



Aetiological relationships between factors associated with postnatal traumatic symptoms among Japanese primiparas and multiparas: A longitudinal study



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ABSTRACT

Objective: this study aims to identify the aetiological relationships of psychosocial factors in postnatal traumatic symptoms among Japanese primiparas and multiparas.

Design: a longitudinal, observational survey.

Setting: participants were recruited at three institutions in Tokyo, Japan between April 2013 and May 2014. Questionnaires were distributed to 464 Japanese women in late pregnancy (> 32 gestational weeks, Time 1), on the third day (Time 2) and one month (Time 3) postpartum.

Measurements: The Japanese Wijma Delivery Expectancy/Experience Questionnaire (JW-DEQ) version A was used to measure antenatal fear of childbirth and social support, while the Impact of Event Scale Revised (IES-R) measured traumatic stress symptoms due to childbirth.

Findings: of the 464 recruited, 427 (92%) completed questionnaires at Time 1, 358 (77%) completed at Time 2, and 248 (53%) completed at Time 3. Total 238 (51%) were analysed. A higher educational level has been identified in analysed group ($p=0.021$). Structural equation modelling was conducted separately for primiparas and multiparas and exhibited a good fit. In both groups antenatal fear of childbirth predicted Time 2 postnatal traumatic symptoms ($\beta=0.33-0.54$, $p=0.002-0.007$). Antenatal fear of childbirth was associated with a history of mental illness ($\beta=0.23$, $p=0.026$) and lower annual income ($\beta=-0.24$, $p=0.018$). Among multiparas, lower satisfaction with a previous delivery was related to antenatal fear of childbirth ($\beta=-0.28$, $p < 0.001$).

Key conclusions: antenatal fear of childbirth was a significant predictor of traumatic stress symptoms after childbirth among both primiparous and multiparous women. Fear of childbirth was predicted by a history of mental illness and lower annual income for primiparous women, whereas previous birth experiences were central to multiparous women.

Implication for practice: the association between antenatal fear of childbirth and postnatal traumatic symptoms indicates the necessity of antenatal care. It may be important to take account of the background of primiparous women, such as a history of mental illness and their attitude towards the upcoming birth. For multiparous women, focusing on and helping them to view their previous birth experiences in a more positive light are vital tasks for midwives.

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Introduction

Childbirth is a significant life event. *Many women* are overjoyed by the birth of their child, which may constitute the greatest happiness in their life. However, this is not always the case. In Western countries, 24–33% of postpartum women are reported to exhibit one or more traumatic stress symptoms due to childbirth (Olde et al., 2006; Grekin and O'Hara, 2014). Traumatic symptoms following childbirth (postnatal traumatic symptoms) consist of four domains: (a) re-experiencing traumatic events, (b) avoidance of situations that recall the traumatic events, (c) negative cognitions and moods related to the traumatic events and (d) alterations in arousal and reactivity (American Psychiatric Association, 2009). Women suffering from postnatal traumatic symptoms are emotionally detached from and afraid of caring for the baby (Nicholls and Ayers, 2007). Furthermore, it has been reported that they avoid sexual activity (Allen, 1998). Healthcare professionals should pay more attention to mothers who report postnatal traumatic symptoms due to the high prevalence and negative impact on the woman and her family.

Primary prevention may be feasible because healthcare professionals, including midwives, have ample opportunity to provide women with psychological support in routine care. A number of authors have emphasized that preventive interventions should be based on the underlying psychological mechanism of traumatic stress symptoms (Ayers et al., 2008; Garthus-Niegel et al., 2013). However, the aetiology of these symptoms remains unclear. Nevertheless, a variety of factors have been reported in previous studies. They include (a) factors existing prior to the current pregnancy (pre-existing factors) such as younger age, new motherhood, low socioeconomic status, history of mental disorders, personality characteristics (e.g., trait anxiety) and previous traumatic experience(s) (e.g., history of sexual abuse and poor attachment to partner) (Czarnocka and Slade, 2000; Olde et al., 2006; Söderquist et al., 2002, 2009), (b) psychological factors during the current pregnancy (pregnancy-related factors) such as psychological distress (e.g., antenatal fear of childbirth) and perceived lower social support from family and healthcare professionals (Wijma et al., 1998a, 1998b; Fairbrother and Woody, 2007; Söderquist et al., 2009), and (c) factors related to the present birth (birth-related factors) including obstetric interventions such as emergency Caesarean section, instrumental and induced delivery (Ryding et al., 2003; Czarnocka and Slade, 2000), negative birth experience and pain during labour (Creedy et al., 2000; Söderquist et al., 2002; Furuta et al., 2014). Although these three categories may contribute to the development of postnatal traumatic symptoms, their aetiological relationships remain unknown.

Previous studies that attempted to reveal the aetiology of postnatal traumatic symptoms were characterised by methodological limitations. Firstly, most were cross-sectional (Wijma et al., 1998a, 1998b; Creedy et al., 2000; Czarnocka and Slade, 2000; Söderquist et al., 2002), making it difficult to determine causal relationships. Secondly, the interaction of independent variables was rarely taken into account (Slade, 2006). Multivariate regressions were often employed, in which conceptually similar and temporally discrete variables were entered into a single regression analysis, meaning that indirect effects of independent variables on dependent variables cannot be ruled out. Thirdly, birth parity should be taken into consideration because the birthing process, labour pain, duration of childbirth and experiences differ between primiparas and multiparas (Waldenström et al., 2004).

In Japan, only one study (Matsumoto et al., 2006) investigated traumatic stress symptoms due to the experience of childbirth among 485 Japanese mothers at one month postpartum. The reported prevalence of severe traumatic symptoms was 8.4%. More evidence of postnatal traumatic symptoms due to childbirth from different samples should be explored. The aim of this longitudinal study was to identify the aetiological relationships of factors associated with postnatal traumatic symptoms among Japanese primiparas and multiparas.

Methods

Setting

A longitudinal, prospective, observational study was conducted between April 2013 and May 2014 at three obstetric facilities in Tokyo (Clinic A and Hospitals B and C), all of which had an outpatient and inpatient obstetrics department. Questionnaires were distributed to the participants on three occasions: late pregnancy (> 32 gestational week: Time 1), early postpartum (on the third day after the birth: Time 2) and one month postpartum (Time 3).

Participants and procedure

Women in late pregnancy (Time 1) were invited to participate in the study while attending the outpatient clinic. Women who were less than 20 years old, unable to read Japanese, hospitalized due to major pregnancy complications or who suffered from serious mental disorders were excluded. Women with a planned Caesarean section were not recruited because their expectations and experience related to childbirth were likely to differ from those undergoing vaginal delivery. However, women who underwent an emergency Caesarean section were included because this intervention generally takes place at the final stage of the childbirth process and includes a combination of normal labour and emergency Caesarean section.

Pregnant women who met the inclusion criteria were asked to complete the first questionnaire in late pregnancy (> 32 gestational weeks, Time 1). Time 1 and Time 2 questionnaires were distributed and collected by the researcher (M.T.). The Time 3 questionnaire was sent to the women's home and returned by post.

Measurements

Pre-existing factors (Time 1)

The participants' age, birth parity, history of disease, history of mental illness, complexity of the pregnancy (pregnancy-induced hypertension, experience of threatened premature labour and placenta praevia) and attendance of husband during childbirth were obtained from medical records. Marital status, educational background and annual income were obtained via the questionnaire. In multiparous women, the experiences of previous births (emergency Caesarean section, instrumental delivery and induced delivery) were obtained from the questionnaire. Satisfaction with the previous birth was assessed by the following question: "Were you satisfied with your previous birth experience?", which was answered on a 5-point scale ranging from "Not at all" (1) to "Very much" (5).

Pregnancy-related factors (Time 1)

Antenatal fear of childbirth. Antenatal fear of childbirth may be a key factor in determining the link between pre-existing variables and postnatal traumatic symptoms. It was measured by the Japanese version (Takegata et al., 2013) of the Wijma Delivery Expectancy/Experience Questionnaire Version A (JW-DEQ: Wijma et al., 1998a, 1998b), in which women are asked to imagine how their birth will be. The instrument consists of 33 items on a 6-point scale ranging from "Not at all" (0) to "Extremely" (5). The minimum score is 0 and the maximum is 165. The JW-DEQ version A has four factors, Fear, Lack of positive anticipation, Isolation and Riskiness (Takegata et al., 2013), which were extracted from an exploratory factor analysis and are consistent with those identified in studies using the English and Swedish versions (Johnson and Slade, 2002; Fenwick et al., 2009). In the present study, Cronbach's alpha for the JW-DEQ total score was 0.93.

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