



Influence of intimate partner violence during pregnancy on fear of childbirth



Vahideh Moghaddam Hossieni^{a,b}, Jocelyn Toohill^{c,d,*}, Arash Akaberi^{e,f}, BibiMarzie HashemiAsl^g

^a Doctoral School of Health Sciences, Faculty of Health Sciences, University of Pécs, Hungary

^b Nursing and Midwifery College, Sabzevar University of Medical Sciences, Sabzevar, Iran

^c School of Nursing & Midwifery, Griffith University, Queensland, Australia

^d Office of the Chief Nursing and Midwifery Officer, Queensland Health, Australia

^e Biostatistician, McGill University, Montreal, Canada

^f Sabzevar University of Medical Sciences, Sabzevar, Iran

^g Samen Health Center, Mashhad University of Medical Sciences, Mashhad, Iran

ARTICLE INFO

Article history:

Received 20 February 2017

Revised 4 August 2017

Accepted 6 September 2017

Keywords:

Intimate partner violence

Pregnancy

Fear of childbirth

Iran

ABSTRACT

Objective: Women are at increased risk of intimate partner violence (IPV) during pregnancy. This may impact women's positive anticipation for birth. Negative feelings around birth often translate to a fear of childbirth. Our aim was to examine the prevalence IPV and whether physical, sexual, psychological IPV during pregnancy predicts fear of childbirth among Iranian pregnant women.

Method: A population-based cross sectional study was conducted in North-East Iran. Pregnant women (n = 174) at least 14 weeks gestation attending health centers were selected for inclusion through a stratified sampling method. IPV, fear of birth, state and trait anxiety and socio-demographic variables were collected using validated instruments. To achieve the final models the Bayesian information criterion was used. A p value of <0.05 was considered statistically significant.

Results: Seventy-three percent of women reported experiencing IPV at least once within their current pregnancy. Fear of birth was prevalent (61.5%). Logistic regression analysis revealed that after adjusting for confounding factors, in nulliparous physical IPV significantly predicted fear of birth (adjusted OR = 12.15; 95% CI, 1.33, 110.96) while, in multiparous psychological IPV associated inversely with fear of birth (adjusted OR = 0.18; 95% CI, 0.04, 0.73). For all participants, physical IPV increased the chance of fear of birth, (adjusted OR = 2.47; 95% CI, 1.01, 6.02).

Conclusion: All pregnant women experiencing physical violence had a higher chance of fear of birth. Screening programs for fear of birth and IPV need to be implemented in particular for nulliparous women. Providing continuity of midwifery care and family therapy may be strategies for early support to reduce IPV to pregnant women.

© 2017 Elsevier B.V. All rights reserved.

Introduction

Intimate partner violence (IPV) against women is recognized globally as a significant health problem [1]. IPV is defined as any type of physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner [1]. Women are at risk during pregnancy of being exposed to IPV [2]. In a study of 19 countries, the prevalence of intimate partner violence in pregnancy ranged from a low of

1.8% in Denmark to a high of 13.5% in Uganda [2]. For many women, IPV initially starts during pregnancy [3]. Variation in reported prevalence may be due to recall response bias, cultural tolerance, or personal reasons such as embarrassment or repercussions of reporting [2]. IPV has been found to impact women's emotional well-being and adaption to parenting. Pregnant women experiencing violence are more likely to report higher levels of depressive symptoms, anxiety, and post-traumatic stress disorder, a lower level of mother to infant attachment and reduced rates of breastfeeding compared to non-exposed women [4–6]. Psychological problems such as depression and anxiety before and following birth are also associated with severe fear of childbirth [7,8]. In developed countries poor psychosocial outcomes are recognized as a major contributor to perinatal maternal mortality rates

* Corresponding author at: Griffith University Logan Campus, Australia.

E-mail addresses: Moghaddamvahideh@gmail.com (V. Moghaddam Hossieni), J.Toohill@griffith.edu.au (J. Toohill), arashdata@yahoo.com (A. Akaberi), HashemiAM3@mums.ac.ir (B. HashemiAsl).

[9,10]. Relatively few studies have explored the impact of violence on fear of childbirth. Around one in five pregnant women experience moderate levels of childbirth fear, and 10% of women suffer severe fear of childbirth [11]. Women's fear can affect sleep and a preoccupation with birth can have an adverse impact on daily functioning [12,13]. Furthermore, fear of birth can contribute to higher rates of maternal request for caesarean birth and also higher incidence of emergency caesarean due to protracted labor or clinicians' concerns for a woman's coping capacity [14,15].

Antenatal care in Iran

Antenatal care in Iran is integrated into primary health services and includes antenatal, labor and birth, postnatal and emergency obstetric care for women and their infants. Services are provided by certified midwives at health centers and hospitals. Almost 98% of women receive at least six visits during pregnancy [16]. Mechanisms for optimizing and monitoring maternal care services include a national maternal mortality surveillance system; integrated management of pregnancy and childbirth across services, mother-friendly accredited hospitals, trained skilled birth attendants for deprived and remote regions, and also a program for strengthening the national family planning program [16]. Based on the United Nations Population Fund, and the Population Reference Bureau report (2010), approximately 97% of births are performed by qualified birth personnel [17]. These policies and programs have led to a dramatic decrease in Iran's maternal mortality rate, reaching 25:100,000. This indicates Iran has met their MDG 5-A targets with 80% improvement in maternal mortality rate from 1990 to 2015 [18]. Likewise, a remarkable reduction in infant mortality rate has been achieved, from 45 in 1990 to 13:1000 live births in 2015 [19]. However, despite these noticeable advancements, high rates of caesarean birth remain problematic in Iran. Based on a recent meta-analysis of 34 studies, the rate of caesarean in Iran is 48%, and ranged from 16.2% to 66.5% between cities.

Fear of normal birth has been identified as an underlying cause for the high caesarean section rates in Iran [20]. Studies have reported that 48% of Iranian primigravidae experienced severe fear of childbirth. Fear of birth was significantly linked to psychosocial characteristics such as state and trait anxiety, perceived stress as well as high requests (62.6%) for cesarean [21–23]. In terms of IPV during pregnancy, a systematic review and meta-analysis revealed that 23% of Iranian women experienced physical violence and 44% reported psychological IPV during pregnancy [24].

These findings show that despite many significant improvements in maternity care in Iran, psychosocial problems particularly IPV during pregnancy and fear of childbirth are still high. Although fear of childbirth and IPV during pregnancy have been considered from different perspectives over recent decades, there is no study taking into account the impact of IPV during pregnancy on fear of childbirth. Therefore, this study aimed to assess whether physical, sexual, psychological IPV during pregnancy predicts fear of childbirth among Iranian pregnant women.

Method

Design

We conducted a population-based cross-sectional study with a convenience sample of pregnant women in North-Eastern Iran.

Setting

In Mashhad, there are five health districts each providing care to a similar size population within a number of health centres

(approximately 12–13 centres). In each district, one health centre was selected via cluster sampling and invited to participate based proportionally to the population size of pregnant women in that district

Participants

Pregnant women who met inclusion criteria were invited to the study in proportion to the population size of pregnant women. Inclusion criteria included being Farsi-speaking, literate and Iranian nationality, age from 18 to 40 years old, having a low-risk singleton pregnancy with a gestational age more than 14 weeks, no history of alcohol and/or drug abuse and also not suffering from any major psychological disorder over the past year. We used a sample size estimation method for correlation coefficient based on a pilot study. With a confidence level of 95% and power of 90%, the estimated sample size was 170.

Measures

A survey including the following self-administered questionnaires was used. Measures included:

Revised Conflict tactics scale (CTS2): this instrument investigates prevalence and types of IPV: Psychological Aggression (8 items), Physical Assault (12 items), Sexual Coercion (7 items), and Injury (6 items) [25]. There are 6 categories of responses ranging from "0 = has never happened" to "6 = more than 20 times over a period of the recent 12 months. We limited the questions to the pregnancy period. The prevalence variable is 0 or 1 dichotomy, with a score of 1 assigned if one or more of the acts in the scale occurred. In other words, an affirmative answer to each question (regardless of how many times it happened) signified violence. This scale has been previously used within an Iranian population with a reported Cronbach alpha score of 0.92 [6]. In the present study, a good Cronbach's alpha co-efficient was achieved on all subscales (0.86 for physical, 0.89 for sexual, 0.79 for psychological and 0.91 for injury).

Revised version of the Fear of Vaginal Delivery questionnaire (rFDQ): this instrument includes 11 items relating to fear of vaginal birth with dichotomous answers of "yes" or "no". Six or more positive answers is deemed to be severe fear of childbirth [26]. Validity and reliability of the Farsi version of this instrument derived a Cronbach alpha of 0.81 [27]. In this study the Cronbach alpha was 0.87.

Spielberger's State-Trait Anxiety Inventory (STAI): this scale examines emotional states and personality traits and consists of two subscales namely state anxiety and trait anxiety comprising 40 items overall. Each item has four response options with scores ranging from 0 to 3 indicating women are 'not anxious' to 'high anxious'. A possible total score range for every part, trait and state anxiety, was 0–60. Mahram assessed validity and reliability and approved the Farsi version of this scale [28]. The Cronbach alpha in the present study is 0.91.

Procedures

Women were advised the aim of the research was to identify psycho-social factors that may impact how they felt about their upcoming birth and that their participation was voluntary. Women could decline without any change to how they would receive their care. Following description of the study women were provided written information. Those agreeing to participate were asked to sign a consent form and were then provided the questionnaire. To meet the participants' privacy, we provided a small discrete room at the health centres for women to complete the questionnaires.

Download English Version:

<https://daneshyari.com/en/article/5565933>

Download Persian Version:

<https://daneshyari.com/article/5565933>

[Daneshyari.com](https://daneshyari.com)