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Risk factors associated with post-traumatic stress symptoms following childbirth in Turkey



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ABSTRACT

Objective: this study examined factors associated with symptoms of post-traumatic stress (PTS) following childbirth in women with normal, low-risk pregnancies in Nigde, Turkey.

Design: a prospective longitudinal design where women completed questionnaire measures at 20+ weeks' gestation and 6–8 weeks after birth.

Setting: eligible pregnant women were recruited from nine family healthcare centres in Nigde between September 2013 and July 2014.

Participants: a total of 242 women completed questionnaires at both time points.

Measures: PTS symptoms were measured using the Impact of Event Scale-Revised (IES-R) 6–8 weeks after birth. Potential protective or risk factors of childbirth self-efficacy, fear of childbirth, adaptation to pregnancy/motherhood, and perceived social support were measured in pregnancy and after birth. Perceived support and control during birth was measured after birth. Demographic and obstetric information was collected in pregnancy using standard self-report questions.

Findings: PTS symptoms were associated with being multiparous, having a planned pregnancy, poor psychological adaptation to pregnancy, higher outcome expectancy but lower efficacy expectancy during pregnancy, urinary catheterization during labour, less support and perceived control in birth, less satisfaction with hospital care, poor psychological adaptation to motherhood and increased fear of birth post partum. Regression analyses showed the strongest correlates of PTS symptoms were high outcome and low efficacy expectancies in pregnancy, urinary catheterization in labour, poor psychological adaptation to motherhood and increased fear of birth post partum. This model accounted for 29% of the variance in PTS symptoms.

Conclusions: this study suggests women in this province in Turkey report PTS symptoms after birth and this is associated with childbirth self-efficacy in pregnancy, birth factors, and poor adaptation to motherhood and increased fear of birth post partum.

Implications for practice: maternity care services in Turkey need to recognise the potential impact of birth experiences on women's mental health and adaptation after birth. The importance of self-efficacy in pregnancy suggests antenatal education or support may protect women against developing post partum PTS, but this needs to be examined further.

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Introduction

Childbirth is a challenging experience for many women and it is now recognised that a small proportion of women may perceive birth as traumatic and develop post-traumatic stress disorder (PTSD) as a result. Others may experience severe symptoms of

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post-traumatic stress (PTS) that are distressing but do not reach threshold for a diagnosis of PTSD (Alcorn et al., 2010; O'Donovan et al., 2014). PTS therefore affects a larger number of women. A difficult or complicated birth can lead to the development of PTS if a woman believes her life or her infant's life is in danger during birth and she feels intense fear, helplessness and horror (American Psychiatric Association, 2000). Symptoms of PTS include intrusive thoughts, flashbacks and nightmares, emotional numbing, avoidance of reminders of the birth, and hyper-arousal such as irritability (APA, 2000). Loss of control, feeling trapped, and vivid memories of the event have also been noted as experiences and perceptions of women after a difficult or traumatic childbirth (Elmir et al., 2010; Goldbord, 2009). Although the disorder of PTSD is clearly defined in diagnostic nomenclature there is controversy over recent revisions to the diagnostic criteria (Hoge et al., 2016). PTS is defined and measured in different ways but a common approach is to use established cut-offs on measures of the frequency of symptoms from non-diagnostic measures, such as the Impact of Event Scale (Horowitz et al., 1979). Measures of PTS are highly associated with PTSD but are not completely aligned.

Studies have reported a range of prevalence rates of PTS after birth. Differences in prevalence are likely to be due in part to the cultural context and health care system of the country in which it is studied (Modarres et al., 2012; Garthus-Niegel et al., 2013; Grekin and O'Hara, 2014). A large study of women in Norway reported that 1.8% of women had severe PTS following childbirth (Garthus-Niegel et al., 2013). In contrast, a study in Iran found that 20% of women had severe PTS following childbirth (Modarres et al., 2012). A meta-analysis of PTS after birth suggested that the average prevalence of birth-related PTS/PTSD is 3.1% in general population and this increases to 15.7% in high risk samples, such as women who develop severe complications in pregnancy (Grekin and O'Hara, 2014).

PTS following childbirth usually arise as a result of complications during pregnancy or birth (Andersen et al., 2012; Grekin and O'Hara, 2014). Reviews and meta-analyses provide fairly consistent evidence that medical complications or interventions, such as emergency caesarean section, are associated with PTS. However, women's *subjective experience* of birth as negative and traumatic is more strongly associated with PTS (Andersen et al., 2012; Verreault et al., 2012; Ayers et al., 2014; Boorman et al., 2014; O'Donovan et al., 2014). It should also be noted that PTS is not only the result of a traumatic birth but that other factors can make women more vulnerable or at risk of developing PTS (Ayers et al., 2016). For example, fear of childbirth during pregnancy puts a woman at greater risk of developing PTS in response to the subsequent birth (Ayers et al., 2016). Psychopathology in pregnancy, such as symptoms of depression and anxiety, are also significantly associated with PTS following childbirth (Grekin and O'Hara, 2014; Ayers et al., 2016).

One potential risk factor for PTS following childbirth that has not been widely examined is low childbirth self-efficacy. Self-efficacy relates to people's beliefs about their capability to influence events that affect their lives. Self-efficacy beliefs can affect how people feel, think, motivate themselves and behave (Bandura, 1994). Childbirth is fundamentally a physiological process, but a woman's thoughts and feelings may directly affect the labour and birth. There is some evidence that self-efficacy for labour and birth is associated with less anxiety about birth and greater perception of control during birth (Sieber et al., 2006). Conversely, research suggests that women with low birth self-efficacy are more likely to have fear of childbirth (Salomonsson et al., 2013).

Care during childbirth can therefore be influential in reducing or increasing the impact of traumatic events. There is now substantial evidence to suggest that support from health professionals during birth can reduce the impact of traumatic or negative

experiences. For example, an experimental study that used birth stories to manipulate levels of support and stress during birth, Ford and Ayers (2009) found that support from healthcare professionals was as, or more, important than the events of birth, particularly for women's perception of control during birth. Other studies have shown an association between perceived support, greater perceptions of control, and less anxiety during childbirth (Ford et al., 2010; Hodnett et al., 2012; Verreault et al., 2012; Vossbeck-Elsebusch et al., 2014). Similarly, meta-analyses have found that post partum PTS symptoms were associated with poor quality of interaction with health care staff, less feelings of control during birth (Grekin and O'Hara, 2014), and less support during birth (Ayers et al., 2016). Conversely, good support and women being satisfied with the support they received from healthcare professionals and their partners is associated with a reduced likelihood of developing PTS symptoms following childbirth (Lemola et al., 2007; Iles, Slade and Spiby, 2011).

According to theoretical models of PTS in other populations, access to adequate social support is important to facilitate cognitive processing and assimilation or accommodation of a traumatic event (Brewin et al., 1996). In relation to perinatal women, Gamble and Creedy (2009) argue that social support is instrumental in women's adjustment and psychological wellbeing after birth.

Qualitative research suggests the impact of PTS on women and their families is substantial (Reynolds, 1997; Ayers et al., 2006; Nicholls and Ayers, 2007; Parfitt and Ayers, 2009). Clinical guidelines and researches for postnatal mental health emphasise that "even subthreshold symptoms can affect a woman's general functioning and the development of her infant" (NICE, 2007, p. 39; Ejaz, 2014). Therefore, regardless of diagnosis, PTS may have negative consequences for the emotional well-being of post partum women and their relationships with their infant and husband/partner (Reynolds, 1997; Ayers et al., 2006; Nicholls and Ayers, 2007; Parfitt and Ayers, 2009). This qualitative research also suggests PTS resulting from traumatic birth experiences may affect the mother–infant relationship in a number of ways. For example, if the mother associates the infant with the traumatic events in birth she might try to avoid contact with the infant (Reynolds, 1997; Elmir et al., 2010). Alternatively, she may become over-anxious about the infant (Ayers et al., 2006; Nicholls and Ayers, 2007).

It is therefore important to identify key protective and risk factors for PTS following childbirth. Although there is an increasing body of research focusing on risk factors for PTS following childbirth, it is not clear whether these are generalisable between cultures (Ayers et al., 2008). Most of the available evidence on risk factors comes from Europe, Australia and North America (Grekin and O'Hara, 2014; Ayers et al., 2016). Cultural variations in healthcare systems and customs around pregnancy and birth mean that there is likely to be variation in both prevalence and risk factors for PTS – particularly in low and middle income countries. A review of common mental health problems in pregnancy and after birth in low and middle income countries found higher prevalence than usually reported in high income countries (Fisher et al., 2012; Ejaz, 2014). Turkey is a middle income country where reformative initiatives have been introduced and implemented over the past 10 years in the healthcare system. Very little research has been conducted in Turkey into women's perinatal mental health and no research has examined PTS after birth. Research is therefore needed to examine PTS after birth and potential protective and risk factors for Turkish women.

This study therefore aims to examine protective and risk factors for post partum PTS for women who have a healthy pregnancy and birth process by conducting a prospective longitudinal study from pregnancy to 6 to 8 weeks after birth. Specifically, the goals of the present study were to (1) examine the relationship between PTS

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