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RESEARCH ARTICLE

PERCEPTION OF TRAUMATIC CHILDBIRTH OF WOMEN AND FACTORS AFFECTING

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ABSTRACT

Backround: Mothers' perceptions of labor, their perspectives on the birth process and the events they experience in this process, and the meanings they attribute to them may differ.

Aim: This study was conducted to determine women's perception of traumatic birth and the affecting factors.

Design and Methods: The data of the study were collected online between February 1 and April 10, 2021. A nonrandom sampling method, the snowball sampling method, was used in the study. Data were collected using The Trauma Perception Scale for Regarding Birth. (TPSRP) The mean, percentage, variance, and Cronbach's α were calculated.

Findings: The mean TPSRB score was calculated as 120.70±14.63. According to the mean score, it was determined that the mothers' perceptions of traumatic birth were high. The difference between the TPSRB scores according to age, education level, employment status, social security, income level, family structure, duration of marriage, number of births, number of children and receiving prenatal care is found statistically significant. ($p<0.05$).

Conclusion: Midwives and nursings have important duties in order to improve the perception of traumatic birth, which affects women so much, and to leave its place to positive birth experiences.

Key words: Childbirth; Postpartum care; Post traumatic stress disorder; Risk factors

INTRODUCTION

Giving birth, a miraculous event, is a unique experience for every woman (1). Women tend to remember these exclusive childbirth experiences with more positive feelings. However, this is not always the case and this experience can often turn into an attritive and traumatic event for the woman (2,3). As it is known from clinical applications, particularly women, who experiencied a traumatic first labor, state that they do not tend to conceive one more time (4). This circumstance may be associated with making a lot of obstetric interventions during childbirth, not letting nature take its course at giving birth, and the very common fear of childbirth (5).

Traumatic childbirth is defined as an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother' or her infant's physical or emotional integrity existed (5-8).Women who experienced traumatic childbirth depict the moment of birth as the moment of helplessness, loss of control, intense fear, and horror (9). Besides, these women may also exhibit symptoms of posttraumatic stress such as the strong recall of childbirth, dreams about the event, and

recurrent memories (6,10). Studies have revealed that 3-4% of the women in the postnatal period and 15-19% of the women who experienced high-risk, complicated, or preterm deliveries exhibited post-traumatic stress disorder symptoms (11,12).

Each woman may perceive the birth process differently and her interpretation and interpretation of the events she experiences may differ (6). While some women who experience negative things at the time of birth consider their birth as traumatic, some women may find this process more normal. Some women who have experienced a traumatic birth, on the other hand, may perceive their birth positively, thinking that this process is completed positively after they hold their babies in their arms (13). Perceptions about childbirth can be affected by women's personality traits and birth experience, as well as society's view of birth and cultural values.

Mothers' perceptions of labor, their perspectives on the birth process and the events they experience in this process, and the meanings they attribute to them may differ. Based on this, women should be able to access qualified midwifery care during preconceptional and interconceptional periods so that birth, which should be a normal, healthy, physiological and natural process in women's lives, is not perceived as traumatic. At the same time, the expectation of the woman's birth and her thoughts about the birth should be understood so that she does not experience a traumatic birth at the time of birth. In the postpartum period, traumatic birth should be closely monitored for possible effects. Losing control, feeling depressed and anxious, and post-traumatic stress disorders are consequences of birth trauma. A woman who has severe pain at the time of birth may also perceive her birth as traumatic and may prefer an elective cesarean section for her next delivery (4,8,9). Regarding the psychological inadequacy of having another child, it is also known that women who have experienced traumatic birth want to take a long break for the next pregnancy and even do not want to have a child again. In addition, this traumatic situation experienced by the mother affects not only the mother, but also the child, father, family and even society (8). Midwives should be able to determine the factors that can positively and negatively affect the birth experience of the woman during the birth process and care should be planned accordingly. This research was carried out to determine the traumatic birth experiences of women and the factors affecting them.

MATERIALS AND METHODS

Study design

The present study used a cross-sectional study design.

Population and sample: The study was conducted between Feburary 1 and April 10, 2021. A nonrandom sampling method, the snowball sampling method, wasused in the study. The mothers participating in the research were reached from social media platforms such as instagram and whatsapp, from groups of mothers with children aged 1 and below and who had a vaginal birth. Data-collection forms prepared with the Google-Docs program were sent online (E-mail, WhatsApp) to mothers who gave vaginal birth between the 1st month and 12th month postpartum, and they were asked to fill in the forms and share them with people around them. In the literature review, the total sample size found using the G*POWER program was calculated as n = 531, with a 0.1858 effect size, 95% power, and a 0.05 error margin, based on the percentage measurement values for the methods to be studied. Power analysis showed that the data collected was sufficient (14).

Data Collection: Data were collected using the following tools: a specially prepared descriptive questionnaire, The Trauma Perceptıon Scale for Regardıng Birth (TPSRB)

Descriptive questionnaire: This form was prepared by the researchers by scanning the literature (1,4-6,11-13). The descriptive questionnaire contained questions on the individual's age, sex, education, working status, social security, income level, family structure, marriage period, number of births, number of children, receiving prenatal care status.

The Trauma Perception Scale for Regarding Birth (TPSRB): Trauma Perception Scale for Regarding Birth was developed by Mucuk (Koç) and Ozkan (14) to evaluate mothers' perceptions of trauma associated with vaginal delivery and can be used across the country as a valid and reliable measurement tool. This scale can be used in the period from the postnatal first week to a year. This scale is thought to enable the determination of the women sensitive to childbirth trauma, evaluating them in terms of trauma symptoms in the process, and providing the required individualized midwifery care in this regard in a more qualified way. This is a 5-point

Table 1. Minimum, maximum and total mean scores of the Trauma Perception Scale for Regarding Birth

	The Trauma Perception Scale for Regarding Birth		
	Minimum	Maximum	Mean±SD
Lowest and highest scores that can be obtained from the scale	39.00	195.00	120.70±14.63
The lowest and highest scores of the mothers from the scale	69.00	169.00	

Likert-type scale. For the negative items in the scale, the rating was as follows: (1) “strongly disagree”; (2) “disagree”; (3) “neither agree nor disagree”; (4) “agree”; (5) “strongly agree”; while for the positive items, (5) “strongly disagree”; (4) “disagree”; (3) “neither agree nor disagree”; (2) “agree”; (1) “strongly agree”. The scale has a one subscale. There are 11 items (4, 5, 11, 13, 15, 17, 18, 29, 30, 31, 36) that need to be reverse scored in calculating the overall scale score. Overall scale scores range between 39-195. The higher score to be obtained from the scale, the higher a woman’s trauma perception. The α reliability value of the scale was .92. Cronbach's α coefficient in this study was .89.

Data analysis: The data were assessed using the SPSS for Windows 22 package program. The mean, percentage, variance, and Cronbach's α were calculated. Dunnet-C and LSD analyzes were performed to determine which group caused the difference in further analysis. P < .05 was considered statistically significant.

Ethical principles: This study was approved by Atatürk University, Ethics Committee of Faculty of Health Sciences (Approval Date: 12.02.2021, Number: 2021/02/04). All the study subjects were assured that participation in the study was voluntary and that all information provided wouldremain confidential. Participants were asked a question on a Google form confirming that they wanted to participate in the research.

RESULTS

As stated in Table 1, the minimum score that mothers got from the Trauma Perception Scale for Regarding Birth was 69.00 and the maximum score was 169.00. It was determined that the mean total score of the mothers from the scale was 120.70±14.63.

As seen in Table 2, the difference between the Trauma Perception Scale for Regarding Birth scores according to age, education level, employment status, social security, income level, family structure, duration of marriage, number of births, number of children and receiving prenatal care is statistically significant. (p<0.05).

In the further analysis to determine from which group the age difference originates (Dunnet C); It was determined that the mean score of the 18-24 age group was higher than the 25-29 and 30-34 age group.

In the further analysis (Dunnet C) to determine from which group the difference stems from the level of education; It has been determined that the average score of those with university and higher education is lower than those of secondary and high school graduates.

Those who do not work and those who do not have social security have a higher birth-related trauma score average.

In the further analysis to determine from which group the difference arises according to income level (Dunnet C); It has been determined that the average score of those whose income is more than their expenses are lower than those whose income is equal to and less than their expenses.

Those living in extended families have a higher birth-related trauma score average.

In the further analysis to determine from which group the difference arises according to the year of marriage (Dunnet C); It has been determined that the average score of those whose marriage year is between 2-4 years is higher than those with 5-9 years and 10 years or more.

In the further analysis (Dunnet C) to determine from which group the difference in the number of births originated; It was determined that the trauma score averages of the women with the first birth were higher than the women in the other group.

In the further analysis to determine from which group the difference is due to the number of children (Dunnet C); It was determined that the trauma score averages of women who had one child were higher than the women in the other group who had more than two children.

Table 2. Comparison of The Trauma Perception Scale for Regarding Birth Scores According to Demographic and Obstetric Characteristics

		n	%	The Trauma Perception Scale for Regarding Birth			
				Mean	SD.	Test	p
Age	18-24	144	27.1	119.40	25.27	F=11.619	**0.000**
	25-29	155	29.2	106.32	20.19		
	30-34	150	28.2	104.53	22.01		
	35 and above	82	15.4	111.10	28.74		
Education Status	Elementary School	41	7.7	112.09	31.24	F=10.883	**0.000**
	Middle School	70	13.2	121.34	27.84		
	High school	242	45.6	111.64	23.01		
	University and higher	178	33.5	103.12	20.48		
Working status	No	392	73.8	112.50	25.22	t=3.865	**0.000**
	Yes	139	26.2	103.35	20.02		
Social security	Yes	436	82.1	107.96	21.56	t=-4.425	**0.001**
	No	95	17.9	119.92	32.49		
Income levels	Income < Expenses	137	25.8	117.20	30.14	F=10.015	**0.000**
	Income= Expenses	278	52.4	109.13	21.87		
	Income > Expenses	116	21.8	104.04	19.82		
Type of family	Nuclear family	437	82.3	108.20	22.16	t=-3.943	**0.002**
	Extended family	94	17.7	118.94	31.03		
Marriage period	1 year	54	10.2	113.55	22.51	F=4.782	**0.003**
	2-4 year	185	34.8	114.70	23.14		
	5-9 year	154	29.0	106.95	24.15		
	10 year and above	138	26.0	110.10	25.59		
Number of birth	1	240	45.2	115.02	23.81	F=9.736	**0.000**
	2	154	29.0	107.28	22.86		
	≥3	137	25.8	104.64	25.15		
Number of children	1	244	46.0	115.27	24.28	F=10.620	**0.000**
	2	159	29.9	106.08	21.82		
	≥3	128	24.1	105.25	25.41		
Status of receiving antenatal care	Yes	417	78.5	108.94	23.81	t=-2.122	**0.034**
	No	114	21.5	114.36	25.62		
Total		531	100.0				

Women who do not receive antenatal care have a higher birth-related trauma score average.

DISCUSSION

Birth, which is a versatile and important life experience for women, may be perceived as traumatic by some women. During the birth process, which is perceived as traumatic, women experience a difficult and tiring birth that they think may hurt themselves or their babies. After such a difficult delivery, women can experience PTSD. The concept of posttraumatic stress related to childbirth is used to describe the state of psychological problems that may occur after birth as a direct result of the birth experience.

Until 2016, there was no scale measuring the perception of traumatic birth in Turkey. Studies with Birth Satisfaction and Wijma Birth Expectation/Experience Scale (W-DEQ) are common. In these studies, W-DEQ scores ranged from 46.4 to 103.30 (1.15-18). In this study, it was determined that the mothers' TPSRB total score average was 120.70±14.63, that is, at a high level. In Aktaş's (2018) study with the traumatic birth perception scale (TBPS) in pregnant women; it has been reported that the mean score of the scale is 70.57 ± 21.89, and 23.6% of women experience a high level of traumatic birth perception (19). In the study conducted by Mr. (2021), using TBPS, he found that the rate of women with "high" and "very high" perceptions of traumatic birth was 33.8%, and the mean score of the scale was 63.45±28.116, at a "moderate" level (20). The difference in birth trauma score averages from the studies in the literature may be due to the different measurement tools used. In addition, it can be thought that women's previous birth experiences, negative birth stories and many individual factors affect the perception of traumatic birth.

The perception of traumatic birth is a multifactorial concept that is affected by many situations. The age of the woman is also one of the individual factors

affecting the positive or negative perception of labor (13,21). The age of the woman is also one of the individual factors affecting the positive or negative perception of labor. It was determined that the birth-related trauma scores of the mothers between the ages of 18-24 who participated in the study were significantly higher than the other age groups. According to the results of the research, it was determined that the perception of trauma decreased as the age increased. The increase in trauma perception among women aged 18-24 may be due to their inexperience in childbirth. Homayi et al.(22) found in their study that mothers between the ages of 18-25 perceived their births more traumatic than mothers aged 31 and over. It is reported that higher education level is associated with high satisfaction at birth (23,24). Research participating universities and higher education fields of trauma perception of the average score, was determined to be lower than middle and high school graduates. Bay (20) found in her study that the traumatic birth perception average score of mothers with university education levels was lower than the other groups. Homayi et al.(22) also found that women with primary school education perceived childbirth as more traumatic. As a result of her research, Celik (25) determined that as the education level increases, the average PTSD score decreases. Although there are studies on PTSD in the literature, which are shown in an example at the education level (26,27) there are studies in the studies on practices that can contribute to postnatal PTSD in the education classroom (28,29). In the studies of Modarres (30) and Zlotogora (29) it is stated that women with low education level are more prone to developing PTSD. The result of this research once again reveals the importance of education, which is one of the important determinants of women's health. Mothers with a higher education level; they can be aware of the negative situations that may occur in the birth and postpartum period, they can access the information they need more easily, they can notice the negative changes in their own bodies more easily and calll for help from the necessary institutions.

The mean birth trauma perception scores of working mothers were significantly lower than those of non-working mothers. Similar to the research finding, Celik (25) found that working mothers had lower PTSD score averages in their study. It was found that the trauma score averages of the mothers without social security were higher. Taghizadeh ve et al.(31) reported in their study that the risk of developing PTSD symptoms increases after delivery in mothers who do not have health insurance. Homayi et al.(22) in the study they carried out to determine the predictors of traumatic birth experiences of primiparous mothers, they determined that the birth trauma score averages of mothers without health insurance were higher. The studies carried out support the research findings. Since this situation brings with it other negative situations such as where the birth took place, insufficient access to necessary information, and lack of social support, it can be thought that it shows that working status, social security or income status are not the only factors that affect the result, which cause the perception of traumatic birth in women. The individual's lack of health insurance or poor income may have caused him to worry about whether the care needs for himself and his baby will be met. In this case, the mother may think that she is helpless and insecure. All these factors are predictive variables of the perception of traumatic birth.

It is known that low income and education levels of women cause physical and mental health problems (32). It is stated in the literature that the perception of low income status is a risk factor for the traumatic birth experience (13,21,32-34). The difference between the groups in the income status of the mothers who participated in the birth trauma study was statistically significant. The mean birth-related trauma perception score of mothers whose income is lower than their expenses is higher than the other two groups. In their research, Bay (20) and Celik (25) found that women with low income perceived their birth as more traumatic, as a result of the research. Gulec et al.(35) reported thatfear of childbirth was associated with income status in their study. On the other hand, in the study of Ust and Pasinlioglu (36) it was reported that the income status of primiparous and multiparous pregnant women did not affect the birth and postpartum anxiety scale scores. There are similar and contradictory findings to the research findings in the literature. Based on this, it is thought that income status may not be alone, but combined with other factors, which may cause the perception of traumatic birth.

It was found that there was a significant difference between the marriage duration of the mothers participating in the study and their perceptions of traumatic birth, and it was determined that the perception of trauma increased as the year of

marriage decreased. This situation may be related to the problems experienced by the individual in the process of adapting to a new situation. The fact that newly married individuals have to adapt to their changing and transforming roles such as parenthood and motherhood before they can adapt to the marriage process may suggest that individuals may experience some problems in this process. Regarding the incompatibility of couples to parenting roles in the literature; There are reasons such as negative thoughts related to pregnancy, inability to fulfill the parental role and lack of experience, and inability to adapt to the differentiation of roles that come with the birth of the child (37,38).

In the literature, inadequate prenatal care (PC) is shown among the risk factors for the perception of traumatic birth (13,33,34,39,40). Pregnancy is a critical period for maternal and newborn health. Antenatal care given during this period provides an important opportunity to improve maternal and newborn health during pregnancy, childbirth and postpartum. During this period, pregnant women can attend prenatal education and childbirth preparation classes. According to the results of the study, it was found that the average score of perception of traumatic birth of mothers who did not receive prenatal care was significantly higher. Evidence shows that midwife-led care is crucial to improving maternal and newborn health and achieving the Sustainable Development Goals (41). WHO recommends that women be given care with a midwife-led continuous care model in regions where there is staff competence (42). In the midwife-led care model, the midwife is the leading health care professional who is responsible for planning and arranging the care given to women in the prenatal, natal and postnatal period (41). Gurol et al.(43) in their study, they stated that women who received prenatal care experienced less fear of childbirth. There are studies in the literature stating that antenatal education reduces the fear of suffering during childbirth and the fear of childbirth (44-47). Sercekus ve Baskale (48) found in their study that women who received antenatal education had lower levels of fear of childbirth. Sercekus ve Okumus (49) state that lack of information about birth, negative perceptions and misinformation about birth cause fear in some people. In his study in which Bay (20) examined the relationship between traumatic birth perception and postpartum depression in women, it was determined that those who received birth preparation training had lower traumatic birth perceptions. Obtaining information/education on birth; it is important for the woman to control her birth, to reduce the worries caused by ignorance, and this can change the perception about childbirth (20).

It is stated in the literature that primigravidas carry a higher risk of developing PTSD than multigravidas (25,50-52). According to the results of the research, as the number of births and the number of children decreased, the average score of mothers' perception of traumatic birth increased. The fear of the unknown due to the lack of birth experience, the insufficient knowledge about labor, postpartum period, mother and baby care, and the negative birth stories they heard from their environment may have led to an increase in the birth-related trauma perception score averages. Alehagen et al.(53) found in their study on 35 primiparous and 39 multiparous women that the fear of childbirth experienced in the early stages of labor was higher in primiparous pregnant women. Bay(20) reported that primiparous women had higher perceptions of traumatic birth, similar to the research finding. In the study comparing the birth and postpartum concerns of primiparous and multiparous; Primiparous pregnant women were found to have higher anxiety (36). Factors such as being nulliparous, uncertain about the mode of birth, being young and adolescent can cause stress, fear and negative perception of birth (19).

Traumatic birth is affected by many factors. The limitation of the study is that risky groups and adolescent mothers were not included in the study.

CONCLUSION

As a result of the research, mothers' perceptions of birth trauma; It was found that it was affected by many individual factors such as age, education level, employment status, social security, income level, family structure, spouse age, spouse education level, spouse occupation, duration of marriage, number of births, number of children and receiving prenatal care. It was determined that the birth trauma scores of the mothers included in the study group were at a high level. Research results show that, nurses and midwives who are members of a professional profession should seriously consider the issue of traumatic birth. Nurses and midwives working in obstetrics clinics and family health centers should know the risk factors related to birth trauma, should be able to identify risky women during prenatal and postnatal follow-ups, and should be able to apply

necessary approaches in the early period. In order to facilitate the adaptation of the woman to the pregnancy, birth and postpartum process, risk factors should be investigated in pre-pregnancy or pregnancy counseling service.

It is not always easy for women to talk about their traumatic birth stories. For this reason, midwives should encourage women and ask open-ended questions while listening to them. Nurses and midwives can protect and improve the health of women and children by providing individualized care to women who have experienced traumatic birth and can save them from the negative effects of traumatic birth.

Midwives and nurses have important duties in order to improve the perception of traumatic birth, which affects women so much, and to leave its place to positive birth experiences. In line with these results;

- Midwives and nurses working in obstetrics clinics and family health centers can evaluate women's perceptions of traumatic birth using scales developed on this subject.
- Midwives and nurses can carry out extensive screening and take the necessary precautions, including the determination of the associated factors that cause trauma to the woman during vaginal delivery.
- The increasing number of cesarean sections today can be associated with the increase in traumatic birth experiences. For this reason, it may become more possible for vaginal births to occur naturally, in their own course, away from the feelings of fear and anxiety, by identifying traumatic births and taking the necessary precautions.
- There are not enough studies in the literature with traumatic birth. It is recommended to conduct birth trauma and affecting factor studies, especially with risky pregnant women and adolescent pregnant women.

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