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Multigravidas' perceptions of traumatic childbirth: Its relation to some factors, the effect of previous type of birth and experience

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Abstract

To investigate the relationship between multigravidas' perceptions of traumatic childbirth (PTC) and their socio-demographic characteristics and the effect of their previous types of birth and experiences on PTC. This descriptive study was conducted in a state hospital in Northern Turkey. The universe of the study consisted of multigravidas. The sample of the study comprised 161 pregnant women determined with G power analysis. The data were collected using the "Pregnant Introductory Information Form" and "Perception of Traumatic Childbirth Scale". The age, gestational week and the number of pregnancy of the participants were 28.27 ± 5.13 , 30.45 ± 7.71 and 1.94 ± 1.07 respectively. The average PTC score was 70.57 ± 21.89 . 1.9%, 28.6% and 39.1% and 23.6% of the pregnant women perceived their birth as "very low", "low", "moderate" and as "high" traumatic respectively. There was a negative correlation between the average PTC score and the gestational age, the number of pregnancies and the duration of the adverse events and positive correlation between the average PTC score and the number of hospital visits during pregnancy ($p < 0.05$). Compared with those who had cesarean section and no intervention, PTC score was higher in those who had a previous vaginal delivery and interventions. The average PTC score of those planning to give vaginal delivery was higher than those planning cesarean birth ($p < 0.05$). The women who had a chronic disease before pregnancy ($p < 0.05$) and those who had a vaginal birth with only a midwife and were satisfied with her communication had lower PTC scores ($p > 0.05$). Six out of every 10 pregnant women perceived their delivery traumatic at a moderate / high level. PTC was higher in those having vaginal birth and an intervention previously and planning a vaginal birth again. The early identification of the risk of PTC before pregnancy or early pregnancy and taking precautions are recommended.

Keywords: Multigravida, traumatic childbirth, correlated factors, vaginal birth, cesarean, birth experience, communication, midwife, obstetrician

Introduction

Childbirth process is a life experience characterized by physiological and psychological changes [1]. Positive or negative perception of this experience may vary, based on mother/family (such as individual, social and cultural reasons), the attitudes and behaviors of the health personnel who assist the birth, the interventions at birth[2-4], types of delivery, the facilities of the unit/place of birth (such as home, hospital), previous birth experience, birth stories and whether the current pregnancy is in low-high risk groups [5-7].

Many women who have experienced birth negatively have a traumatic childbirth perception. "Traumatic childbirth" is defined as a woman's perception of the birth process as a threat of injury or death for herself and the baby. The women with this experience

define the birth moment as very fearful, helpless and terrifying [7-9]. Aktaş et al., (2015) reported that mothers perceived birth as traumatic since they portrayed themselves as "a sheep to be sacrificed" and "burning in hell fire" at birth[10].

A perception of traumatic childbirth (PTC) can occur not only in individuals with birth experience but also in those at different times of life, such as childhood and adolescence[11,12]. When it is evaluated according to life periods and gender in details, it is observed that a perception of traumatic childbirth is most often seen in women at the age of reproduction [8,13]. The rate of traumatic birth is 4- 18 % [2,7,13].

There are many factors that affect the PTC of women. The main ones are related to the negative previous traumatic process, negative birth experience, type of delivery, sexual abuse, socio demographic-obstetric factors[2, 14], negative attitudes and the behaviors of midwife and obstetrician who assist delivery[15], medical interventions at birth, complicated births, the technical facilities of the place of birth, the lack of social support[14,16], participation in prenatal training, systemic diseases, psychological

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problems before and during pregnancy and the spouse [5,7,14]. Especially childbirth fear and negative birth stories may lead to PTC in the society [13,17].

If the PTC is not assessed and treated in women, it can interfere with the mental and physical health of the woman and put the mother and newborn's health at risk [6]. PTC may harm family relationships, reduce breast milk, and lead to emotional, cognitive, and behavioral disorders in the children of these mothers in the long run [2,11,13].

PTC may cause childbirth fear, increased medical interventions at birth, decreased success in birth management, prolongation of birth [11,18], and insistence on a cesarean delivery. In the postpartum period, the posttraumatic stress disorder (PTSD) of a woman and her family [6] causes depression [19] and adversely affects maternal bonding [20] breastfeeding [2,7], and partner relationship. In addition, it may lead to the next pregnancy not to be planned for a long time [21] a negative perception regarding the midwifery and obstetric professions that contribute to birth and dissatisfaction with the unit of birth in the society [22]. Due to all these reasons, the physiological and natural perception of birth requires women to experience their delivery positively [10,19].

For a positive birth perception, communication and professional skills of health professionals who provide pregnancy and childbirth services are significant factors as well as individual factors of a pregnant woman [22,23]. In addition, the ideal birth environment, which takes women's expectations into account and does not create traumatic effects, is also very important [4,24].

If the vaginal birth that is the healthiest delivery type for mothers and newborns is perceived as traumatic, it poses a great risk in increasing the demand for cesarean sections [22,25]. The main reasons why women demand a cesarean section are vaginal birth fear, negative birth experience and stories [26]. Other women's birth experiences are also of great importance in terms women's perception of childbirth and preference of birth type [25]. For this reason, in this study, the sample comprised multigravidas who had previous birth experience.

In our country, the number of studies that measures PTC according to our culture is very limited. This research resulted from such a need and is original due to the fact that there are few studies on the subject in the literature and that it demonstrates the PTC of multigravidas with previous birth experience. Thanks to its feature that points out some traumatic but "preventable" factors at birth, this study is believed to serve the policies the Ministry of Health to reduce cesarean rates.

Material and Methods

Purpose and type of research

It is a descriptive, cross-sectional and relationship searching study [27]. It aims to examine the relationship between PTC and some socio-demographic characteristics of multigravidas and to determine the effect of the previous birth type and experience on the PTC.

Location of the Study

The study was conducted between July- October 2016 at a state hospital in the north of Turkey, with multigravidas admitted to the

pregnancy polyclinic. The universe of the study consisted of the multigravidas admitted to the pregnancy outpatient clinic of the relevant hospital. The sample size of the study was determined using G power analysis. In this analysis, the sample was calculated based on the relationship between the two means.

The sample was determined by the simple random sampling method and the number of samples was determined by G power analysis. In the G power analysis, sample calculation was performed based on the relationship between two means. In the calculation, bi-directional correlation was used, and type 1 error rate was taken as $(\alpha) = 0.05$, and the power of the study $(1 - \beta)$ was taken as 0.90. As a result of the analysis, the sample was calculated as 120 people [28]. Based on the probability of the missing data and the likelihood that the sample will better represent the universe, the data were collected from 161 pregnant women [27].

The criteria for sampling in the study were being literate, volunteer to participate in the research, being over 18 years old, having at least one delivery, having two or more pregnancies (multigravida), not being in high risk group in this current pregnancy (without abortus, placenta previa, preterm birth, fetal anomaly risks, etc., excluded chronic disease before pregnancy), and being at 20th gestational week and above (according to USG or last menstrual date). The reason for the choice of the pregnancies over 20 weeks was the improbability of abortion and the high possibility of performing the birth at any time. For the study, multigravidas were selected to demonstrate the PTC for the previous birth style and experiences of the pregnant women. The pregnancies with known psychiatric disorders and the women whose delivery already started were excluded from the study.

Data collection

The data were collected from the pregnant women who applied to the pregnant outpatient clinic of the relevant hospital using two forms. These were;

Pregnant Introductory Information Form (PIIF)

It consists of 16 questions prepared by the researcher scanning the literature, including the socio-demographic (age, education etc.) and obstetric (the number of pregnancy, previous birth type, health assistants helping delivery etc.) characteristics of the pregnant woman. This form was collected by a face to face interview method.

Perception of Traumatic Childbirth Scale (PTCS)

It was developed by Yanlız, Canan, Genç, Kuloğlu and Geçici (2016) [9] in order to determine the perceptions of traumatic childbirth levels of the women in reproductive age. The scale consists of a total of 13 questions covering the feelings and thoughts, anxiety, fear, worries and trauma that can be experienced when the woman thinks about the birth concept. There is 0-10 scoring for each problem from the strongest to none. The mean total score of the scale represents the level of traumatic birth perception. The minimum and maximum score in the scale is 0 and 30. Total score averages of the scale indicate that the range of 0-26 is very low, 27- 52 is low, 53-78 is moderate, 79-104 is high and 105-130 is very high level of traumatic birth perception. The Cronbach alpha reliability coefficient of the scale is 0.895[9]. PIIF and PTCS forms were applied with a face-to-face interview technique in 15-20 minutes .

Data Analysis

The data were analyzed using the SPSS 20 program. In the data analysis, percent, frequency, mean and standard deviation were used. The relationship between PTC scores of the women and their socio-demographic and obstetric characteristics was evaluated with Pearson and Spersan correlation analysis. If the data were normal distribution as a result of the Kolmogorov Smirnov analysis, Student t and Variance Analysis were used to assess the data. $p < 0.05$ was considered significant in the statistical evaluation[27].

Ethical considerations

Before starting the research, institution permission and written and verbal consent from the pregnant women were obtained. In the study, the related ethical principles of “Informed Consent Policy,” “Volunteer Policy,” and “Privacy Protection Policy” have been fulfilled since the use of human subjects requires the protection of individual rights.

Limitations of the research

The limitation of the study is that the study was conducted with the pregnant women who are having at least one delivery, being multigravida, not being in high risk group in this current pregnancy and being at 20th gestational week and above.

Results

Some mean values of pregnant women; age 28.27 ± 5.13 , gestational week 30.45 ± 7.71 , marriage duration 5.13 ± 4.15 , and the number of pregnancies 1.94 ± 1.07 . 46% of them were high school graduates, 75.2% did not work, 64.6% had moderate income level, 80.7% had nucleus family type 73.9% had a planned pregnancy (Table 1).

The mean score of the Perception of Childbirth Trauma (PCT) Scale of the participants was 70.57 ± 21.89 (Table 2). 1.9%, 28.6%, 39.1% and 23.6% of the women perceived their delivery as traumatic at “very low”, “low”, “moderate” and “high” level respectively (Figure 1).

In the correlation analysis, a significant negative correlation was found between the PTC score of the pregnant women and their age, marriage age, the number of pregnancies, the number of alive children and there was a significant positive correlation between their PTC scores and the number of hospital visits during this pregnancy ($p < 0.05$). There was a negative correlation between the PTC scores and the duration of the negative experience (death, separation, earthquake, violence, etc.) they had in recent periods ($p < 0.05$). There was no significant relationship between the PTC score and gestational week, the level of education and perception of income ($p > 0.05$) (Table 2).

The PTC scores of the women who had a chronic disease (diabetes, hypertension, etc.) previously and ongoing pregnancies were found to be lower than those without a disease ($p < 0.05$). There was not a statistically significant difference between PTC scores based on pregnancy planning ($p > 0.05$). The mean PTC score of an one who the number of pregnancy and of who pre-pregnancy trauma was found higher than others ($p < 0.05$) (Table 3).

The PTC of the pregnant women were determined based on the ones who had a vaginal delivery, a vaginal intervention, a cesarean delivery and no intervention at birth ($p < 0.05$). The mean PTC score of those who thought to give a vaginal birth was higher than those who thought a cesarean ($p < 0.05$). The PTC score of the women who had an intervention in the previous vaginal birth (synthetic

oxytocin, episiotomy, fundal pressure) was found to be higher than those who did not ($p < 0.05$). Those who were assisted by a midwife in their previous vaginal birth and were satisfied with her communication and those who wanted to be assisted by the same midwife had low PTC scores. However, the difference between the mean scores was not statistically significant ($p > 0.05$) (Table 4).

Table 1. Socio-demographic and obstetric characteristics of the pregnant women (n = 161)

Characteristics of the pregnant women	Mean $\pm$ SS (Min-Max)	
Alone	28.27 $\pm$ 5.13 (Min:19 Max: 42)	
With the spouse	30.45 $\pm$ 7.71 (Min:20 Max: 41)	
With the spouse and children	5.13 $\pm$ 4.15 (Min:4 Max: 20)	
With other family members without spouse	1.94 $\pm$ 1.07 (Min:1 Max: 5)	
Total	7.71 $\pm$ 1.87 (Min:3-Max:10)	
	n	%
Education level		
Primary/secondary school	55	34,1
High school	74	46,0
University	32	19,9
Working status		
Yes	40	24,8
No	121	75,2
Type of family		
Nucleus	130	80,7
Extended	31	19,3
Place of residence		
Village	26	16,1
Province	55	34,2
City	80	49,7
Perception of income		
Bad	3	1,9
Moderate	104	64,6
Good	54	33,5
Number of pregnancy		
2	78	48,4
3	50	31,1
≥ 4	33	20,5
Pregnancy planning		
Planned	121	73,9
Unplanned	40	26,1
TOTAL	161	100.0

Table 2. An Investigation of Relationship between the Scores of Perception of Traumatic Childbirth and Some Variables

Features	r	p
Number of pregnancy ***	-.325	0.000*
Gestational week ***	+.050	0.524
Duration of marriage ***	-.289	0.000*
Number of children ***	-.306	0.000*
Age ***	-.257	0.001*
Education level ****	+.146	0.065
Income perceptions****	-.185	0.206
The number or of hospital control during pregnancy***	+.207	0.008*
Duration of trauma (year) ***	-.085	0.045**

* $p < 0.01$ ** $p < 0.05$ *** Pearson Correlation Analysis *** Spersman Correlation Analysis

Table 3. Perception of Traumatic ChildBirth (PTC) Total Score, The Comparison of PTC According to the Obstetric Characteristics of Pregnant Women (n=161)

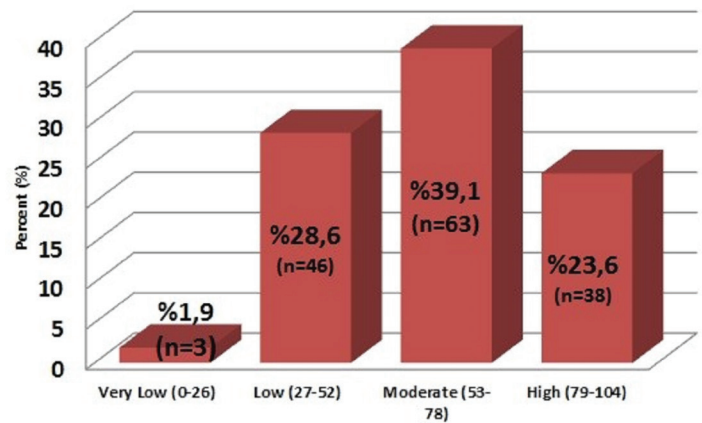
PTC Total Score			Mean ±SS 70.57±21.89 (Minimum 3- Maximum 123)	
Obstetric Features	n	%	PTC Score ±SS	Statistics and p Value
The number of pregnancy				
Two	78	48,4	76,47±15,61	KW =2,779** p=0.006*
Three	50	31,1	65,43±17,61	
≥Four	33	20,5	62,62±24,53	
Pregnancy planning				
Planned	119	73,9	66,90±22,81	t =0,238***
Unplanned	40	24,8	65,90±22,04	p=0.812
Presence of a chronic disease before pregnancy				
Yes	51	31,6	59,39±21,03	t=-,784***
No	110	68,4	70,02±23,17	p=0.006*
Pre-pregnancy trauma (death, separation, violence, etc.)				
Yes	40	24,8	73,29±23,88	KW=2,137** p=0.037
No	103	63,9	63,55±22,96	
No answer	18	11,3	65,72±20,12	

* p <0.05, ** Kruskal Wallis test *** Student t test

Table 4. The Comparison of Perception of Traumatic Birth (PTC) Scores According to the Previous Birth Types and Childbirth Experiences of Pregnant Women

Characteristics	n	%	PTC Score	Statistics and P Value
The type of birth planned for this pregnancy				
Vaginal delivery	105	65,2	70,04±22,30	t:2,351***
Cesarean	53	32,9	61,15±22,76	P=0.020*
Indecisive ****	3	1,9	71,70±20,53	
Previous Birth Type				
Vaginal	108	67,0	70,48±22,00	t=3,348***
Cesarean	53	33,0	54,40±18,25	p=0.001*
Health professional who helped with vaginal birth (n=108)				
Only midwife	67	62,0	67,95±22,93	t=-,547***
Only physician ****	7	6,6	72,57±17.63	p=0,587
Both midwife and physician	34	31,4	70,51±23,37	
Interventions at previous vaginal birth (episiotomy, synthetic oxytocin, fundal pressure etc.) (n = 108) *				
Yes	68	63,0	69,89±18,22	t: 2,439***
No	26	24,1	57,81±15,92	p=0.017*
Does not remember ****	14	12,9	60,12±12,57	
Perceived communication of the midwife who helped the previous birth (n=67)				
Good	50	74,6	68,14±17,20	KW:6,989**
Bad	5	7,5	94,80±16,17	p=0.030*
Both good and bad	12	17,9	67,08±17,47	
Requesting the midwife at previous birth for this coming birth (n=67)				
Yes	44	65,7	68,47±17,24	KW:6,371**
Does not matter	9	13,5	62,66±19,34	p=0.095
Requesting another midwife	10	14,9	73,00±17,05	
Requesting physician not midwife	4	5,9	97,66±17,61	

* p <0.05, ** Kruskal Wallis test *** Student t test **** those who did not decide the delivery type, who did not remember the intervention in the previous vaginal delivery and who gave birth with the help of a doctor were not included in statistical evaluation

**Figure1.** Pregnant Women's Perception of Traumatic Childbirth Levels

Discussion

This study was carried out to investigate the multigravidas' PCT-related factors and the effect of their previous birth types and experiences on PCT. There is not a study in Turkey that examines PCT of pregnant women as a society-specific scale as in this study. Therefore, the discussion section of the study is limited to its own data.

The study demonstrated that four out of ten participants had "moderate" PTC and more than two out of ten had "high" PTC (Figure 1). The great majority of the studies on birth traumas in the literature were carried out using "Posttraumatic Stress Disorder (PTSD)" scale [6,7,13]. İşbir et al. found the PSD prevalence as 5.8% in pregnancy and 11.9% in the early postpartum period (4-6 weeks). In a meta-analysis study of 59 studies, the prevalence of PSD in high-risk pregnancies was approximately 19% [29]. In our study, the average PTC score of the pregnant women was 70.57 $\pm$ 21.89 (Table 3). This score showed that it was close to the upper value of the middle range of the scale (53-78 points) and that the participants had "high" PCT. The high PCT of the pregnant women suggested that the average gestational week (30.45 $\pm$ 7.71; Table 1) of the women was high and their fear of coming birth increased and the negative effect of the previous birth experience was possibly influential.

The factors such as being nullipar, uncertainty about the type of birth, being young and adolescent can cause stress, fear and the negative perception of birth [14,17]. In this study there was a negative correlation between the PTC of the women and their age, the age of marriage, the number of pregnancies, the number of living children, and a positive relationship between PTC and the number of hospital visits during the pregnancy (p <0.05) (Table 2). In a systematic review, it was suggested that the woman's age, education and economic situation are influential in her perception of birth[30]. In our study, the previous experiences of multigravidas, and the fact that those having a previous cesarean knew that they would have a cesarean section again removed uncertainties and may have reduced the level of PTC. This was a pleasing finding. Additionally, it is also thought that as age, the duration of marriage, and the number of children increased, the participants' skills of coping and managing stress/ anxiety might have increased and they might have perceived birth less traumatized. Similarly, Grekin and O'Hara[24] indicated that PSD decreased as age progressed. On the other hand, in some studies,

the PTC, postpartum depression and the risk of PSD of those who experienced complications in their previous births [16,31], had a poor relationship with their spouse, had a large number of children and had depressed pregnancies increased [7,11,32].

There was a negative relationship between the PTC score and the number of hospital visits during pregnancy, the negative previous experiences (death, separation, earthquake violence, etc.) ($p < 0.05$) and no relationship was determined between education level, income perception and gestational week ($p > 0.05$) (Table 2). Apart from routine applications, frequent ultrasonographic and NST evaluations and some screening tests in pregnancies may increase the anxiety of the pregnant women [33]. In this study, the fact that the participants were multigravidas and 31.6% of them had a chronic disease (Table 1) in the past may have caused by frequent hospital visits. Frequent hospital visits during the pregnancy may reduce the discomfort of pregnancy and anxiety [33,34], but they may also create a sense of “risk presence” for the fetus’s health and causing fear and traumatic effects [33,35]. Therefore, before and after all interventions, pregnancies should be informed by health professionals [34].

In this study, pregnant women with chronic illness before pregnancy had a lower PTC than those without it ($p < 0.05$) (Table 3). The presence of a chronic problem in pregnancy was reported to cause stress and anxiety and could be perceived as threatening in some studies [34, 35] while in some other studies it was stated that it facilitated to adopt the disease as a pregnant woman improved a problem solving and coping ability with time and transformed it into positive emotion [36,37]. In this study, it is conceivable that multigravidas with chronic illnesses may have developed skills to cope with the illness and developed a positive point of view beforehand, thus reducing the PTC. According to the status of pregnancy planning in the study, there was not a statistically significant difference between the PTC average scores ($p > 0.05$) but there was a lower PTC score in unplanned pregnancies (Table 3). Contrary to this work, there are studies showing that non-planned pregnancies perceived the birth as more traumatic [20,24].

The PTC of pregnant women is affected especially by sexual abuse in childhood [7], the deaths of relatives and loved ones and immigration. In this study, a negative correlation was found between the PTC scores of the participants indicating that they had negative experiences (the death of first degree relatives, living in a different city etc) in the past at a traumatic level and the duration of this condition ($p < 0.05$) (Table 3). In other words, the longer the duration of the adverse event is, the lower the PTC becomes. In a study by Modarres et al., PTC and post stress disorders were found to be high in those who had trauma stories in the past [12]. It is of great importance that such women become pregnant after the traumas are healed as it is important for maternal and newborn health [16].

There was no relationship between the education level, income perception and gestational week of the pregnant women and their PTC ($p < 0.05$) (Table 2). In many studies, it was stated that those who had the low level of education and income, had no social security, migrated due to a war and natural disasters, had language problems and cultural differences perceived their birth highly traumatic [7,29,31,38]. However, in Stankovicin’s study, it was reported that those with the higher educational level perceived

birth more negatively [4].

The type of delivery (vaginal or cesarean section), the interventions performed at delivery [25, 26], and the communication skills of the midwife and physician who assist delivery are important obstetric factors affecting the way birth is perceived [14,23]. The type of the birth can cause traumatic effects, creating fear in especially in nulliparas and those who had negative previous birth experiences. Fear at birth suppresses contractions by increasing cortisol levels, increases the number of interventions at birth and causes traumatic births [3,32,39]. In this study, PTC was found to be higher in the pregnant women having a previous vaginal birth and planning vaginal birth than those who had cesarean ($p < 0.05$) (Table 4). Gamble and Creddey in England [18], Stankovic in Serbia [4], Priddis et al., in Australia [40], İşbir et al., in Turkey [11] showed that the vast majority of the women who experienced a traumatic delivery and postpartum trauma had a vaginal delivery and were applied interventions such as synthetic oxytocin, vacuum, forceps, episiotomy at birth. In addition, the women who wanted to have cesarean section but who had a vaginal birth experienced more traumas [8,41].

The type of birth and the interventions at birth can create a traumatic effect during the birth and postpartum period [5,38]. In a longitudinal study, 60% of which comprised multigravidas, İşbir et al. stated that 65.7% of them gave birth vaginally, 62.9% were given oxytocin at birth, and the rate of PTSD in the early postpartum period was 11.9% [11]. The interventions applied reduce the feeling of control, extend the duration of the birth, cause pain and fear, and cause traumatic perception [18,24]. In a mixed method study by Aktaş and Aydın (2017), the mothers who underwent fundal pressure at birth stated that they saw the application in their dreams immediately after birth and woke up shouting with great fear [15]. Again, in a qualitative study, a mother stated that the long-term application of synthetic oxytocin at birth gave him a feeling of “burning in the fire of hell” and experienced birth very badly [10]. Similar to these studies, PTC was found to be higher in the participants who were applied interventions in our study ($p < 0.05$) (Table 4). As a result of traumatic births, it is not desired to be pregnant or the delivery is planned with a caesarean section [4,18,41].

Health professionals assisting birth and their communication skills can influence the perception of birth [23]. In this study, 62%, 6% and 31.4% of the women who gave vaginal births were assisted only by a midwife, only by a physician, and by a physician and a midwife respectively. There was no statistically significant difference among the PTC scores of the women ($p > 0.05$), but the PTC score was lower in those who gave birth only with the help of a midwife (Table 4). In a study by Oweis, the birth satisfaction score was higher in those assisted by a midwife (109.9 ± 17.6) than that of the ones assisted by a physician (101.3 ± 12.5) ($p < 0.05$) [5]. The results of this research may be interpreted with the fact that the physician’s workload was excessive, s/he spent limited time for delivery, s/he applied intervention at birth more frequently, and midwives established a more emotional relationship with the mother [10,22]. In our study, the ratio of the pregnant women who established a good communication with the midwife in their previous birth and desired to give vaginal birth again was found high (Table 4). In the study by Aktaş and Pasinlioğlu, the

mothers whose emphatic communication expectations fulfilled by the midwives had higher birth satisfaction ($p < 0.05$) [23]. In an otherwise unusual case, as noted in a meta-analysis study, the negative attitude and behavior of the midwife and physician at birth created a traumatic effect on the women [24].

Conclusions

In Simkin's (1992) study, it was demonstrated that although the twenty years passed after their delivery, women could still remember the negative communication of health professionals [16]. Poor communication, which creates a traumatic effect at birth, also increases the preference of women for a cesarean section [4,25,41]. Sydsjö et al. suggested that the rate of cesarean delivery increased by 5.2 times in the women who experienced traumatic pregnancies previously [3]. A cesarean section performed except a medical necessity poses risks for mothers and newborns [26].

A result of the findings of the study,

- The early identification of the risk of childbirth trauma before pregnancy or early pregnancy and taking precautions (such as psychological support, medication),
- Obtaining the obstetric anamnesis of women admitted to hospital for birth by examining physical and psychological aspects or the early identification of the risks (such as stillbirth, intervened and prolonged birth),
- The early postpartum identification and treatment of the women who experienced traumatic birth,
- Pregnant women's participation in a prenatal training to reduce their fear of vaginal birth trauma and encourage a vaginal birth and
- The formation of the ideal birth environment in which women will experience positive birth are recommended.

It is also suggested that the health professionals who will help to give birth should

- Strengthen their communication skills,
- Avoid any unnecessary interventions that may cause trauma at birth (episiotomy, fundal pressure, synthetic oxytocin, etc.) and
- Join trainings regarding the approaches in traumatic births (such as psychoeducation).

In addition, it is also important to increase the studies on PTC and conduct prospective qualitative and quantitative studies with primigravidas and investigate the effects of PTC on next life of mother and newborn.

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