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Adjustment disorders in the postpartum resulting from childbirth: a descriptive and exploratory study

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ABSTRACT

Introduction: The experience of childbirth may result in the appearance of adjustment disorders (AD), jeopardizing maternal and newborn health. **Aim:** Check for signs of AD in mothers and their possible relationship with the birth experience. **Method:** This is a descriptive exploratory study. Data were collected at two moments in time: in the immediate postpartum period and between 90 to 180 days after delivery, in which we applied the Impact of Events Scale (IES). The study population consisted of 98 mothers at a hospital in São Paulo. **Results:** Of the 98 women, 9.2% reported signs of AD related to the childbirth experience. This was more common in those who have had c-sections and in those who were not accompanied by a companion. **Conclusion:** The use of IES allowed us to check for signs of AD, its association with the type of delivery, and with the presence of a companion.

Keywords: Adjustment Disorders; Violence against Women, Postpartum Period

INTRODUCTION

The postpartum is a period of the woman's life that should be evaluated with special care as it involves several physical, hormonal and psychological changes as well as social inclusion, which may reflect directly on their mental health[1].

Some authors[2,3] have pointed out that the emotional and psychological state of women during this period is critical to the healthy relationship of both mother and child for the mother's health and that of her family. In this regard, Byrom et al.[2] emphasize that postpartum psychological problems can be as common as physical ones, associating them with previous mental health problems, low levels of postnatal support, and traumatic birthing experiences.

During the process of labor and birth, women are particularly vulnerable and become more susceptible to violence which, according to Wolff and Waldow[4], is "consensual", that is, accepted. According to the authors, women do not speak up due to fear or perhaps because of oppression, or even due to concerns about experiencing something totally new and unknown. When the parturition process is finished, the mother usually tries to forget the bad aspects of the bith experience due to the new demands and tasks required by the baby, as well as the satisfaction experienced as a result of the birth. However, some women will suffer psychosocial effects resulting from the obstetric assistance received, many of which are linked to feelings and disorders of the postpartum period.

There are three major types of mental disorders in the postpartum period described in the literature[1,3,5,6] today: the so-called "Baby Blues" or "Maternity Blues", postpartum depression and puerperal psychosis, considered to be a psychiatric emergency that requires intensive treatment.

All these disturbances have, as their main focus, the individual component, either in terms of social support deficiency or due to women's previous mental health problems. Its determination does not, to any great extent, take into account how the health

system, especially obstetric assistance, is organized, and how the negative experience of childbirth may lead to a negative situation in the postpartum period.

For this reason, some authors[1-3,6,7] also describe problems associated with stressful events, which, according to Neves[7], are often classified as transient, and thus are referred to as Adaptation Disorders (AD). These problems usually occur between 90 to 180 days after the stressor event, and are characterized essentially by the development of significant emotional or behavioral symptoms in response to one or more identifiable psychosocial stressors. These stressors lead to distress and significant impairment in the individual's social life, and may last for months.

In the event that they happen after birth, ADs may lead to symptoms of depression and anxiety[7], bringing damage to the health of mother and newborn child and may even interfere in baby care, breastfeeding, the establishment of bonding and in the development of the newborn. In some cases, these disorders can evolve into more complex behavioral disorders[1 to 3.6].

Still considering the factors that influence the childbirth experience, Byrom et al.[2] describe some invasive obstetric procedures, such as emergency cesarean section, labor induction and the vaginal birth using instruments, commonly perceived as a trauma by women and associated with post-traumatic stress disorder. On this topic, Figueiredo et al.[8] reported that the presence and the monitoring by a significant person during labor, the type of delivery and the pain experienced, interfere with how a woman interprets this experience.

Postpartum is recognized as a period lacking in attention on the part of healthcare systems, especially concerning the psychosocial health of the women concerned. When adaptation problems arise, the mothers or family members usually seek the help of physicians or nurses who are not always prepared to recognize the signs of mental and emotional disorders characteristic of the period[1.2].

In this context, the role of the health professional is to be aware of the mental and emotional health of women in the postpartum period. The approach should be made to maintain emotional support, understanding and assistance in caring for the baby[1]. It is

important for the woman to receive all the necessary information about what is happening, and she should be forwarded to a specialized care unit in the event of the symptoms persisting for more than two weeks. This may avoid the appearance of postnatal depression or even puerperal psychosis[6].

Given the importance of the impact of labor on women's health, we came up with the idea for this study. It is justified by the importance of an early diagnosis and consequent support intervention, or even the forwarding of those mothers who might report some type of emotional disorder or AD signals. Furthermore, the study may provide clues on how obstetric practices in childbirth, often violent and forceful to women, are correlated with the appearance of these disturbances.

Keeping these considerations in mind, this study aims to verify the presence of AD signs in women who are in the postpartum period, and their possible relationship with the birth experience.

METHOD

This is an exploratory and descriptive study in which we use a quantitative approach. The subjects of the research are 98 women who were in Rooming-in Care, in the public and private sectors, of a hospital in eastern São Paulo. The inclusion criteria were being over 18 years of age and agreeing to take part in the study by signing two copies of the Statement of Informed Consent Form (ICF). The exclusion criteria were: birth care in another location (home, transfer from other hospitals) and neonatal loss.

Data collection occurred during the months of May and June 2010 and was performed in two stages. In the first stage, a direct contact with the women interned in the joint lodgings of the institution was carried out, and they formally approved the research. In this initial contact, data for the identification and the characterization of women were collected using a pre-designed form, and a bond was created in order to sensitize them to participation in the second stage which occurred after 90 to 180 days of confinement.

In this second approach, the women were contacted by phone to answer the items on the Impact of Events Scale (IES), identifying delivery as the stressor event.

The IES, already translated and validated in Brazil[9], consists of 15 items that measure, according to attributes of frequency, the presence of intrusive and avoidant symptoms after the occurrence of traumatic situations that, in the case of this study, occurred or were experienced during childbirth. On this scale, women reported Likert-style how they were feeling on each of the issues raised, according to four attributes of frequency: never, rarely, sometimes, and always.

According to Horowitz[10], the 9author who created the IES, questions 2, 3, 7, 8, 9, 12, 13 and 15 are related to avoidance behavior, while the others indicate signs of intrusion. According to Zambaldi et al.[11] the avoidance behavior consists of the removal of situations, people, places and thoughts that make the subject remember the stressor event. Signs of intrusion are characterized by distressing recollections of the event, such as images, ideas, dreams or emotions.

About IES, it is important to add that Horowitz[10] and recent studies[12,13] refer to the need for establishing scores for each response. These authors[10,12,13] propose the attribution of values as follows: never=0, rarely=1, sometimes=3, and always=5. The cut-off limit, according to the criteria proposed in the most recent classification of IES, is a score greater than 25[12,13]. That is, the individuals who scores on this level may show signs of disorder related to the stressor event.

The analysis of all data was performed with the support of descriptive statistics tools incorporating measures of absolute and relative frequency.

According to Resolution 196/96 of the National Health Council, permission was requested of the women by reading and signing an informed consent form, in which case data confidentiality was guaranteed throughout the process. Furthermore, the study was approved by the Ethics Committee in Research of the School of Nursing, University of São Paulo, opinion No.. 912/2010/CEP-NSUSP.

RESULTS

Table 1 shows data for social, demographic and obstetric characterization of the 98 study participants.

Table 1. Social, demographic and obstetric characterization of women. São Paulo, 2010. (N=98)

Characteristics	N	%
Educational level		
1 to 4 years of study	1	1,0
5 to 8 years of study	16	16,3
9 to 11 years of study	72	73,5
12 and up years of study	5	5,1
Complete Higher Education	4	4,1
Age group		
Between 18 and 20 years	14	14,3
Between 21 and 25 years	35	35,7
Between 26 and 30 years	19	19,4
Between 31 and 35 years	17	17,3
More than 36 years	13	13,3
Paid work		
Yes	57	58,2
No	41	41,8
Marital Status		
Married	40	40,8
Divorced	2	2,0
Consensual Union	45	46,0
Single	11	11,2
Self-attributed skin color		
White	45	46,0
Black	11	11,2
Brown	38	38,8
Yellow	2	2,0
Indian	2	2,0
Children before the current delivery		
No	42	42,8
One	39	39,8
Two	13	13,3
Three or more	4	4,1
Number of pregnancies		
Primigravida	36	36,7
Secundigravida	36	36,7
Tercigravida	17	17,4
Multigravida	9	9,2

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Characteristics	N	%
Number of childbirths		
Primiparous mother	40	40,8
Two deliveries	40	40,8
Three deliveries	14	14,3
Multipara	4	4,1
Type of delivery (current childbirth)		
Cesárea	50	51,0
Normal	48	49,0
Companion in childbirth (current childbirth)		
Yes	74	75,5
No	24	24,5
Total	**98**	**100**

Women participating in the study were characterized by having schooling from nine to 11 years (73.5%), which amounts to complete or incomplete high school; being 21 to 25 years old (35.7%); performing paid work (58.2%); living in a consensual union (46%), while 13.3% were unmarried; having at least one living child before the most recent birth (57.2%); have been submitted to a cesarean delivery (51%); and staying with the companion of their choice during childbirth (75.5%).

Table 2 presents the response of women during the implementation of the IES. It is observed that the scale items are properly adapted to a stressor in the form of childbirth, as the participants were asked during the telephone contact. All items of the IES were mentioned with the frequency attribute "*Always*" by the women, albeit in small percentages. The questions with the highest rates of answers "*Sometimes*" or "*Always*" were no. 10 (30.6%) and no. 1 (18.4%), which belong to the group of items dealing with intrusion, followed by the question. 2 (17.3%), that belongs to the avoidance group.

Table 2. Responses of women to IES, according to the stressor "childbirth". São Paulo, 2010. (N=98)

Items	*Never*		*Rarely*		*Sometimes*		*Always*	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
1) I thought about childbirth when I did not want to.	68	69,5	12	12,2	12	12,2	6	6,1
2) I avoided getting upset when I thought about childbirth or when I remembered it.	67	68,4	14	14,3	12	12,2	5	5,1
3) I tried to remove it from my memory.	80	81,6	5	5,1	7	7,2	6	6,1
4) I had trouble falling asleep or I was awake because of images or thoughts about childbirth that kept returning to my mind.	84	85,7	9	9,2	3	3,1	2	2,0
5) I had waves of strong feelings about childbirth.	76	77,6	10	10,2	6	6,1	6	6,1
6) I had dreams about childbirth.	80	81,7	11	11,2	4	4,1	3	3,0
7) I avoided things that would remind me of the birth.	82	83,7	9	9,2	4	4,1	3	3,0
8) I felt as if it had not happened or as if it were not real.	79	80,6	11	11,2	5	5,1	3	3,1
9) I avoided talking about childbirth.	79	80,6	10	10,2	5	5,1	4	4,1
10) Images of the childbirth kept returning to my mind.	52	53,1	16	16,3	18	18,4	12	12,2
11) Other things made me think about childbirth.	64	65,3	21	21,4	10	10,2	3	3,1
12) I knew I had many feelings about childbirth, but I did not want to deal with them.	78	79,6	9	9,2	6	6,1	5	5,1
13) I tried not to think about childbirth.	74	75,5	10	10,2	10	10,2	4	4,1
14) Any reminder would bring back feelings about childbirth.	71	72,5	13	13,3	7	7,1	7	7,1
15) My feelings about childbirth seemed to be far away.	81	82,7	11	11,2	4	4,1	2	2,0

In Table 3 one can see the score achieved according to the type of delivery. The women undergoing cesarean delivery obtained higher final scores, higher average values and higher standard deviation values compared to those who had their babies vaginally.

With regard to the total score of the IES, 90.8% of women have not reached the limit of the cut of 25 points. Of the remainder, 7.2% had between 30 and 39 points, 1% scored

48 points and 1% scored 71. These corresponded to nine mothers who, according to the IES, showed signs of AD related to the delivery stress factor.

Table 3. Scores according to the type of delivery. São Paulo, 2010. (N=98)

Type of delivery	Average	SD	Minimum	Median	Maximum
Cesarean Section (N=50)	12,1	14,5	0	6	71
Normal (N=48)	5,5	8,2	0	2	31

The characterization of women with a score greater than 25 in the IES can be verified on Table 4.

Table 4. Characterization of women with scores higher than 25 in the IES. São Paulo, 2010. (N=9)

Characteristics	N	%
Educational level		
9 to 11 years of study	8	88,9
Complete Higher Education	1	11,1
Marital Status		
Consensual Union	5	55,6
Single	2	22,2
Married	2	22,2
Number of deliveries		
Primiparous mother	4	44,4
Two deliveries	3	33,4
Three deliveries	2	22,2
Type of delivery (current childbirth)		
caesarean section	6	66,7
Normal	3	33,3
Companion in childbirth (current childbirth)		
Yes	4	44,4
No	5	55,6
Total	9	100

The scores above the cutoff occurred mostly in women who had undergone cesarean section (66.7%) as well as those with higher education (88.9%), living in a consensual union (55.6%), primiparous (44.4%) and who did not have a companion during labor and birth (55.6%).

DISCUSSION

With regard to the characterization data of the women involved, particularly with respect to the degree of education, the authors[14] relate low educational level to an increased psychosocial vulnerability, which may be a factor that interferes when AD symptoms appear.

Coutinho et al.[14] also describe the relationship between socio-demographic variables and affective, anxiety, phobic or somatoform disorders. In this study, the presence of these conditions, commonly referred to as minor psychiatric disorders, was associated with the female gender, and with low schooling and unemployment, but they can be modified by their relationship to other variables.

However, in this study, there was no association between low education and other items of characterization and the development of AD. On the contrary, most women with scores above 25 indicated nine to 11 years of education, and there was one of them who had completed a progam of higher education. Moreover, it was not possible to identify, similarly to the situation in other studies, the social and demographic characteristics most commonly associated with postpartum disorders[6].

Therefore, it is important to note that a combination of biological, obstetric, social and psychological factors are pointed to in determining disorders and postpartum depression. One set of authors[6] claim that it is possible to identify an association between the occurrence of such disorders and the little support offered by the partner or other persons with whom the woman have a relationship; the lack of planning of her pregnancy; the premature birth and death of the newborn; the difficulty associated with breastfeeding and difficulties during childbirth.

It is observed in this study, however, that there was a relationship between parity and signs of AD. Women who have experienced a first birth were in the majority. However, it was not possible to find such an association in the literature available on the subject.

As stated, the type of delivery most predominant among the participants was the cesarean section. In this respect, it is noteworthy that the prevalence rate (51%) is in a

proportion almost two and half times greater than the rate of 15% indicated by the World Health Organization (WHO) for any country[15,16]. Still, according to several authors[8,15-17] the unnecessary high level of cesarean increases the risk of complications for mother and baby, whether in terms of physical or psychosocial aspects.

Cesarean section was also more common in women who had achieved scores above 25 in the IES. Furthermore, the higher scores occurred with regard to the participants who had submitted to surgical delivery, although these participants did not reach values that indicated the presence of disturbances. One may think, therefore, that this type of delivery is a predisposing factor for the development of AD, which is consistent with the literature on the subject.

A review conducted by Figueiredo[8] shows that several authors reported that women who underwent cesarean section, especially the emergency ones, had a much less positive perception of the birth experience compared to the women who had experienced a normal delivery. In general, they would experience greater fear during the procedure, would take longer to establish a bond with the baby, and would have problems providing care and breastfeeding during the first days of life.

The majority of the women in this study (75.5%) reported having had a companion of their choice during childbirth. In this regard, it is noted that the remaining, 24.5%, could not make use of this right, which is at odds with Law No. 11,108[18], that ensures the mothers the right to the presence of a companion during labor, delivery and immediate postpartum.

In this context, Rattner[19] states that the presence of a significant companion for the women is the best "technology" available for a successful delivery. The author emphasizes that women who had continuous emotional support during labor and childbirth were less likely to receive analgesia, to have cesarean section and who reported greater satisfaction with the experience. This emotional support was associated with greater benefits when it was provided by someone who was not a member of the hospital staff and when it was available from the beginning of labor.

In a more striking manner, a fact that draws attention is the large increase in the percentage of women who did not have a companion, which rose from 24.5%, in the population, to 55.6% among women with signs of AD, in spite of the fact that the presence of the companion has been highlighted and reported by several authors[8.17] as relevant to a positive childbirth experience.

It is necessary to consider that, in addition to quantitative variables that are used in this study, there is also, in a special way, the presence of feelings and insights which are fundamental to the experience of birth. A review conducted by Zambaldi[11] shows an association between postpartum disorders related to childbirth and women's perception of having received little support by the health team on that occasion. For the author, "…this factor could be minimized if the health care team, who assists women during labor, were attentive to the possibility of deliveries experienced as psychologically traumatic and furthermore would be willing to provide more information and support to women at that very significant moment."

It should be emphasized that, although this study is focused on the experience of birth, feelings related to postpartum adaptation can also arise from changes in everyday life, in behavior and physical changes that occur during the period, as described by Salim et al.[20]. For these authors, the new roles regarding maternity and parenting and their performance, require adjustments in relation to the new human being that becomes real, differently from the gestational period, when the child was imagined and dreamed up.

To illustrate, we present the speech of a woman with identified signs of AD by the application of IES. When answering the questions, she showed feelings of intrusion and avoidance, characteristic of the disorder:

> *I avoid thinking about the delivery. When I think, I turn on the TV to watch something else. (24 years, cesarean delivery, score = 39 points)*

CONCLUSION

We conclude that it was possible to check, through the use of the Impact of Events Scale, the presence of possible signs of AD related to childbirth as a stressing factor in women, as well as its association with certain characteristics such as type of delivery and presence of a companion.

It is noteworthy that the mothers identified with scores higher than 25 were referred for specific professional evaluation.

Regarding the methodology employed in the research, it is necessary to emphasize that the use of scales such as the IES, can contribute to the screening, monitoring and appropriate support of women with signs of AD that may result in more serious or complex disorders.

However, memories of the birth, which is a lifetime event linked to many emotions and feelings, are not necessarily associated with emotional disorders. The use of a scale may enable a closer relationship with women in order to gather information on the emotional aspects of postpartum, mobilize feelings and memories that may even require greater support from the health system. It is also important to highlight that the emotional state of women in the postpartum period is difficult to analyze, solely by using one instrument that follows a pre-defined pattern.

Despite perceiving signs indicating AD in 9.2% of women, it was not possible to delve more deeply into the individual history of each one of them, as well as the history of their experience during childbirth, which might have contributed to a better understanding of the feelings experienced.

The variables were analyzed in a single way, considering the women who showed signs of AD and observing the absolute and relative percentages for each category. However, behavioral changes are much more complex than that; the information and categories are interrelated, and produce a third effect that may be protective or hazardous. These are the main limitations of this work that lead to the need for a deepening of the subject.

It is important to add how the presence of the partner, chosen by the woman, may be a protective factor in terms of avoiding AD. It is worth emphasizing the need for better surveillance by the authorities, so that the Law on the Right to a Companion (18) is indeed fulfilled in the health institutions, because, besides being a woman's right, it can contribute to her having a more positive perception of her labor experience, and to also being protected from the appearance of emotional disorders during the postpartum period.

In this context, emphasis should be placed on the type of delivery, cesarean section, and its relationship with the signs of AD in the women in this study. Changing the culture of childbirth in our country should be related, not only to the necessary lowering of the rates of maternal and perinatal morbidity and mortality associated with cesarean section, but also to the effects of this surgery on the psychosocial status of women. Given all that is published on the topic, it is unacceptable that we still observe rates as high as those found in this study, and which probably result in unnecessary emotional disorders for women. Reversing this picture is a matter of respect for human rights, because women are biologically and psychologically affected by a procedure performed without proper care and attention in most cases.

Both the issue of a companion and the type of delivery are related mainly to the model of prevalent obstetric care in most health care institutions, which does not take into account the legal rights and the protagonism of women in the process of labor and birth.

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