



Maternal emotional wellbeing over time and attachment to the fetus when a malformation is detected



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ARTICLE INFO

Article history:

Received 5 December 2014

Revised 19 March 2015

Accepted 12 April 2015

Keywords:

Ultrasound screening

Fetal malformation

Maternal–fetal attachment

Emotional wellbeing

Postnatal depression

ABSTRACT

Objectives: To explore women's emotional wellbeing and attachment to the fetus when informed during pregnancy of a fetal malformation.

Methods: In a longitudinal community-based study, 56 pregnant women with a detected fetal malformation and continued pregnancy were invited to complete questionnaires in mid-pregnancy, two months postpartum and one year postpartum. The questionnaire included the Edinburgh Postnatal Depression Scale, the Cambridge Worry Scale, the State-Trait Anxiety Inventory, and the Maternal–Fetal Attachment Scale. Socio-demographics and obstetric background data were also collected. Descriptive statistical analyses were performed.

Results: Approximately 84% returned the questionnaires and 37% of women in mid-pregnancy, 26.5% two months postpartum and 22% one year postpartum were found to have depressive symptoms. In mid-pregnancy 8.9% had thoughts of harming themselves, and almost all reported at least one major worry. Worry about the relationship with their husband or partner increased two months postpartum and one year postpartum. The means of both state and trait anxiety levels were high on all three measuring occasions and the mean score for maternal–fetal attachment was 3.7 (SD 0.67), indicating a high level of attachment.

Conclusion: The results highlight the importance of adequate support when fetal malformations are detected on ultrasound examination.

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Introduction

The diagnostic benefits of ultrasound scanning in pregnancy are well documented [1]. As ultrasound technology develops and improves, the increasing detection rate of severe structural fetal abnormalities must be addressed. Detection rates vary from 15% to 94% [2,3], depending on gestational age, type of anomaly, maternal body habitus, scanning time, operator skill and experience [4,5]. The screening ultrasound examination is almost universal among pregnant women in Sweden, who are generally satisfied with it. However, they lack information about possible risks [6] and most look forward to the examination for confirmation of a healthy fetus [7,8].

Therefore, an adverse fetal ultrasound finding is usually unexpected and leads to more anxiety in affected mothers than in those with normal findings [8]. Information before and during the

examination, continuity of health care professionals, and good support are important for decreasing women's anxiety when abnormalities are detected [9,10]; however, therapeutic options are limited [11]. Whether or not a woman continues the pregnancy, more attention must be paid to her psychological reactions and stress related to prenatal diagnostic procedures [12].

Pregnancy is characterized by biological, psychological, and social changes in a woman's life [13]. As a consequence of these changes, pregnancy is frequently associated with increased sensitivity, vulnerability, and anxiety [14]. Pregnancy is often described positively as a time of happiness for women. Recent studies, however, show that depression and anxiety during gestation and postpartum are common, and pregnancy is thus also a time of psychological vulnerability [15,16]. The reported prevalence of prenatal depressive symptoms varies from 10% to 20% of pregnant women depending on the study design [17,18]. Prenatal depression negatively affects the woman [19], her partner [20], and the whole family [18]. An increased risk of postpartum depression is also correlated with prenatal depression [21]. Both pre-pregnancy and prenatal depression may increase the risk of prematurity, fetal distress, and neonatal behavioral differences [22].

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How prenatal depression may affect a woman's attachment to her unborn baby has been studied [23]. Attachment during pregnancy has been described as the first important mother–child interaction [24–26]; its significance is well documented and forms the basis of attachment theory [27]. It has also been associated with the subsequent maternal–infant relationship [28,29], and prenatal/postnatal attachment has been correlated with the development of the maternal–infant relationship [26]. One study [30] found that depression and anxiety during pregnancy may induce risks for behavior disorders in the child and disrupt maternal–fetal attachment. It has also been shown that whether some women are pre- or postnatally depressed depends on several factors [31–33]. One of the most important influences on prenatal attachment is support from the woman's partner [34], but other social support is also crucial for the women's adaptation to pregnancy and their prenatal attachment to the fetus [18]. While early detection of a fetal malformation may provide parents the opportunity for emotional preparation, it also may advance a long period of suffering.

The aim of this study was to explore women's emotional well-being and attachment to the fetus when informed during pregnancy of a fetal malformation.

Methods

Design and setting

The design of the study was descriptive. Upon detection of a fetal anomaly the pregnant woman was invited to take part in a questionnaire study.

Participants

The study included sixty-seven women in four fetal care referral centers in Stockholm, Sweden between September 2007 and June 2009. The selection of participants was consecutive and recruitment took place after the woman's decision about continuing the pregnancy. The women were informed verbally by caregivers at the ultrasound units about the aim and the method of the study; the women also received written information. The first author telephoned those who had agreed to confirm their participation. Women not fluent in Swedish were offered an interpreter to enable their participation. Women expecting a baby with a sex chromosome abnormality were excluded to avoid influencing the parents to view these babies as abnormal. Participant characteristics and fetal malformations are presented in Table 1.

Data collection

The questionnaires included common self-report instruments, socio-demographic questions, and obstetric history. All participants gave signed, informed consent and were advised of their right to withdraw from the study at any time without repercussion. The questionnaires were distributed in gestational week 30 (or three weeks after diagnosis if the malformation was detected later than gestational week 30), two months postpartum, and one year postpartum.

The instruments

Edinburgh Postnatal Depression Scale (EPDS)

The EPDS includes 10 items, assessed on a four-point scale (0–3), specific to prenatal and postpartum symptoms of depression, anxiety, and feelings of guilt [35]. Total scores range from 0 to 30, and scores ≥ 13 indicate depressive symptoms [36].

Table 1

Participant characteristics and fetal malformations.

Characteristic/malformation	n = 56
Age, years, mean (SD)	34.4 (5.3)
22–34 ys	27 (49.1)
35–48 ys	28 (50.9)
Marital status n, %	
Married or cohabiting	52 (92.9)
Single/divorced	2 (3.6)
Native language n, %	
Swedish	45 (80.4)
Other than Swedish	11 (19.6)
Education n, %	
College or university	28 (50.0)
High school	17 (30.4)
Elementary	9 (16.1)
Other	2 (3.6)
Obstetric history n, %	
Parity: nullipara	29 (51.8)
Previous miscarriage	13 (23.2)
Previous abortion	13 (23.2)
Previous stillbirth	1 (1.8)
Infertility	5 (8.9)
Previous baby with malformations	1 (1.8)
Detection of fetal malformation gestational week n, %	
0–12 gw	4 (7.1)
13–18 gw	28 (50.0)
19–22 gw	14 (25.0)
23–40 gw	10 (17.9)
Types of malformations	
Cerebral malformation	1
Neural tube defects	2
Intra-abdominal and gastrointestinal defects	13
Thorax and lung defects	7
Fetal heart defects	11
Renal defects	5
Skeletal defects	1
Tumors	1
Chromosomal abnormalities	1
Talipes	3
Cleft lip	2
Miscellaneous defects	9

Cambridge Worry Scale (CWS)

The CWS measures women's worries during pregnancy. It includes 16 items on a Likert scale (0–5) [37]. Forced choice responses range from 0 (“not a worry”) to 5 (“major worry”) [38] and the items were dichotomized into 0–3 (“not a major worry”) and 4–5 (“a major worry”) [39].

State-Trait Anxiety Inventory (STAI)

The STAI presents 40 statements assessed on a four-point scale (1 “not at all” to 4 “very much”), describing two distinct anxiety concepts: trait anxiety (A-Trait), which measures general feelings, and state anxiety (A-State), which describes feelings at a particular time. The STAI-scores can vary from 20 to 80 and were divided into low anxiety (≤ 39), moderate anxiety (40–59), and severe anxiety (≥ 60) [40]. The STAI is a well-validated scale for the evaluation of anxiety [41].

Maternal–Fetal Attachment Scale (MFAS)

The MFAS comprises 24 items measuring 5 dimensions of maternal–fetal relationship (MFR) behaviors: *role taking* (R, four items), *Differentiation of self from fetus* (D, four items), *giving of self* (G, five items), *Interaction with the fetus* (I, five items), and *Attributing characteristics and intentions to the fetus* (A, six items) [42]. Items are scored on a five-point Likert scale (0 “definitely no” to 5 “definitely yes”). In a previous study, the Cronbach's alpha coefficient has shown satisfying consistency of 0.82–0.91 for the total scale and from 0.52 to 0.73 for the subscales [37].

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