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The birth experience and women's postnatal depression: A systematic review

Aleeca F. Bell, PhD, RN, CNM (Assistant Professor)[a,*],
Ewa Andersson, PhD, RNM (Senior Lecturer)[b]

[a] University of Illinois at Chicago, College of Nursing, Department of Women, Children and Family Health Science, 845 S. Damen Ave. M/C 802, Chicago, IL 60612, USA
[b] Karolinska Institutet, Department of Women's and Children's Health, Division for Reproductive Health, Retziusväg 13 A, 17177 Stockholm, Sweden

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ABSTRACT

Background: maternal postnatal depression confers strong risk for impaired child development. Little is known about the association between women's postnatal birth experience and postnatal depression.
Purpose: to systematically identify and review studies examining the association between the birth experience and postnatal depression.
Methods: a systematic search strategy was employed using the Matrix Method (Garrard, 2014) and guided by the PRISMA reporting process.Criteria included broad search terms, English language, and publication years 2000–2015. The search revealed 1536 abstracts narrowed to full-text review of 112 studies.
Findings: eleven of the 15 studies meeting search criteria demonstrated a significant association between women's postnatal birth experience and postnatal depression. Results show heterogeneity in birth experience instruments. Strength of evidence and potential for bias are discussed.
Key conclusions: in spite of methodological limitations, the weight of evidence suggests that a negative birth experience may contribute to postnatal depression. Further research is warranted.
Implications for practice: to promote a positive birth experience healthcare providers should provide supportive, nurturing care that promotes women's confidence, trust, respect, privacy, shared decision making, and feeling of safety. Healthcare policy that promotes quality caregiving may reduce risk of postnatal depression.

Contents

* Corresponding author.
E-mail addresses: abell2@uic.edu (A.F. Bell), ewa.andersson@ki.se (E. Andersson).

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Introduction

Postnatal depression (PND) is estimated to have 13–19% prevalence in western nations (O'Hara and McCabe, 2013). According to the American Psychiatric Association (2013), a major depressive episode occurring within pregnancy or 4 weeks after birth is depression with a perinatal onset. Diagnostic standards vary, but many define PND as occurring anytime within the first year, and especially within 6 months, after birth. Evidence on predictors and outcomes of PND mainly use self-report measures of elevated depressive symptoms rather than diagnostic interviews (Myers et al., 2013). PND differs from 'baby blues' which are common, mild, symptoms self-limited to the first two weeks after birth and appear to be influenced by drastic hormonal shifts. PND also differs from postnatal psychosis which is a rare and acute condition beginning the first 2 weeks after birth and is associated with a higher risk of suicide or infanticide. Negative sequelae of PND include altered mother-infant interaction: a strong predictor of insecure attachment and impaired social, cognitive, emotional and physical child development (Beck, 1995, 1998; National Research Council and Institute of Medicine, 2009; Tronick and Reck, 2009). Developmental impairments include low empathy, bullying, irritability, negativity, difficulties in school, cognitive deficits, psychopathologies, and poor stress reactivity (Leclere et al., 2014).

Known risk factors of PND are a history of psychopathology, depression or anxiety during pregnancy, poor social support, and stressful life events (Robertson et al., 2004), but there has been less exploration of the link between the experience of childbirth and PND. Childbirth predictors of PND have been assessed using objective birth events, and women's perception of their birth experience. For instance, evidence is strong that mode of birth is not associated with risk of PND (Carter et al., 2006; Adams et al., 2012) but evidence is limited, and conclusions are inconsistent, on whether other birth events increase risk of PND, such as interventions, complications, and delayed mother-infant contact after birth (Johnstone et al., 2001; Rowe-Murray and Fisher, 2001; Blom et al.,. 2010; Gausia et al., 2012). Any relationship between PND and childbirth may be best identified through the study of women's perceptions of their birth experience, whether through global questions of birth satisfaction or specific birth experience factors that have been identified as important to women: respect, privacy, support, inclusion in decision making, and feeling nurtured (Public Health Agency of Canada, 2009; Hildingsson, 2013).

While the birth experience is a multifaceted, highly personal experience, universal themes have been identified. A concept analysis by Larkin et al. (2009) defined the birth experience as a complex psychological individual experience, with elements of universal physiological processes and life event significance. A qualitative descriptive study by Karlstrom et al. (2015) revealed the primary meaning of a positive birth experience as 1) trusting in one's strength and ability to give birth, and 2) experiencing safe and supportive persons at the birth. Likewise, a qualitative descriptive study by Lavender et al. (1999) showed that critical aspects of the labour experience were supportive care, information, decision-making, control (i.e., dignity) and pain relief. A negative birth experience can reduce women's desire for more children, and increase women's desire for cesarean surgery if there is a subsequent pregnancy (Gottvall and Waldenstrom, 2002; Pang et al., 2008). No matter what type of complicated or difficult birth events actually occurred, if women perceived supportive caregiving from their childbirth providers, women's long-term memories of the birth experience were positive (Stadlmayr et al., 2006). Thus, it is important to know whether a positive birth experience can reduce the risk of PND, since providers may only have limited control over birth events but are able to promote positive caregiver interaction through respectful, supportive, shared decision-making, and nurturing care throughout women's labour and birth experience.

The aim of this systematic review is to present the state of the science on the association between women's postnatal perspective of the birth experience and PND. This review excludes assessing comorbid psychopathologies of PND (Reck et al., 2008; Soderquist et al., 2009) due to the established link between traumatic birth and symptoms of post-traumatic stress (Grekin and O'Hara, 2014) and the limited published studies reporting on women's birth experience and postnatal anxiety (Giakoumaki et al., 2009; Bell et al., 2016).

Methods

This systematic review was guided by the Matrix Method to identify, organize and critically evaluate known literature on the review topic (Garrard, 2014). Steps of the Matrix method included: (1) establish the aim of the review; (2) maintain an organized paper trail when screening and selecting scientific papers that meet specified criteria; (3) abstract pertinent study components; (4) summarize across studies; and (5) draw conclusions based on the review results. The PRISMA statement was used to guide the reporting process (Moher et al., 2009).

Search strategy

In June 2015, both authors of this review separately conducted a search of three electronic databases PubMed, CINAHL and PsycINFO, using MeSH and free text search terms of birth (the independent variable), and postnatal or postpartum depression (the dependent variable). Narrow search terms, such as satisfaction or perception of the birth experience, were avoided to identify as many possible articles for inclusion in this review. Inclusion criteria were published peer-reviewed journal articles between 2000 and 2015 with search terms of birth and postnatal or postpartum depression, human and original studies, English language, and full-text availability (from two research-intensive university libraries). Any study design, including qualitative methodology, was acceptable addressing the relationship between women's birth experience and PND. Titles and abstracts were screened for eligibility. Full text articles were assessed to verify whether each study met the inclusion criteria of the review. Studies were excluded if measures of birth were limited to mode of childbirth or other birth events, rather than women's subjective experience of birth. A manual search of reference lists from the included articles was also undertaken to identify studies not captured by the electronic search.

Selection process

The initial search of electronic databases produced 1536 records: PUBMED 871, CINAHL 141, and PsycINFO 524. After review of all titles, 16 relevant duplicates were removed and 638 records