Discussion

This is the first in Russia study exploring antenatal education and individual labour support within one cohort at the same time to compare their effects on the mode of birth, number of types of obstetric violence, birth satisfaction, and women's physical wellbeing after childbirth.

We did not find any statistically significant association between antenatal education, birth satisfaction, and birth outcomes, which corresponds with a study in Spain by Artieta-Pinedo et al. [13] who assumed that it is associated with high medicalization of childbirth in Spain where antenatal education cannot impact the general birth culture and actions of healthcare professionals. The maternal healthcare system in Russia also often fails to consider the needs of labouring women and remains rather medicalized [32; 10], which is confirmed by our study in the previous year on a Russian sample 84.6% of which reported that they experienced at least one medical intervention during their childbirth [37]. Medicalization of childbirth is understood as high rates of medical interventions, including their use for non-medical problems, and intensive medical control over childbirth process [9; 30].

Table 3

Mean values of the main variables depending on the type of labour support

Type of labour support	Birth satisfaction (within 0—12 range) Mean/Standard deviation	Obstetric violence (within 0—4 range) Mean/Standard deviation	Wellbeing after childbirth (within 0—10 range) Mean/Standard deviatio n
None	7.33 / 3.32	0.49 / 0.89	6.18 / 2.80
Partner	8.24 / 2.83	0.25 / 0.54	6.81 / 2.60
Partner+private midwife or doula	8.52 / 2.97	0.20 / 0.50	6.91 / 2.79
Private midwife or doula	8.67 / 2.62	0.23 / 0.55	6.99 / 2.55

At the same time, several studies showed beneficial effects of the psychological component of antenatal education on birth outcomes and adjustment to a new social role [2; 3]. Moreover, antenatal education can serve as an orientation in a new parenting role [1]. In this study we did not investigate the contents of different antenatal educational courses, yet these could vary tremendously from hospital-based classes to traditional "women circles", providing evidence-based information or ethnoscience [7]. Therefore, there is a need in a more detailed study on the quality of different models of antenatal education and their potential impact on birth satisfaction and subjective birth experience.

It is important to note that according to our data women who used some type of antenatal education faced obstetric violence more often. However, most probably that not is associated with a higher risk of obstetric violence for those who had some antenatal education, it might mean that these women are more able to recognize acts of obstetric violence. Unfortunately, even if women are informed about their rights, they are too vulnerable during childbirth to confront violent actions of medical staff [32]. There is a pressing need for raising awareness about ethical communication with patients and humanization of childbirth in Russia and around the world.

Approximately a quarter of the participants (27%) gave birth with individual labour support. This is first of all explained by the fact that we collected data during the COVID-19 pandemic when most maternity care hospitals and maternity units around the world imposed restrictions on continuous labour support in order to prevent the spread of the virus and protect pregnant women and newborns from a potential threat to their life and health [8]. Therefore, according to our data, actual support during labour was of even higher importance. Unlike antenatal education, individual labour support was associated with all the variables we studied. Women who gave birth without labour support were less satisfied with their birth, experienced more obstetric violence, had more CBs, and felt worse in after childbirth. Thus, non-medical labour support is a safe way to reduce the rates of CBs and obstetric violence and to improve birth experiences and maternal quality of life in general. Based on our data, we can assume that presence of a close one or a helper during labour may be of great support for a woman because in a stressful situation she might find it hard to apply the skills and knowledge acquired at antenatal educational courses. Some studies report that women who give birth with labour support receive breastfeeding support more often, which is a great contribution to children's health and development [26]. Our data emphasize that women need not only medical assistance, but also psychological comfort during labour and delivery.

It is interesting to note that in our study the highest scores on the birth satisfaction scale and physical wellbeing after childbirth were reported by women who gave birth with a doula/ private midwife. This corresponds with data of previous studies where support was most effective when provided by a woman who was neither part of the hospital staff nor the woman's social network before pregnancy [24]. There are also studies that analyze the psychological component of labour support where women emphasize that continuous presence of a companion, non-judgmental emotional support, presence of someone to share their emotions with were especially valuable and helped reduce their anxiety [15; 25; 33]. Hence, it is important that perinatal specialists, maternity care hospitals, and society in general ensure continuous labour support both by a partner/child's father and by any other companion of choice, including a private midwife or doula.

Conclusions

This is the first in Russia study exploring association between antenatal education and individual labour support and birth outcome and subjective birth experience. Our results showed no direct association between antenatal education and birth satisfaction and birth outcomes. However, we revealed an important trend: women that prepare to childbirth more often recognize unacceptable behavior of healthcare professionals, specifically, obstetric violence. This means that women are getting more and more involved in the process of their childbirth, are aware of their rights, and want respectful attitude from medical staff. Our results show that individual labour support is very important for significant improvement of childbirth experience and outcomes. Non-medical labour support can potentially reduce the rates of CBs and obstetric violence and improve maternal physical wellbeing and quality of life in general.

Thus, it is important that perinatal specialists, maternity care hospitals, and society in general ensure continuous individual labour support both by a partner and any other companion of choice, including a private midwife or doula.

Limitations and Future Research Directions

The main limitation of our study is that the data were collected anonymously and online. The researchers and participants do not have any direct contacts, which may reduce the participants' trust to the researchers and as a result impact the reliability of their responses. Second, all the data are based on self-reports, with no medical records such as statements from medical charts. Finally, the third limitation is related to the characteristics of our cohort: the majority of the respondents are officially married, have higher education, and live in big Russian cities, which may limit the generalizability of our results to other social strata.

An important direction for future research would be a more detailed study of the content of antenatal education courses and self-education to explore significance of effects of their different components on birth satisfaction. Phycological components of labour support also need further in-depth research.

Access to childbirth medical records would have enabled more substantial conclusions based on our data.

References

1. Zakharova E.I. Predstavlenie o kharaktere sotsial'noi roli, kak sredstvo orientirovki v ee ispolnenii [Individual Notions of Social Role Characteristics as Means of Orientation]. *Kul'turno-istoricheskaya psikhologiya* [*Cultural-Historical Psychology*], 2012. Vol. 8, no. 4, pp. 38—41. (In Russ.).
2. Zakharova E.I. Roditel'stvo kak vozrastno-psikhologicheskii fenomen: Avtoref. dis. … dok. psikhol. nauk. [Parenthood as developmental psychological phenomenon Dr. Sci. (Psychology) Thesis]. Moscow, 2017. 46 p. (In Russ.).
3. Lantsburg M.E. Rol' psikhologicheskoi podgotovki i podderzhki v realizatsii roditel'skikh funktsii [The Role of Psychological Training and Support in the Implementation of Parenting Functions]. *Psikhologicheskaya nauka i obrazovanie* [*Psychological Science and Education*], 2011. Vol. 16, no. 1, pp. 15—26. (In Russ.).
4. Manukhin I.B., Silaev K.A., Vuchenovich Yu.D. Vliyanie sovremennoi metodiki dorodovoi psikhoprofilakticheskoi podgotovki beremennykh i al'ternativnykh sposobov vaginal'nogo rodorazresheniya na techenie i iskhod rodov [Influence of modern methods of prenatal psychoprophylactic preparation of pregnant women and alternative methods of vaginal delivery on the course and outcome of labor]. *Akusherstvo i ginekologiya* [*Obstetrics and Gynecology*], 2018, no. 2, pp. 115—119. DOI:10.18565/aig.2018.2.115-119 (In Russ.).
5. Ozhiganova A.A. "Aktivnoe nedoverie" vracham: sluchai yuridicheskogo soprovozhdeniya rodov [Active mistrust' of doctors: A case study of legal support during childbirth]. *Sibirskie istoricheskie issledovaniya*

[*Siberian Historical Research*], 2020, no. 4, pp. 195—216. DOI:10.17223/2312461X/30/10 (In Russ.).
6. Ozhiganova A.A. Istoriya rossiiskogo dvizheniya za domashnie rody i osoznannoe roditel'stvo (1980-e gody—nastoyashchee vremya) [History of the Russian Movement for Home Birth and Attachment Parenting (from 1980s to Present Time)]. *Meditsinskaya antropologiya i bioetika* [*Medical anthropology and bioethics*], 2019. Vol. 17, no. 1, pp. 93—105. DOI:10.33876/2224-9680/2019-1-17/05 (In Russ.).
7. Ozhiganova A.A. "Soznatel'nye" roditeli i patsienty: Chto izuchayut na kursakh podgotovki k rodam ["Conscious" parents and patients: what they are learning at the childbirth preparation courses?]. *Zhurnal Issledovanii Sotsial'noi Politiki* [*The Journal of Social Policy Studies*], 2022, no. 2, pp. 229—246. DOI:10.17323/727-0634-2022-20-2-229-246 (In Russ.).
8. Ozhiganova A.A., Molodtsova M.O. Rody v usloviyakh karantina: pozitsiya douly [Birth during Quarantine: Doula's Stance]. *Meditsinskaya antropologiya i bioetika* [*Medical anthropology and bioethics*], 2020. Vol. 19, no. 1, pp. 158—173. DOI:10.33876/2224-9680/2020-1-19/09 (In Russ.).
9. Temkina A.A. Medikalizatsiya reproduktsii i rodov: bor'ba za kontrol' [Medicalization of the reproduction and childbirth: a struggle for control]. *Zhurnal issledovanii sotsial'noi politiki* [*The Journal of Social Policy Studies*], 2014. Vol. 12, no. 3, pp. 321—336. (In Russ.).
10. Shalygina N.V. Sovremennoe rodovspomozhenie v Rossii kak sotsiokul'turnyi fenomen (metodologicheskie podkhody k izucheniyu) [Modern maternal healthcare in Russia as a socio-cultural phenomenon (methodological research approaches)]. *Meditsinskaya antropologiya i bioetika* [*Medical Anthropology and Bioethics*], 2019. Vol. 19, no. 1, pp. 145—167. DOI:10.33876/2224-9680/2019-1-17/07 (In Russ.).
11. Shevtsova E.P., Miroshnikov A.E., Shatilova Yu.A., Zharkin N.A. Kompleksnaya podgotovka beremennykh s rubtsom na matke k vaginal'nym rodam [Integrated preparation of pregnant woman with a uterine scar to vaginal parturition]. *Arkhiv akusherstva i ginekologii im. V.F. Snegireva* [*V.F. Snegirev Archives of Obstetrics and Gynecology*], 2019. Vol. 6, no. 1, pp. 38—42. DOI:10.18821/2313-8726-2019-6-1-38-42 (In Russ.).
12. American College of Obstetricians and Gynecologists (College), Society for Maternal-Fetal Medicine, Caughey A.B., Cahill A.G., Guise J.M., Rouse D.J. Safe prevention of the primary cesarean delivery. *American journal of obstetrics and gynecology*, 2014. Vol. 210, no. 3, pp. 179—193. DOI:10.1016/j.ajog.2014.01.026
13. Artieta-Pinedo I. et al. The benefits of antenatal education for the childbirth process in Spain. *Nursing Research*, 2010. Vol. 59(3), pp. 194—202. DOI:10.1097/NNR.0b013e3181dbbb4e
14. Bell A.F., Andersson E. The birth experience and women's postnatal depression: A systematic review. *Midwifery*, 2016. Vol. 39, pp. 112—123. DOI:10.1016/j.midw.2016.04.014
15. Bohren M.A. et al. Continuous support for women during childbirth. *The Cochrane database of systematic reviews*, 2017. Vol. 7(7), pp. CD003766. DOI:10.1002/14651858.CD003766.pub6
16. Borozdina E., Novkunskaya A. Patient-centered care in Russian maternity hospitals: Introducing a new approach through professionals' agency. *Health (London, England: 1997)*, 2022. Vol. 26(2), pp. 200—220. DOI:10.1177/1363459320925871
17. Çankaya S., Şimşek B. Effects of Antenatal Education on Fear of Birth, Depression, Anxiety, Childbirth Self-Efficacy, and Mode of Delivery in Primiparous Pregnant Women: A Prospective Randomized Controlled Study. *Clinical Nursing Research*, 2021. Vol. 30, no. 6, pp. 818—829. DOI:10.1177/1054773820916984
18. Ferguson S., Davis D., Browne J. Does antenatal education affect labour and birth? A structured review of the literature. *Women Birth*, 2013. Vol. 26(1). E5-8. DOI:10.1016/j.wombi.2012.09.003
19. Ford E., Ayers S., Wright D.B. Measurement of maternal perceptions of support and control in birth (SCIB). *Journal of women's health*. 2009. Vol. 18, no. 2, pp. 245—252. DOI:10.1089/jwh.2008.0882
20. Garthus-Niegel S., von Soest T., Vollrath M.E., Eberhard-Gran M. The impact of subjective birth experiences on post-traumatic stress symptoms: a longitudinal study. *Archives of Women's Mental Health,* 2013. Vol. 16, pp. 1—10. DOI:10.1007/s00737-012-0301-3
21. Gilliland A.L. After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada. *Midwifery*, 2011. Vol. 27, no. 4, pp. 525—531.
22. Goodman P., Mackey M.C., Tavakoli A.S. Factors related to childbirth satisfaction. *Journal of advanced nursing*, 2004. Vol. 46(2), pp. 212—219. DOI:10.1111/j.1365-2648.2003.02981.x
23. Hauck Y., Fenwick J., Downie J., Butt J. The influence of childbirth expectations on Western Australian women's perceptions of their birth experience. *Midwifery*, 2007. Vol. 23(3), pp. 235—247. DOI:10.1016/j.midw.2006.02.002
24. Hodnett E.D., Gates S., Hofmeyr G.J., Sakala C. Continuous support for women during childbirth. *Cochrane Database Syst Rev,* 2013. Vol. 7. CD003766. DOI:10.1002/14651858.CD003766.pub5
25. Hofmeyr G.J. et al. Companionship to modify the clinical birth environment: effects on progress and perceptions of labour, and breastfeeding. *Br J Obstet Gynaecol*, 1991. Vol. 98, no. 8, pp. 756—764.

26. McFadden A. et al. Support for healthy breastfeeding mothers with healthy term babies. *The Cochrane database of systematic reviews,* 2017. Vol. 2(2), pp. CD001141. DOI:10.1002/14651858.CD001141.pub5

27. Martin C.R., Hollins Martin C., Redshaw M. The Birth Satisfaction Scale-Revised Indicator (BSS-RI). *BMC Pregnancy Childbirth*, 2017. Vol. 17, p. 277. DOI:10.1186/s12884-017-1459-5

28. Martínez-Galiano J.M., Martinez-Vazquez S., Rodríguez-Almagro J., Hernández-Martinez A. The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study. *Women and birth: journal of the Australian College of Midwives*, 2021. Vol. 34(5), pp. 526—536. DOI:10.1016/j.wombi.2020.10.002

29. Pascali-Bonaro D., Kroeger M. Continuous female companionship during childbirth: a crucial resource in times of stress or calm. *Journal of Midwifery & Women's Health*, 2004. Vol. 49, no. 4, Supplement, pp. 19—27.

30. Sabetghadam S. et al. Assessment of Medicalization of Pregnancy and Childbirth in Low-risk Pregnancies: A Cross-sectional Study. *Int J Community Based Nurs Midwifery*, 2022. Vol. 10, no. 1, pp. 64—73.

31. Scandurra C. et al. Obstetric violence in a group of Italian women: socio-demographic predictors and effects on mental health. *Culture, health & sexuality*, 2021, pp. 1—15. DOI:10.1080/13691058.2021.1970812

32. Temkina A., Litvina D., Novkunskaya A. Emotional styles in Russian maternity hospitals: juggling between khamstvo and smiling. *Emotions and Society*, 2021. Vol. 3(1), pp. 95—113. URL: https://bristoluniversitypressdigital.com/view/journals/emsoc/3/1/article-p95.xml (Accessed 12.10.2022).

33. Thurston L.A.F. et al. Improving birth and breastfeeding outcomes among low resource women in Alabama by including doulas in the interprofessional birth care team. *Journal of Interprofessional Education & Practice,* 2019. Vol. 17, p. 100278.

34. Uslu Yuvaci H. et al. Effects of antepartum education on worries about labor and mode of delivery. *Journal of Psychosomatic Obstetrics & Gynaecology*, 2021. Vol. 42(3), pp. 228—234. DOI:10.1080/0167482X.2020.1725465

35. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement [Electronic resource]. *World Health Organization*, 2014. URL: https://apps.who.int/iris/handle/10665/134588 (Accessed 12.10.2022).

36. World Health Organisation. WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience [Electronic resource]. *World Health Organization*, 2018. URL: https://www.who.int/reproductivehealth/intrapartum-care/en/ (Accessed 12.10.2022).

37. Yakupova V., Suarez A. Postpartum PTSD and birth experience in Russian-speaking women. *Midwifery*, 2022. Vol. 112, p. 103385. DOI:10.1016/j.midw.2022.103385

Литература

1. *Захарова Е.И.* Представление о характере социальной роли, как средство ориентировки в ее исполнении // Культурно-историческая психология. 2012. № 4(8). С. 38—41.

2. *Захарова Е.И.* Родительство как возрастно-психологический феномен: Автореф. дисс. … док. психол. наук. М., 2017. 46 с.

3. *Ланцбург М.Е.* Роль психологической подготовки и поддержки в реализации родительских функций // Психологическая наука и образование. 2011. № 1(16). С. 15—26.

4. *Манухин И.Б., Силаев К.А., Вученович Ю.Д.* Влияние современной методики дородовой психопрофилактической подготовки беременных и альтернативных способов вагинального родоразрешения на течение и исход родов // Акушерство и гинекология. 2018. № 2. С. 115—119. DOI:10.18565/aig.2018.2.115-119

5. *Ожиганова А.А.* «Активное недоверие» врачам: случай юридического сопровождения родов // Сибирские исторические исследования. 2020. № 4. С. 195—216. DOI:10.17223/2312461X/30/10

6. *Ожиганова А.А.* История российского движения за домашние роды и осознанное родительство (1980-е годы—настоящее время) // Медицинская антропология и биоэтика. 2019. № 17(1). С. 93—105. DOI:10.33876/2224-9680/2019-1-17/05

7. *Ожиганова А.А.* «Сознательные» родители и пациенты: Что изучают на курсах подготовки к родам // Журнал Исследований Социальной Политики. 2022. № 2. С. 229—246. DOI:10.17323/727-0634-2022-20-2-229-246

8. *Ожиганова А.А., Молодцова М.О.* Роды в условиях карантина: позиция доулы // Медицинская антропология и биоэтика. 2020. № 19(1). С. 158—173. DOI:10.33876/2224-9680/2020-1-19/09

9. *Темкина А.А.* Медикализация репродукции и родов: борьба за контроль // Журнал исследований социальной политики. 2014. № 3(12). С. 321—336.

10. *Шалыгина Н.В.* Современное родовспоможение в России как социокультурный феномен (методологические подходы к изучению) // Медицинская антропология и биоэтика. 2019.

№ 1(17). С. 145—167. DOI:10.33876/2224-9680/2019-1-17/07

11. *Шевцова Е.П., Мирошников А.Е., Шатилова Ю.А., Жаркин Н.А.* Комплексная подготовка беременных с рубцом на матке к вагинальным родам // Архив акушерства и гинекологии им. В.Ф. Снегирева. 2019. № 6(1). С. 38—42. DOI:10.18821/2313-8726-2019-6-1-38-42

12. American College of Obstetricians and Gynecologists (College), Society for Maternal-Fetal Medicine, Caughey A.B., Cahill A.G., Guise J.M., Rouse D.J. Safe prevention of the primary cesarean delivery // American journal of obstetrics and gynecology. 2014. Vol. 210(3). P. 179—193. DOI:10.1016/j.ajog.2014.01.026

13. *Artieta-Pinedo I. et al.* The benefits of antenatal education for the childbirth process in Spain // Nursing Research. 2010. Vol. 59(3). P. 194—202. DOI:10.1097/NNR.0b013e3181dbbb4e

14. *Bell A.F., Andersson E.* The birth experience and women's postnatal depression: A systematic review // Midwifery. 2016. Vol. 39. P. 112—123. DOI:10.1016/j.midw.2016.04.014

15. *Bohren M.A. et al.* Continuous support for women during childbirth // The Cochrane database of systematic reviews. 2017. Vol. 7(7). P. CD003766. DOI:10.1002/14651858.CD003766.pub6

16. *Borozdina E., Novkunskaya A.* Patient-centered care in Russian maternity hospitals: Introducing a new approach through professionals' agency // Health (London, England: 1997). 2022. Vol. 26(2). P. 200—220. DOI:10.1177/1363459320925871

17. *Çankaya S., Şimşek B.* Effects of Antenatal Education on Fear of Birth, Depression, Anxiety, Childbirth Self-Efficacy, and Mode of Delivery in Primiparous Pregnant Women: A Prospective Randomized Controlled Study // Clinical Nursing Research. 2021. Vol. 30(6). P. 818—829. DOI:10.1177/1054773820916984

18. *Ferguson S., Davis D., Browne J.* Does antenatal education affect labour and birth? A structured review of the literature // Women Birth. 2013. Vol. 26(1). E5-8. DOI:10.1016/j.wombi.2012.09.003

19. *Ford E., Ayers S., Wright D.B.* Measurement of maternal perceptions of support and control in birth (SCIB) // Journal of women's health. 2009. Vol. 18(2). P. 245—252. DOI:10.1089/jwh.2008.0882

20. *Garthus-Niegel S., von Soest T., Vollrath M.E., Eberhard-Gran M.* The impact of subjective birth experiences on post-traumatic stress symptoms: a longitudinal study // Archives of Women's Mental Health. 2013. Vol. 16. P. 1—10. DOI:10.1007/s00737-012-0301-3

21. *Gilliland A.L.* After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada // Midwifery. 2011. Vol. 27. № 4. P. 525—531.

22. *Goodman P., Mackey M.C., Tavakoli A.S.* Factors related to childbirth satisfaction // Journal of advanced nursing. 2004. Vol. 46(2). P. 212—219. DOI:10.1111/j.1365-2648.2003.02981.x

23. *Hauck Y., Fenwick J., Downie J., Butt J.* The influence of childbirth expectations on Western Australian women's perceptions of their birth experience // Midwifery. 2007. Vol. 23(3). P. 235—247. DOI:10.1016/j.midw.2006.02.002

24. *Hodnett E.D., Gates S., Hofmeyr G.J., Sakala C.* Continuous support for women during childbirth // Cochrane Database Syst Rev. 2013. Vol. 7. CD003766. DOI:10.1002/14651858.CD003766.pub5

25. *Hofmeyr G.J. et al.* Companionship to modify the clinical birth environment: effects on progress and perceptions of labour, and breastfeeding // Br J Obstet Gynaecol. 1991. Vol. 98. № 8. P. 756—764.

26. *McFadden A. et al.* Support for healthy breastfeeding mothers with healthy term babies // The Cochrane database of systematic reviews. 2017. Vol. 2(2). P. CD001141. DOI:10.1002/14651858.CD001141.pub5

27. *Martin C.R., Hollins Martin C., Redshaw M.* The Birth Satisfaction Scale-Revised Indicator (BSS-RI) // BMC Pregnancy Childbirth. 2017. Vol. 17. P. 277. DOI:10.1186/s12884-017-1459-5

28. *Martínez-Galiano J.M., Martinez-Vazquez S., Rodríguez-Almagro J., Hernández-Martinez A.* The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study // Women and birth: journal of the Australian College of Midwives. 2021. Vol. 34(5). P. 526—536. DOI:10.1016/j.wombi.2020.10.002

29. *Pascali-Bonaro D., Kroeger M.* Continuous female companionship during childbirth: a crucial resource in times of stress or calm // Journal of Midwifery & Women's Health. 2004. Vol. 49. № 4. Supplement. P. 19—27.

30. *Sabetghadam S. et al.* Assessment of Medicalization of Pregnancy and Childbirth in Low-risk Pregnancies: A Cross-sectional Study // Int J Community Based Nurs Midwifery. 2022. Vol. 10. № 1. P. 64—73.

31. *Scandurra C. et al.* Obstetric violence in a group of Italian women: socio-demographic predictors and effects on mental health // Culture, health & sexuality. 2021. P. 1—15. DOI:10.1080/13691058.2021.1970812

32. *Temkina A., Litvina D., Novkunskaya A.* Emotional styles in Russian maternity hospitals: juggling between khamstvo and smiling // Emotions and Society. 2021. Vol. 3(1). P. 95—113. URL: https://bristoluniversitypressdigital.com/view/journals/emsoc/3/1/article-p95.xml (дата обращения: 12.10.2022).

33. *Thurston L.A.F. et al.* Improving birth and breastfeeding outcomes among low resource women

in Alabama by including doulas in the interprofessional birth care team // Journal of Interprofessional Education & Practice. 2019. Vol. 17. P. 100278.

34. *Uslu Yuvaci H. et al.* Effects of antepartum education on worries about labor and mode of delivery // Journal of Psychosomatic Obstetrics & Gynaecology. 2021. Vol. 42(3). P. 228—234. DOI:10.1080/0167482X.2020.1725465

35. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement [Электронный ресурс] // World Health Organization. 2014. URL: https://apps.who.int/iris/handle/10665/134588 (дата обращения: 12.10.2022).

36. World Health Organisation. WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience [Электронный ресурс] // World Health Organization. 2018. URL: https://www.who.int/reproductivehealth/intrapartum-care/en/ (дата обращения: 12.10.2022).

37. *Yakupova V., Suarez A.* Postpartum PTSD and birth experience in Russian-speaking women // Midwifery. 2022. Vol. 112. P. 103385. DOI:10.1016/j.midw.2022.103385

Information about the authors

Anna D. Suarez, PhD in Psychology, Research Fellow, Lomonosov Moscow State University, Moscow, Russia, ORCID: https://orcid.org/0000-0001-5935-2498, e-mail: anna.suarez.fig@gmail.com

Liubov A. Shraibman, doula, Interregional Nonprofit Organization for Advocating for Practical, Informational, and Psychological Support for Families in Pregnancy, Labor & Birth, & Postpartum “Association of Professional Doulas” (INO “APD”), Novosibirsk, Russia, e-mail: doula.nsk@gmail.com

Vera A. Yakupova, PhD in Psychology, Researcher at Lomonosov Moscow State University, Faculty of Psychology, Moscow, Russia, ORCID: https://orcid.org/0000-0002-9472-8283, e-mail: vera.a.romanova@gmail.com

Информация об авторах

Суарэз Анна Дмитриевна, кандидат психологических наук, научный сотрудник, ФГБОУ ВО «Московский государственный университет имени М.В. Ломоносова» (ФГБОУ ВО МГУ), г. Москва, Российская Федерация, ORCID: https://orcid.org/0000-0001-5935-2498, e-mail: anna.suarez.fig@gmail.com

Шрайбман Любовь Анатольевна, доула, Межрегиональная общественная организация содействия практической, информационной и психологической поддержке семьи в беременности, родах и послеродовой период «Ассоциация профессиональных доул» (Ассоциация профессиональных доул), г. Новосибирск, Российская Федерация, e-mail: doula.nsk@gmail.com

Якупова Вера Анатольевна, кандидат психологических наук, научная сотрудница факультета психологии, ФГБОУ ВО «Московский государственный университет имени М.В. Ломоносова» (ФГБОУ ВО МГУ), г. Москва, Российская Федерация, ORCID: https://orcid.org/0000-0002-9472-8283, e-mail: vera.a.romanova@gmail.com

Получена 02.12.2022
Принята в печать 20.02.2023

Received 02.12.2022
Accepted 20.02.2023