ISSN 2354-8428
e-ISSN 2598-8727

JURNAL KEPERAWATAN

KOMPREHENSIF

COMPREHENSIVE NURSING JOURNAL

Published by :

Sekolah Tinggi Ilmu Keperawatan
PPNI Jawa Barat

Vol. 9 Special Edition, June 2023

JURNAL KEPERAWATAN KOMPREHENSIF	VOL. 9	Special Edition	Bandung June 2023	ISSN 2354-8428	e-ISSN 2598-8727

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

Jurnal Keperawatan Komprehensif
Vol. 9 Special Edition June 2023

Research Article

The Effect of Therapeutic Communication on the Intensity of Labor Pain in Active Phase I at Cengkareng Hospital

Lia Idealistiana[1] | Trias Ayu Nugraheny[2]*

[1]Lecturer of Nursing, Sekolah Tinggi Ilmu Kesehatan Abdi Nusantara, Jakarta – Indonesia

[2]Student of Midwifery, Sekolah Tinggi Ilmu Kesehatan Abdi Nusantara, Jakarta – Indonesia

***contact**

triasnugraheny@gmail.com

Received : 26/06/2023
Revised : 28/06/2023
Accepted : 29/06/2023
Online : 29/06/2023
Published : 30/06/2023

Abstract

Aims: A study of birth mothers in England showed that 93.5% of women described severe or unbearable pain. Pain that cannot be handled alone will result in anxiety and stress. Anxiety can cause labor to go slow. Stress increases catecholamine and interferes with the release of oxytocin resulting in decreased blood flow to the uterus resulting in acidosis and hypoxia in the fetus. For mothers giving birth, it can reduce uterine contractions, so that labor will take longer. The gate control theory states that many factors influence an individual's perception of pain intensity, and some of these factors are psychological, not physiological. One of the factors that can be done is that midwives can provide mental support by providing good communication to mothers during labor, which is known as Therapeutic Communication.
Methods: This research employs a Quasy Experimental research design with a Pretest-Posttest Control Group Design. The sampling technique used is purposive sampling, with a total sample size of 44 respondents. The T-Test is used to process data.
Results: The results showed that there was an effect of providing therapeutic communication in reducing the intensity of labor pain in mothers in the first active phase of labor at Cengkareng Hospital with a p value <0.005, namely a p value obtained 0.000.
Conclusions and Suggestions: There is an effect of the application of therapeutic communication on reducing labor pain in mothers in the active phase of the first stage of labour. Suggestion: It is expected to be able to apply therapeutic communication to mothers in labor.

Keywords:
First Stage of Labor, Pain Intensity, Therapeutic Communication

INTRODUCTION

The Sustainable Development Goals (SDGs) are one of the goals to reduce the Maternal Mortality Rate (MMR). MMR in Indonesia is still very high compared to ASEAN countries. In Indonesia, the MMR in 2017 was 255 per 100,000 live births, in 2019 it was 305 per 100,000 live births, and is the highest maternal mortality rate in ASEAN countries (1). Labor pain that comes and goes or continues can occur due to cervical activity which is starting to be active and experiencing contractions that continuously appear progressively, causing the pain to get worse. Labor pain that is not adapted to by pregnant women can be dangerous and life-threatening for pregnant women and the fetus and can increase the mother's body metabolism which will have an impact on increasing blood pressure, pulse, respiratory rhythm and increasing temperature which affects the gastrointestinal, urinary and respiratory systems (2). A study of birth mothers in the UK showed that 93.5% of women described the pain as severe or unbearable. Pain that cannot be handled alone will result in anxiety and stress.

https://doi.org/10.33755/jkk

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

Jurnal Keperawatan Komprehensif
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Anxiety can cause labor to go slow. Stress increases catecholamine and interferes with the release of oxytocin resulting in decreased blood flow to the uterus resulting in acidosis and hypoxia in the fetus. For mothers giving birth, it can reduce uterine contractions, so that labor will take longer (3).

Labor pain can be reduced both by using pharmacological and non-pharmacological methods. The gate control theory states that many factors influence an individual's perception of pain intensity, and some of these factors are psychological, not physiological. One of the factors that can be done is that midwives can provide mental support by providing good communication to mothers during labor, which is known as Therapeutic Communication (4). Therapeutic communication practices can clearly be found in several hospitals and other health service practice places. Both doctors and midwives and nurses in hospitals are required to have the ability to communicate with their patients in addition to providing midwifery care and medical care. In order to be able to overcome the patient's anxiety which will affect the level of pain during childbirth, so that the delivery goes smoothly and the patient and baby are healthy until the end of the treatment period. Based on the initial survey that was conducted by researchers in the last 2 months at the Cengkareng Hospital, data were obtained on the number of mothers giving birth spontaneously in August 2022 97 patients, September 2022 118 patients. Almost all patients experience severe pain during labour. And most of them experience hysterics during childbirth. Therefore researchers are interested in further researching "The Influence of Therapeutic Communication on the Intensity of Labor Pain during the Active Phase I in Cengkareng Hospital".

METHODS

The purpose of this quantitative study is to ascertain the impact of therapeutic communication on pain experienced by patients during active phase I of labor, and the study's design is a quasi-experimental with one group pretest and posttest. The researchers in this study utilized a quasi-experimental method, administering pre- and post-tests without a control (self-control) group to compare results against (5).

Patients who gave birth normally in the Cengkareng Hospital delivery room comprised the study population. There were a total of 160 mothers who gave birth in the delivery room at Cengkareng Hospital between May and June; of those, 80 were included in the study population since they gave birth during active phase I. All moms who gave birth in the first active phase at Cengkareng Hospital were included in the sample. "Consecutive sampling" is utilized, which is a method of taking samples that meet the requirements throughout time until the number of samples is met. A total of 44 participants were randomly selected for this study's sample. In this investigation, an observation sheet serves as a tool. In the first section, the researcher will evaluate the mother's demographic information, such as her name (initials), age, education level, and profession. In the second section, you'll answer questions designed to elicit information about the degree to which a mother is experiencing pain on a numeric range from 0 to 10. Before and after the intervention, the mother was asked to rate how much pain she was in, and the researcher then filled in the form based on the mother's reported pain levels. Therapeutic communication's impact on first-stage labor pain is investigated here. Research amplification is evaluated by a method that measures pain, namely a numerical pain scale (6).

https://doi.org/10.33755/jkk

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

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RESULTS

Univariate analysis

Table 1. Sample Distribution Based on Mother's Age

Mother's age	N	%
< 20	11	25,0
20-35	23	52,3
>35	10	22,7
Total	44	100

According to the table above, 52.3% of the 44 sample mothers were between the ages of 20 and 35, making up the majority of the reproductive age group.

Table 2. Sample Distribution Based on Mother's Education and Occupation

Mother's Education	N	%
College	2	4,5
SENIOR HIGH SCHOOL	21	47,7
JUNIOR HIGH SCHOOL	15	34,1
ELEMENTARY SCHOOL	6	13,6
Total	**44**	**100**
Mothers Job	N	%
Work	5	11,4
Does Not Work	39	88,6
Total	**44**	**100**

According to the table above, of the 44 samples, it was determined that the majority of mothers had a recent high school diploma, totaling 47.7%, and that the majority of mothers did not work, totaling 88.6%.

Table 3. Average Pain Intensity

Pain Intensity	Pre	Post
Mean	3,02	1,98
Standar Deviasi	0,628	0,590

Based on the data in the table above, it is known that the average intensity of severe pain was found prior to therapeutic communication, but that the average intensity of pain decreased to moderate after therapeutic communication.

Table 4. Sample Distribution Based on Pain Intensity Before Therapeutic Communication

Pain Intensity	N	%
Mild pain	0	0
Moderate pain	8	18,2
Severe pain	27	61,4
Pain is very heavy	9	20,4
Total	44	100

https://doi.org/10.33755/jkk

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

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According to the data presented in the table above, 61.4% of the 44 samples had severe discomfort prior to therapeutic communication.

Table 5. Distribution of Samples Based on Pain Intensity after Therapeutic Communication

Pain Intensity	N	%
Mild pain	8	18,2
Moderate pain	29	65,9
Severe pain	7	15,9
Pain is very heavy	0	0
Total	**44**	**100**

According to the data in the table above, 65.9% of the 44 samples of pain intensity after therapeutic communication had moderate pain.

Bivariate Analysis

Table 6. Effect of Pain Intensity Before and After Therapeutic Communication

Pain Intensity	N	Mean	SD	P Value
Pre	44	3,02	0,628	0,000
Post	44	1,98	0,590	

According to the above table, the p value is 0.000 0.05, indicating that there is a correlation between pain intensity before and after therapeutic communication.

DISCUSSION

Pain Intensity Before Therapeutic Communication

The study's findings revealed that, among the 44 samples analyzed, 61.4% experienced acute discomfort before receiving therapeutic communication. This is due to the fact that women who reported severe pain also reported a high level of dread and anxiety about the upcoming delivery procedure and the lack of support they would receive. Intense suffering was endured by the ordinary mother before the therapeutic communication was implemented. This is due to several factors, one of which is during observation, the average mother has entered the first stage of the active phase, namely opening 4-8 where in (7) at opening 4-8 the pain feels intense, stabbing and stiff caused by uterine contractions that are getting stronger, above 3 times in 10 minutes for 40 seconds or more, and the lower part of the fetus pressing and pulling parts in the pelvic area. In addition, the pain threshold varies from respondent to respondent, and a mother's mental state, especially if she is anxious or feeling weak, can have a significant impact on her ability to deal with the pain she is feeling. This is consistent with the idea proposed by (7), which claims that the experience of pain at his moment is very subjective, dependent not only on the intensity of his but also on the mental state of the person experiencing it. Women who aren't anxious or fearful of giving birth have a far easier time of it than those who are.

As the dose and frequency of pain medication are increased, the intensity of labor pain decreases. According to (8), forewarned women experience less discomfort during childbirth. Anxiety and dread, among other negative emotions, have been linked to an exaggerated experience of

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

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pain during labor. Fear of pain or the anticipation of pain can cause worry, which can lead to stress, exhaustion, and a lack of sleep (the dick-read approach) (3), all of which can make existing discomfort worse. The mother's reaction to discomfort during labor may also be influenced by her previous delivery experiences. For moms who have not had experience giving birth or mothers who give birth for the first time, they will feel worried and terrified in facing labor. The discomfort and intensity of uterine contractions might be exacerbated by psychological or physiological stress or fear (9). Similar research on the efficacy of therapeutic counseling and communication in alleviating labor pain was conducted by (10) at Kendari City Hospital; both studies found that the majority of respondents experienced pain at the level described here before therapeutic communication was carried out. possible up to 18 individuals in weight (56.2%).

Pain Intensity After Therapeutic Communication

The study found that after therapeutic dialogue, the majority (65.9%) of the 44 samples of pain severity were classified as moderate. Because mothers who reported just mild discomfort had been better mentally prepared for giving birth, they were able to move through labor and delivery with greater ease and confidence. (11) that providing care and support to mothers throughout labor and birth, as well as providing accurate information about the birth process and the care that will be provided, leads to improved maternal and infant outcomes. Establishing rapport, attending to the client, listening to complaints, physically helping the client, informing the client, making physical contact, praising the client for his efforts, and providing information are all forms of communication.

In order to alleviate labor pain, midwives should be able to instill a sense of confidence in their patients through therapeutic conversation. If a patient is unprepared for the physical and emotional challenges of giving birth, their anxiety will only serve to heighten their discomfort during the process (12). In line with previous research (10) on the impact of midwife therapeutic communication on the intensity of labor pain at the Kendari City Hospital, the results obtained showed that there was a significant change or decrease in pain levels after receiving therapeutic communication, where the p value was (0.000), which means (P0.05). These findings suggest that therapeutic conversation is an effective method for alleviating discomfort during childbirth.

Effect of Pain Intensity Before and After Therapeutic Communication

The statistical analyses indicated that there was a difference in pain levels before and after the therapeutic conversation (p value 0.000 0.05). According to the statistical test results obtained p value 0.05 (0.000), this study accepts the alternative hypothesis, which is consistent with previous research conducted by (10) on therapeutic communication and found that there was an effect of therapeutic communication on labor pain in mothers in labor in the obstetric and delivery room at the Kendari City Regional General Hospital. Many factors, including the midwife's attitude, demeanor, and communication in contacts, are thought to contribute to the mother's experience. The mother's anxiety and mental strain can be alleviated if the midwife takes the time to explain the interaction.

Setiawan and Tanjung's findings suggest that therapeutic conversation can help lower patients' levels of anxiety and terror. Therefore, it may be argued that these therapeutic communication approaches will alleviate labor pain brought on by fear, worry, and panic. Understanding or accepting oneself is the first step in therapeutic communication, as is learning to manage one's feelings and thoughts, overcoming self-doubt, and positively impacting one's relationships with others and the world around them. Therapeutic communication during childbirth, as defined

https://doi.org/10.33755/jkk

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

Jurnal Keperawatan Komprehensif
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(13,14), entails providing aid to moms who are about to give birth through childbirth counseling activities. Midwives are communicators because they bolster new mothers during childbirth. Therefore, it can be concluded that according to a number of preexisting theories, labor pain that arises due to anxiety, fear, or panic, which can exacerbate labor pain, will be able to be overcome by providing therapeutic communication, where it is seen that the purpose of this therapeutic communication is to reduce the burden on the mind of fear and anxiety faced by patients.

Effect of Age on Pain Intensity

The results show that of the 44 samples, 52.3% were in the prime reproductive years (defined as being between the ages of 20 and 35). This suggests that the majority of mothers are physiologically capable of reproducing. Women's responses to labor pain will vary depending on their stages of development. The maturation of the mind creates a more intense response to pain, while the maturation of bodily organs means they can't perform reproductive functions until later in life. When a woman is of a too-young age, it can be challenging to manage the agony of labor. As reported by (6).

Effect of Mother's Education on Pain Intensity

From the data collected, we can observe that over half (46.7%) of the 44 sampled respondents had completed at least high school. Mothers' awareness of labor pain and pain management will improve as a result of their exposure to educational materials about childbirth. Knowledgeable women report less discomfort throughout labor and delivery than their less informed counterparts.

Effect of Mother's Occupation on Pain Intensity

The results of the study show that among the 44 samples, 88.6% of the respondents were unemployed. It's possible that a mother's exhaustion stems from her time spent caring for her children. Mothers who work outside while pregnant are more likely to become exhausted. However, no hypothesis can be found to account for this.

CONCLUSION

The study found that 61.4% of the 44 samples had severe pain before therapeutic communication. This was mostly because of fear and worry about the delivery process and a lack of support. How the mother deals with things depends a lot on how she feels. Less labor pain is felt when pain relief is used more often and well. How a mother reacts to pain can also be affected by how she felt when she gave birth before. After therapeutic communication, 65.9% of the 44 samples had moderate pain. This is because responders who had moderate pain were mentally better prepared for the birthing process. Support and talking to people during labor and birth can make people feel safe and help things go well. Therapeutic conversation is very important for easing labor pain because it helps people feel more confident in themselves and less afraid and anxious. Research by (10) found that after getting therapeutic communication, pain intensity decreased significantly. The way midwives act, talk, and act in general can also help reduce nervousness and fear. The goal of therapeutic communication is to help patients feel less fear and worry. Most of the people who took part in the study were between 20 and 35 years old, and having a high school education affected what they knew about childbirth and how to deal with pain. But there is no evidence to back the idea that working makes pregnant women tired. This study was done on 44 women in their first active phase who gave birth on their own at Cengkareng Hospital in West Jakarta between November and December 2022. After the data has been processed and talked about, it can be said that there is a connection between therapeutic communication and the intensity of labor pain in the first stage of the active phase at Cengkareng Hospital in 2022.

https://doi.org/10.33755/jkk

p-ISSN : 2354 8428 | e-ISSN: 2598 8727

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