



HOLISTIC MIDWIFERY CARE



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gece
kitaplığı

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PREFACE

Midwifery is recognized as one of the oldest and most deeply rooted health professions, extending back to the earliest periods of human history. As witnesses to the beginning of life, midwives have historically served not merely as health professionals accompanying the birth process, but also as representatives of a profession that assumes essential responsibilities in the protection, promotion, and maintenance of the health of women, newborns, children, and families. In contemporary practice, midwifery is shaped by evidence-based approaches while also embracing a holistic model of care that considers individuals within their physical, psychological, social, and cultural dimensions.

This book has been prepared to examine Traditional and Complementary Medicine practices and the solution-focused approach within the framework of current scientific knowledge, placing holistic midwifery care at its center. It is our belief that this work will serve as a scientific resource for health professionals, academics, and students in the field of midwifery, while also contributing to the greater visibility of holistic care in midwifery practice.

This book is dedicated to all midwives who stand beside women, babies, and families with knowledge, compassion, patience, and devotion during life's most special and precious moments, and who practice their profession with love and commitment.

INTRODUCTION

Midwifery care is a professional field of care that addresses women's physical, psychological, social, and cultural needs during pregnancy, childbirth, the postpartum period, and lactation in a holistic manner. Today, women's desire to take a more active role in childbirth and breastfeeding processes, their tendency to use non-pharmacological methods to cope with pain and anxiety, and their expectation that individual preferences will be considered in care have increased the importance of traditional and complementary medicine practices in midwifery care. Traditional and complementary medicine practices should not be considered as alternatives to modern medical care, but rather as supportive approaches that can be used under appropriate conditions and within safe and evidence-based boundaries (Kaya Bayıroğlu et al., 2023).

Complementary approaches used during pregnancy and childbirth are important in terms of promoting relaxation, reducing labor pain and anxiety, increasing adaptation to childbirth, and supporting a positive birth experience. It has been reported that methods such as hypnosis, music, breathing therapy, aromatherapy, massage, reflexology, therapeutic touch, acupuncture/acupressure, and transcutaneous electrical nerve stimulation are used during labor to reduce pain and anxiety, promote relaxation, and increase birth satisfaction (Ersöz et al., 2024). Therefore, it is important for midwives to recognize the complementary methods preferred by women during childbirth, to understand their potential benefits and risks, and to provide safe counseling.

In the postpartum and lactation periods, mothers may encounter problems such as perceived insufficient milk supply, nipple problems, pain, engorgement, mastitis, fatigue, stress, and early cessation of breastfeeding. During this process, practices such as hypno-breastfeeding, music therapy, yoga and relaxation exercises, massage and compression, reflexology, phytotherapy, aromatherapy, and acupuncture/acupressure may be used to initiate and maintain breastfeeding and to reduce lactation-related problems (Turan et al., 2024). However, for these practices to be evaluated safely, the midwife should inform the mother and her family, question the methods being used, raise awareness about possible side effects, and refer the mother to appropriate health services when necessary (Turan et al., 2024).

The counseling role of the midwife regarding traditional and complementary medicine practices is not limited to providing information. The midwife should listen to the woman

without judgment, systematically question the traditional or complementary practices she uses, and evaluate the possible effects of these practices in relation to the current pregnancy, childbirth, postpartum, or lactation process. In addition, the midwife should explain that the perception that “everything natural is safe” is not always accurate and should provide counseling on possible contraindications, drug interactions, allergic reactions, and maternal-infant safety in relation to herbal products, aromatic oils, massage, reflexology, acupressure, and other complementary methods. The literature also emphasizes that midwives should have knowledge about the benefits and possible adverse effects of traditional and complementary medicine practices, keep their knowledge up to date, and assume an educational and counseling role for individuals, families, and society (Turan et al., 2024).

Another area that strengthens the holistic approach in midwifery care is solution-focused counseling. The solution-focused approach focuses on women’s strengths, previous coping experiences, existing resources, and achievable goals rather than on their problems. In this respect, it is compatible with the woman-centered philosophy of midwifery. It can be used as a supportive counseling model to increase women’s self-efficacy, motivation, and coping skills during pregnancy, fear of childbirth, and breastfeeding. Indeed, solution-focused psychoeducation has been reported to be effective in reducing fear of childbirth and increasing childbirth self-efficacy, and it may also be beneficial in supporting breastfeeding motivation and reducing the perception of insufficient milk (Dağlı & Aktaş Reyhan, 2024; Kaya & Güler, 2022).

In this regard, by using the solution-focused counseling approach, the midwife should not address situations such as fear, anxiety, feelings of inadequacy, or breastfeeding difficulties solely from a problem-focused perspective. Instead, the midwife should support the woman in recognizing her strengths, remembering previous successful experiences, setting realistic goals, and making small positive changes visible. Integrating the solution-focused approach into midwifery care can increase women’s active participation in the care process while also strengthening their self-confidence, self-efficacy, and motivation (Dağlı & Aktaş Reyhan, 2024; Kaya & Güler, 2022).

In conclusion, traditional and complementary medicine practices and the solution-focused approach are two important areas that strengthen holistic, woman-centered, and supportive care in midwifery. However, the integration of these approaches into midwifery care should be carried out in line with scientific evidence, ethical principles, patient safety, legal

regulations, and professional responsibilities. In this process, before assuming an implementing role, midwives have an important responsibility as counseling health professionals who inform women, assess risks, support safe use, provide referrals when necessary, and monitor the care process (Ersöz et al., 2024; Kaya Bayıroğlu et al., 2023; Turan et al., 2024).

Evaluation of Midwifery Students' Knowledge and Attitudes towards Complementary Medicine and Traditional Medicine: A multisite cross-sectional study¹

INTRODUCTION

Traditional and complementary medicine (CAM) has been used across societies for many years and continues to attract increasing attention worldwide. In recent decades, this interest has grown in many countries, partly because of the burden of chronic or difficult-to-treat diseases, the cost of conventional health services, limited time allocated to patients, and concerns about the adverse effects or adequacy of existing treatment options (World Health Organization, 2019; Khorshid & Yapucu, 2005).

The World Health Organization describes traditional and complementary medicine as health-related knowledge, skills, and practices that are shaped by cultural theories, beliefs, and experiences and used for maintaining health, preventing illness, and managing physical or mental disorders, regardless of whether these practices are fully explained by contemporary biomedical models (WHO, 2000). It has also been reported that a considerable proportion of the world population uses CAM methods and that these approaches are frequently preferred in chronic conditions (Edirne et al., 2010). The National Center for Complementary and Integrative Health classifies complementary approaches according to their primary therapeutic focus, including nutritional, psychological, physical, and combined approaches (NCCIH, 2021).

Rates of CAM use differ markedly across countries. Previous reports have indicated rates of 42.1% in the United States, 49.3% in France, 70.4% in Canada, 48.2% in Australia, 71% in Chile, 70% in China, and 40% in Colombia (Ozcelik & Fadiloglu, 2009). In Turkey, commonly reported CAM practices include massage, leech therapy, reflexology, aromatherapy, apitherapy, mesotherapy, homeopathy, herbal and nutritional therapies, hypnotherapy, acupuncture, and cupping; the overall use rate has been reported as 60.5% (Simsek et al., 2017).

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CAM use is also common among healthcare professionals. International findings have shown use rates of 92.4% among nurses, 64.9% among physicians, and 83.3% among pharmacists (Thandar et al., 2017). In Turkey, physicians have been reported to know several CAM methods, such as music therapy, hypnosis, leech therapy, acupuncture, and ozone therapy (Tekci, 2018). Midwives also encounter CAM practices in professional contexts. Harding and Foureur (2009) reported that many midwives used CAM to facilitate normal birth and reduce induction-related interventions. Similarly, Hall et al. (2012) noted that midwives used CAM in relation to labour induction and progress, nausea and vomiting, relaxation, back pain, anaemia, malpresentation, perineal discomfort, postpartum depression, and breastfeeding problems. Frequently recommended approaches included massage, phytotherapy, relaxation practices, nutritional supplements, aromatherapy, homeopathy, and acupuncture. Because CAM practices may be used together with conventional medical care, healthcare professionals should be able to evaluate their potential benefits, limitations, risks, and contraindications (Cinar et al., 2016; Lafci & Kasikci, 2014).

Although CAM methods are widely known and used in Turkey, evidence regarding the frequency of use, preferred methods, and professional perspectives remains limited (Cinar et al., 2012). This gap is particularly important for midwifery, since midwives contribute to public health protection and health promotion and are likely to face increasing demand for CAM-related guidance.

For these reasons, midwifery students should acquire accurate and evidence-based knowledge about CAM before entering professional practice. This study aimed to determine the knowledge and attitudes of undergraduate and graduate midwifery students in Turkey regarding complementary and traditional medicine practices.

2. MATERIALS AND METHODS

2.1 Design and setting

This descriptive, multisite, cross-sectional study was carried out as an online survey between March 4 and May 30, 2020. The study included students enrolled in undergraduate and graduate midwifery programmes in Turkey.

2.1.1. Recruitment and data collection

The study population consisted of students registered in undergraduate and graduate midwifery programmes at 57 public and private universities in Turkey. Participants were reached through WhatsApp groups and social media platforms using convenience sampling. The invitation message provided information about the purpose of the study, emphasized voluntary and anonymous participation, and included links to the informed consent form and the online questionnaire. The survey was prepared using Google Forms and remained accessible between March and May 2020. To increase participation, three reminder messages were shared through the same communication channels during data collection.

2.1.2. Sample size

The estimated number of eligible students at the participating universities was 16,000. Based on the known-population sample size formula and using the Raosoft sample size calculator, the minimum required sample was calculated as 376 students with $\alpha = 0.05$ and $1-\beta = 0.95$ (Raosoft, n.d.). The final sample included 1,061 students.

Inclusion criteria: Students were included if they were enrolled in an undergraduate or graduate midwifery programme in Turkey, agreed to participate voluntarily, had internet access, and completed all questionnaire items.

Exclusion criteria: Students studying at universities outside Turkey, students from fields other than midwifery, and students enrolled in health vocational high schools were excluded.

2.2. Survey instruments

Data were collected using two instruments: an information form and the Scale for Attitudes towards Complementary and Alternative Medicine (SACAM).

Information form: The information form included 19 items addressing students' sociodemographic characteristics, such as year of study, age, place of residence, family type, and perceived family income, as well as their views and experiences regarding complementary and alternative medicine.

Scale for Attitudes towards Complementary and Alternative Medicine (SACAM): SACAM was developed by Araz and Harlak (2006) to assess individuals' attitudes toward

complementary and alternative medicine. The scale is scored on a five-point Likert format ranging from 1 (strongly disagree) to 5 (strongly agree). It consists of eight items and two subscales, labelled 'alternative' and 'complementary'. Possible total scores range from 0 to 40, with higher scores reflecting more positive attitudes toward CAM. In the original study, Cronbach's alpha coefficients were 0.76 and 0.77 for the subscales, and 0.85 for the total scale. In the present study, Cronbach's alpha was 0.79.

2.3. Ethical considerations

Ethical approval was granted by the Kirklareli University Clinical Researches Ethics Committee (Reference No: 54001588-199-E.4639; Date: 02/03/2020). All study procedures were conducted in accordance with ethical principles for research involving human participants and complied with institutional and national research ethics standards, as well as the 1964 Declaration of Helsinki and its subsequent amendments.

2.4. Data analysis

Data were analysed using IBM SPSS Statistics version 23.0 (SPSS Inc., Chicago, IL, USA). The Kolmogorov-Smirnov test was used to assess whether quantitative variables followed a normal distribution. For normally distributed variables, independent-samples t tests were used for comparisons between two groups, while one-way analysis of variance was used for comparisons involving three or more groups. Logistic regression analysis was performed to identify variables associated with the use of complementary and alternative treatment methods, and both univariate and multivariate models were examined. Quantitative findings were summarized as mean $\pm$ standard deviation and median (minimum-maximum), whereas categorical variables were presented as frequencies and percentages. Statistical significance was accepted at $p < 0.05$.

3. Results

3.1 Demographic characteristics

The study was completed with 1,061 students from six state universities in Turkey. Most participants were third-year undergraduate midwifery students (29.1%, $n = 309$). Nearly half reported that they had lived most of their lives in a county (46.9%). The majority had a nuclear family structure (82.0%) and a medium perceived income level (69.3%). Most mothers and fathers had completed primary school (69.7% and 53.3%, respectively). In addition, 51.6% of

the participants reported type B personality traits, and 91.1% stated that they did not have a chronic disease (Table 1).

When SACAM scores were compared according to sociodemographic characteristics, most variables were not significantly associated with mean scores. However, a significant difference was observed according to fathers' education level ($p = 0.042$), whereas other sociodemographic variables were not significant ($p > 0.050$) (Table 1).

Table 1. Comparison of SACAM scores by socio-demographic characteristics

	n	%	Mean. $\pm$ SD	Mean. (Min. - Max.)	Test statistics	P
Age						
18-25	1030	97.1	20.9 $\pm$ 2.2	21 (18 - 38)		
25-38	31	2.9				
Class						
1 st -class	255	24	21.97 $\pm$ 2.61	22 (15 - 28)		
2 nd -class	221	20.8	22.14 $\pm$ 2.47	22 (14 - 29)		
3 rd -class	309	29.1	22.18 $\pm$ 2.46	22 (15 - 30)	F=.769	.572
4 th -class	257	24.2	21.87 $\pm$ 2.43	22 (15 - 29)		
Master's degree	14	13	22.71 $\pm$ 2.3	22 (20 - 27)		
PhD	5	0.5	22.2 $\pm$ 1.92	22 (20 - 25)		
Place of residence						
Province	418	39.4	22.19 $\pm$ 2.62	22 (16 - 29)		
County	498	46.9	21.95 $\pm$ 2.42	22 (14 - 30)	F=1.074	.342
Town-village	145	13.7	22.03 $\pm$ 2.28	22 (15 - 28)		
Family type						
Core	871	82.1	22.06 $\pm$ 2.47	22 (14 - 30)		
Extended	190	17.9	22.02 $\pm$ 2.53	22 (15 - 29)	t=.194	.846
Family income*						
Medium	735	69.3	22.04 $\pm$ 2.39	22 (14 - 30)		
High	325	30.7	22.09 $\pm$ 2.67	22 (15 - 29)	t=-.239	.811
Mother's education level						
Illiterate	100	9.4	22.26 $\pm$ 2.97	22 (15 - 29)		
Primary school	740	69.7	22.1 $\pm$ 2.37	22 (14 - 29)		
High shool	177	16.7	21.77 $\pm$ 2.5	22 (15 - 30)	F=1.003	.394
University	44	4.1	21.93 $\pm$ 3.05	22 (15 - 28)		
Father's education level						
Illiterate	21	2	23.57 $\pm$ 2.87 ^a	23 (19 - 29)	F=2.741	.042

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Primary school	565	53.3	22.05 ± 2.46 ^b	22 (14 - 29)		
High shool	315	29.7	22.00 ± 2.49 ^b	22 (15 - 30)		
University	160	15.1	21.97 ± 2.47 ^b	22 (16 - 29)		
Personality trait						
Type A (enthusiastic, impatient personality)	513	48.4	22.18 ± 2.61	22 (15 - 30)	t=1.577	.115
Type B (calm, quiet, organized personality)	548	51.6	21.94 ± 2.36	22 (14 - 29)		
Chronical diseases						
Yes	94	8.9	21.83 ± 2.82	22 (15 - 28)	t=-.912	.362
No	967	91.1	22.07 ± 2.45	22 (14 - 30)		

F: Variance analysis; t: paired samples; a-b: no difference between those which are shown with the same letter, *the number of observations for 'less income than expenses' was one, and therefore it was not included in the analysis.

3.2. Evaluation of student's beliefs and attitudes towards alternative and complementary medicine and SACAM scale scores

A significant difference was identified between students' knowledge of specific CAM methods and their mean SACAM scores ($p = 0.023$). The highest mean score was observed among students who reported knowing reflexology (22.62 ± 2.32), compared with other method categories (Table 2). Mean SACAM scores also differed significantly according to the CAM methods students reported using, including aromatherapy, reflexology, phytotherapy, homeopathy, cupping, ozone therapy, or no method ($p = 0.032$). Furthermore, students' reasons for using CAM were associated with SACAM scores. Significant differences were found among those who used CAM for chronic diseases, oncological diseases, gynaecological problems, aesthetic purposes, or did not use CAM ($p = 0.001$). The source from which students learned about CAM was another significant factor. SACAM scores varied according to whether students obtained information from healthcare professionals, family members, friends, television or social media, books, or had no knowledge of CAM methods ($p = 0.009$). Students who believed that CAM methods were easy to apply had significantly different SACAM scores compared with those who did not share this view ($p < 0.001$). Similar significant differences were observed for the beliefs that CAM supports the body's healing process, should be recommended to others, and is effective (all $p < 0.001$) (Table 2).

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Table 2. Comparison of the thoughts on complementary and alternative medicine and SACAM scores

	N	%	Mean± SD	Mean (Min.-Max.)	Test statistics	P
Overall scale score			22.1 ± 2.5	22 (14 - 30)		
What complementary and alternative medicine methods do you know?						
Aromatherapy	506	47.7	21.94±2.45 ^{ab}	22 (15 - 29)	F=2.464	.023
Reflexology	78	7.4	22.62 ±2.32 ^b	23 (17 - 28)		
Phytotherapy	33	3.1	21.45 ±2.29 ^{ab}	21 (16 - 28)		
Homeopathy	21	2	20.71 ± 2.00 ^a	20 (17 - 24)		
Cupping	277	26.1	22.19 ±2.34 ^{ab}	22 (15 - 29)		
Ozone therapy	6	0.6	22.17 ±2.93 ^{ab}	21,5 (19 - 26)		
None	140	13.2	22.23 ±2.94 ^{ab}	22 (14 - 30)		
Do you use complementary and alternative medicine methods?						
Yes	779	73.4	21.83 ± 2.51	22 (15 - 30)	t=-1.762	.078
No	282	26.6	22.13 ± 2.47	22 (14 - 29)		
What complementary and alternative medicine methods do you use?						
Aromatherapy	184	17.3	21.54 ± 2.44 ^b	21.5 (15 - 28)	F=2.464	.032
Reflexology	38	3.6	21.39 ±2.41 ^{ab}	21 (16 - 28)		
Phytotherapy	35	3.3	22.46 ±1.77 ^{ab}	22 (18 - 28)		
Homeopathy	15	1.4	21.8 ± 2.4 ^{ab}	21 (18 - 26)		
Cupping	88	8.3	22.23 ±2.49 ^{ab}	22 (15 - 29)		
Ozone therapy	12	1.1	22.58 ±4.27 ^{ab}	21,5 (15 - 30)		
None	689	64.9	22.18 ± 2.48 ^a	22 (14 - 29)		
Why do you use complementary and alternative medicine methods?						
For chronic diseases	100	9.4	21.64 ±2.75 ^{ab}	22 (14 - 29)	F=4.497	.001
For Oncological diseases	9	0.8	22.67 ±1.58 ^{ab}	23 (20 - 25)		
For the treatment of gynecological diseases (such as premenstrual syndrome)	134	12.6	21.73 ±2.36 ^{ab}	22 (15 - 28)		
For aesthetic reasons (such as hair, skin care)	251	23.7	21.72 ± 2.45 ^a	22 (15 - 30)		

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Not using	567	53.4	22.34 ± 2.46 ^b	22 (15 - 29)		
Where did you learn complementary and alternative medicine methods?						
Healthcare personnel	168	15.8	21.85 ± 2.59 ^a	22 (15 - 29)	F=3.075	.009
Family	201	18.9	22 ± 2.62 ^{ab}	22 (15 - 28)		
Friends	95	9	22.16 ± 2.52 ^{ab}	22 (15 - 29)		
TV/Social media	274	25.8	22.01 ± 2.23 ^{ab}	22 (14 - 30)		
Books	143	13.5	21.64 ± 2.4 ^a	21 (15 - 28)		
I have not learned any complementary and alternative medicine methods	180	17	22.63 ± 2.56 ^b	23 (16 - 29)		
I think complementary and alternative medicine methods are easily applicable.						
Yes	736	69.4	21.79 ± 2.48	22 (15 - 30)	t=-5.153	<.001
No	325	30.6	22.64 ± 2.39	23 (14 - 29)		
I think complementary and alternative medicine treatments help the body to heal itself.						
Yes	841	79.3	21.8 ± 2.47	22 (14 - 29)	t=-6.574	<.001
No	220	20.7	23.01 ± 2.29	23 (16 - 30)		
I recommend people around me to use complementary and alternative medicine methods.						
Yes	759	70.6	21.66 ± 2.49	22 (14 - 30)	t=-8.728	<.001
No	302	29.4	23.00 ± 2.2	23 (16 - 29)		
I think complementary and alternative medicine and treatments work.						
Yes	941	88.7	21.9 ± 2.5	22 (14 - 30)	t=-6.696	<.001
No	120	11.3	23.23 ± 1.99	23 (18 - 29)		

F: Variance analysis; t: paired samples; a-b: no difference between those which are shown with the same letter, *the number of observations for 'less income than expenses' was one, and therefore it was not included in the analysis.

3.3. Factors associated with CAM use

In the univariate logistic regression model, year of study was the independent variable associated with CAM use. In contrast, the other independent variables did not show a statistically significant effect ($p > 0.050$). Compared with first-year students, second-year students were 0.774 times less likely to use CAM methods, whereas fourth-year students and graduate students were 0.623 and 1.445 times more likely to use these methods, respectively (Table 3).

Increasing age was associated with a 0.097-fold increase in the likelihood of CAM use. Students living in towns or villages were 0.839 times less likely to use CAM compared with those living in provinces. Compared with students whose mothers were illiterate, students whose mothers had completed high school and university education were 0.841 and 0.926 times more likely to use CAM, respectively. Students with chronic diseases were 1.04 times more likely to use CAM than those without chronic diseases.

Compared with students who did not know any CAM method, the likelihood of CAM use was higher among those who knew aromatherapy (2.755 times), reflexology (2.172 times), phytotherapy (2.273 times), and cupping (1.105 times). Students who used CAM for chronic diseases, oncological diseases, gynaecological diseases, and aesthetic purposes were also more likely to use CAM than those who did not use any alternative medicine method, with corresponding odds of 3.557, 3.700, 4.159, and 3.373, respectively.

The source of information was also related to CAM use. Compared with students who had not learned any CAM method, the odds of CAM use were higher among those who obtained information from healthcare personnel (3.63 times), family (4.259 times), friends (3.102 times), television or social media (3.38 times), and books (3.989 times). Students who had used CAM once and those who had used it more than once were 3.874 and 5.684 times more likely to use CAM, respectively, compared with students who had never used it. In addition, CAM use was more likely among students who considered CAM easy to apply, believed that CAM supports self-healing, recommended CAM to people around them, or believed that CAM treatments work (Table 3).

Table 3. Examination of independent variables affecting complementary and alternative treatment by logistic regression analysis

	Model I		Model II	
	Odds ratio	%95 CI	Odds ratio	%95 CI
Class (1 st -class)				
2nd-class	0,774	0,283 - 0,753	0,086	0,41 - 2,897
3rd-class	0,252	0,881 - 1,879	0,551	0,641 - 4,698
4th-class	0,623	1,271 - 2,736	0,323	0,458 - 4,167
Master's degree	1,445	1,416 - 12,7	-0,481	0,03 - 12,576
PhD	0,229	0,087 - 7,249	-1,45	0 - 570,588
Mother's education level (Illiterate)				
Primary school	0,544	0,997 - 2,977	0,539	0,599 - 4,906
High school	0,841	1,261 - 4,267	0,349	0,4 - 5,027
University	0,926	1,12 - 5,693	0,178	0,226 - 6,329
Chronical diseases (No)				
Yes	1,04	1,839 - 4,35	0,891	0,836 - 7,101
What complementary and alternative medicine methods do you know? (None)				
Aromatherapy	2,755	6,807 - 36,288	1,321	0,94 - 14,943
Reflexology	2,172	3,376 - 22,801	1,894	1,343 - 32,875
Phytotherapy	2,273	3,217 - 29,305	1,935	0,671 - 71,457
Homeopathy	0,855	0,442 - 12,499	-0,737	0,022 - 10,62
Cupping	1,105	1,234 - 7,392	1,479	1,04 - 18,53
Ozone therapy	18,097	0 - 0	-19,37	0 - 0
Why do you use complementary and alternative medicine methods? (Not using)				
For chronic diseases	3,557	18,817 - 65,283	0,93	0,787 - 8,155
For Oncological diseases	3,700	9,967 - 164,091	3,294	3,346 - 217,135
For the treatment of gynecological diseases (such as premenstrual syndrome)	4,159	35,074 - 116,736	1,18	1,059 - 10,006
For aesthetic reasons (such as hair, skin care)	3,373	16,954 - 50,177	0,558	0,618 - 4,941
Where did you learn complementary and alternative medicine methods? (I have not learned any complementary and alternative medicine methods)				

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Healthcare personnel	3,63	9,003 - 157,961	0,071	0,158 - 7,293
Family	4,259	17,075 - 292,938	1,215	0,508 - 22,36
Friends	3,102	5,057 - 97,896	0,621	0,259 - 13,359
TV/Social media	3,380	7,099 - 121,588	0,674	0,299 - 12,862
Books	3,989	12,87 - 226,574	1,131	0,438 - 21,914
I think complementary and alternative medicine methods are easily applicable. (No)				
Yes	1,357	2,669 - 5,651	0,424	0,709 - 3,295
I think complementary and alternative medicine treatments help the body to heal itself. (No)				
Yes	0,788	1,487 - 3,248	-0,726	0,166 - 1,411
I recommend people around me to use complementary and alternative medicine methods (No)				
Yes	1,947	4,43 - 11,089	1,03	0,968 - 8,106
I think complementary and alternative medicine and treatments work. (No)				
Yes	1,388	2,122 - 7,57	0,458	0,414 - 6,04

DISCUSSION

This study examined the knowledge, beliefs, and attitudes of undergraduate and graduate midwifery students in Turkey regarding CAM. The findings showed that students generally had positive attitudes toward CAM, although their knowledge and sources of information appeared to be limited and uneven. Given the growing public interest in CAM, these results are important for midwifery education and practice.

The mean SACAM score in the present study was 22.1 ± 2.5 , indicating a generally positive attitude. This result is consistent with previous studies reporting favourable attitudes toward CAM among nursing and midwifery students (Abdollahi et al., 2020; Cinar et al., 2016; Shorofi & Arbon, 2017; Walker & Budd, 2002). However, the methods known or used by students differed across studies. Abdollahi et al. (2020) reported aromatherapy as a commonly recognized CAM method, whereas other studies emphasized massage and acupuncture (Bahall & Legall, 2017; Lafci & Kasikci, 2014). These differences may be related to cultural context, curricular exposure, clinical learning opportunities, and the availability or visibility of particular

CAM practices in each country.

The logistic regression results indicated that students most often used CAM for aesthetic purposes and gynaecological complaints. This pattern differs from findings reported by Balouchi et al. (2018), who found CAM use mainly for stress and anxiety, and from Harding and Foureur (2009), who emphasized midwives' use of CAM to reduce induction and caesarean rates and to support normal birth. In the present study, the narrower range of reported indications may reflect limited knowledge about mechanisms of action, indications, and evidence-based use of CAM methods.

Students most frequently learned about CAM through television and social media. This finding is noteworthy because informal sources may provide incomplete, inaccurate, or non-evidence-based information. Previous studies have similarly identified media, books, family members, friends, and individuals using CAM as important sources of information (Arzu et al., 2007; Bozkaya et al., 2008; Topaloglu et al., 2013). By contrast, Harding and Foureur (2009) reported that midwives often learned CAM through courses, books, and colleagues, while Gorucu and Sayilan (2020) noted training programmes, scientific meetings, television, and the internet as sources. The present findings therefore support the need for structured CAM content within midwifery curricula rather than reliance on informal media-based learning.

Nearly all participants perceived CAM methods as beneficial. Similar findings have been reported in studies showing that midwives considered CAM to strengthen midwifery care and support normal birth (Harding & Foureur, 2009). Other research has also suggested that students and healthcare professionals may view CAM as a useful complement to modern medicine (Cutshall et al., 2010; Samuels et al., 2010). Nevertheless, positive attitudes should not be interpreted as sufficient competence for clinical guidance. Healthcare professionals must also understand indications, contraindications, possible interactions, and evidence limitations before recommending CAM to patients.

Although many students recommended CAM methods, the rate of recommendation was lower than that reported in some previous studies (Arslan et al., 2017; Bahall & Legall, 2017; Set et al., 2012). This may be explained by uncertainty regarding what CAM includes and how these methods should be used safely. Interestingly, 73.4% of students stated that they used CAM, while 64.9% selected 'none' when asked which methods they used. This inconsistency may indicate conceptual confusion about CAM terminology and classification. Therefore,

educational content should not only list CAM methods but also clarify definitions, legal responsibilities, safety principles, and the boundaries of professional practice.

Overall, the findings suggest that midwifery students require stronger, evidence-based preparation in CAM. Since midwives are expected to provide holistic care and guide women and families, undergraduate and graduate curricula should include content on CAM indications, side effects, mechanisms of action, contraindications, evidence levels, and safe counselling. Such education may improve students' ability to respond to patient questions and to distinguish between appropriate complementary support and unsafe or unsupported practices.

RESULTS

The increasing use of CAM in society has made it important for future midwives to understand these practices within an evidence-based framework. This descriptive, multisite, cross-sectional study showed that Turkish midwifery students had generally positive attitudes toward CAM but also demonstrated limitations in knowledge and relied substantially on informal information sources. Integrating CAM-related content into midwifery education may help students provide accurate counselling about indications, application methods, side effects, contraindications, and safe use during future professional practice.

Limitations

Several limitations should be considered. First, the study was conducted online; therefore, it was not possible to reach the entire target population. Second, the distribution of participants across universities was not fully known, which may have affected the representation of attitudes from institutions with different participation levels. Third, participation was voluntary, creating the possibility of self-selection bias. Finally, the number of graduate-level participants was relatively small. These factors may limit the generalizability of the findings to all midwifery students in Turkey, particularly graduate students.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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Solution-Focused Approach and the Role of Midwives in the Management of Fear of Childbirth²

Fear of childbirth (FOC) is recognized as an intense and persistent fear related to pregnancy and the birth process that extends beyond the level of anxiety commonly experienced by expectant mothers. Unlike the transient concerns that accompany normal pregnancy, severe fear of childbirth may interfere with emotional well-being, daily functioning, and decision-making throughout pregnancy. Women experiencing high levels of childbirth fear are more likely to avoid vaginal delivery and may request an elective cesarean section despite the absence of medical indications. Clinically, fear of childbirth is classified as either primary or secondary. Primary fear occurs in women with no previous childbirth experience, whereas secondary fear develops following adverse reproductive experiences such as traumatic birth, miscarriage, stillbirth, or pregnancy loss (Kitamura et al., 2024; Abdelaziz et al., 2025).

The development of fear of childbirth is multifactorial and results from the interaction of biological, psychological, and social influences. Numerous studies have identified previous traumatic birth experiences, sexual abuse, anxiety disorders, depression, post-traumatic stress disorder, limited childbirth self-efficacy, exposure to negative birth experiences, and inadequate social support as important contributing factors. Elevated antenatal anxiety has consistently been reported as one of the strongest predictors of severe childbirth fear. Additional factors, including younger maternal age, nulliparity, and negative expectations regarding labor and delivery, have also been associated with higher levels of fear during pregnancy (Adewunmi et al., 2026).

The consequences of severe fear of childbirth extend beyond psychological distress and may influence both maternal and neonatal outcomes. Women with pronounced childbirth fear are more likely to experience persistent stress, sleep disturbances, panic symptoms, avoidance of vaginal birth, unnecessary requests for cesarean delivery, postpartum depression, and difficulties in establishing early maternal–infant attachment. These adverse outcomes highlight the importance of identifying childbirth fear during routine antenatal care. Early screening followed by timely psychological support may contribute to improved maternal mental health

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while promoting more favorable pregnancy and neonatal outcomes (Adewunmi et al., 2026; Abdelaziz et al., 2025).

Current perspectives on fear of childbirth have evolved considerably in recent years. Although it was traditionally regarded as a specific phobia, accumulating evidence suggests that its clinical presentation extends beyond the characteristics of a classical phobic disorder. Cognitive processes related to trauma, intrusive or obsessive thoughts, and overvalued beliefs appear to play an important role in maintaining childbirth fear. Consequently, comprehensive psychological assessment should not be limited to measuring childbirth-related anxiety alone but should also consider accompanying psychiatric symptoms and underlying emotional conditions that may influence women's responses to pregnancy and childbirth (Kitamura et al., 2024).

Given the multidimensional nature of fear of childbirth, increasing attention has been directed toward psychosocial interventions that not only reduce fear but also strengthen women's psychological resources, improve coping abilities, and enhance childbirth self-efficacy. Within this context, the Solution-Focused Approach has emerged as a promising counseling model because it emphasizes individuals' existing strengths, available resources, and future possibilities rather than concentrating primarily on psychological deficits or pathological processes.

Solution-Focused Brief Therapy is a structured, short-term, and goal-directed counseling approach that encourages individuals to identify their strengths and develop practical solutions instead of focusing extensively on the origins of their problems. Developed during the 1980s in the United States by Steve de Shazer and Insoo Kim Berg, SFBT is grounded in systems theory and social constructionism. Rather than exploring the underlying causes of psychological difficulties in depth, the approach seeks to identify previous successes, existing competencies, and personal resources that can facilitate meaningful change. The central objective is to help individuals recognize their own capabilities, strengthen their confidence, and build realistic, attainable goals that promote positive change (Arslan & Gümüşçağlayan, 2018; Ateş, 2018; Güner, 2018; Yağcı & Duyan, 2020).

The theoretical foundations of the Solution-Focused Approach were strongly influenced by Milton Erickson's view that every individual possesses the internal knowledge, abilities, and resources necessary to overcome personal challenges. Building on this perspective, de Shazer and Berg proposed that counseling should focus on identifying and amplifying these existing

strengths rather than attempting to create new capacities or extensively analyze pathology. Accordingly, the counselor functions as a collaborative partner who facilitates the client's discovery of effective solutions instead of acting as an expert responsible for interpreting problems or determining their underlying causes. Through collaborative dialogue, encouragement, and the recognition of clients' strengths, solution-focused counseling seeks to foster hope, increase self-efficacy, and support sustainable positive change (Bannink, 2010; Burns, 2005).

The Solution-Focused Approach is grounded in the belief that every individual possesses strengths, previous successful experiences, and personal resources that can be utilized to facilitate meaningful change. Rather than viewing people through the lens of their difficulties, this perspective emphasizes their existing competencies and capacity for growth. A central assumption of the approach is that even modest behavioral changes may initiate a broader process of positive and sustainable change. Consequently, the counseling process places greater emphasis on clients' previous successes, available resources, and desired future outcomes than on exploring the origins or persistence of their problems. By directing attention toward the construction of solutions rather than the analysis of problems, solution-focused counseling seeks to enhance hope, strengthen confidence, and increase individuals' belief in their own ability to cope effectively with challenges. These principles are reflected in the well-known solution-focused assumptions: *"If it isn't broken, don't fix it," "If it works, do more of it,"* and *"If it doesn't work, do something different."* Guided by these principles, clients are encouraged to maintain strategies that have previously been successful while replacing ineffective coping patterns with more adaptive alternatives (Connie & Metcalf, 2009).

A variety of structured techniques are used within the Solution-Focused Approach to help clients recognize their strengths and identify practical pathways toward change. Commonly employed techniques include solution-focused language, collaborative goal setting, the miracle question, scaling questions, exception questions, the identification of pre-session changes, positive feedback, and homework assignments. Among these, the miracle question occupies a central role because it invites individuals to imagine how their lives would change if their problem were suddenly resolved. This process enables clients to define meaningful goals and visualize realistic future outcomes. Scaling questions provide an opportunity for individuals to assess the current severity of their concerns, monitor progress over time, and acknowledge even small improvements achieved during counseling. Exception questions encourage clients to identify situations in which the problem is absent or less intense, thereby highlighting

personal strengths, effective coping strategies, and previous successes that can be incorporated into future solution-building (Grant, 2012; Burns, 2005).

Another defining feature of the Solution-Focused Approach is the active role assigned to clients throughout the therapeutic process. Rather than relying on the counselor to generate solutions, individuals are encouraged to become active participants in identifying their own strengths, setting realistic goals, and implementing manageable steps toward positive change. As counseling progresses, this collaborative process promotes greater self-efficacy, increased optimism, enhanced confidence, and stronger problem-solving abilities. Owing to its brief, future-oriented, and client-centered nature, the Solution-Focused Approach has been successfully implemented across a wide range of professional settings, including psychological counseling, mental health services, education, social work, and healthcare (Bannink, 2010; Gingerich & Eisengart, 2000; Macdonald, 2007).

Evidence supporting the application of the Solution-Focused Approach in maternity care has also begun to emerge. One of the earliest randomized controlled trials investigating its effectiveness in reducing fear of childbirth was conducted by Sharifzadeh et al. (2018). The study enrolled 60 pregnant women between 22 and 30 weeks of gestation who reported fear of childbirth and expressed a preference for cesarean delivery. Participants were randomly assigned to either an intervention group or a control group. In addition to receiving routine antenatal care, women in the intervention group participated in six sessions of solution-focused midwifery counseling, whereas those in the control group received standard prenatal care alone. During the counseling sessions, participants explored their childbirth-related concerns, reflected on previous situations in which they had successfully managed difficult experiences, identified their personal strengths and available resources, and developed individualized strategies for coping with childbirth-related fear. Following completion of the intervention, women in the counseling group demonstrated a significant reduction in Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) scores. Moreover, the proportion of participants who preferred vaginal birth increased to 74%, indicating that solution-focused counseling not only reduced childbirth fear but also positively influenced birth preferences. Based on these findings, the authors concluded that solution-focused midwifery counseling represents a practical, feasible, and effective intervention for reducing fear of childbirth (Sharifzadeh et al., 2018).

The findings of Sharifzadeh et al. (2018) further suggest that the benefits of the Solution-Focused Approach extend beyond symptom reduction. Solution-focused techniques such as the

miracle question, exception finding, scaling, and strength identification appeared to enhance women's confidence in their own abilities while fostering more positive expectations regarding labor and childbirth. As participants increasingly recognized their previous successes and existing coping resources, they reported greater confidence in their capacity to manage the childbirth experience. These findings support the view that strengthening self-efficacy and promoting a more optimistic outlook may represent important mechanisms through which solution-focused counseling reduces fear of childbirth and facilitates positive behavioral change (Sharifzadeh et al., 2018).

Additional evidence supporting the effectiveness of solution-focused counseling during pregnancy has been reported by Karrabi et al. (2019). In this randomized controlled trial, 108 primigravid women between 6 and 19 weeks of gestation who obtained a score of 55 or higher on the Cambridge Worry Scale were enrolled. Participants were randomly assigned using block randomization to either an intervention group ($n = 54$) or a control group ($n = 54$). Women allocated to the intervention group received solution-focused group counseling in addition to routine prenatal care, whereas those in the control group continued to receive standard prenatal care alone.

The intervention consisted of five weekly group sessions, each lasting approximately 90 minutes, and was delivered by a researcher trained in the Solution-Focused Approach. Participants attended counseling in small groups comprising 13–14 women. During the initial session, women were introduced to the principles of the counseling program, pregnancy-related concerns were identified, and individualized counseling goals were established. The second session focused on reviewing homework assignments and encouraging participants to reinforce coping strategies that had proven effective while replacing ineffective behaviors with more adaptive alternatives.

The third session emphasized the identification of personal strengths and existing resources. Through the use of exception questions and the miracle question, participants were encouraged to recognize previous successful coping experiences and apply these strengths to current pregnancy-related concerns. During the fourth session, counseling focused on promoting more adaptive patterns of thinking, emotional regulation, and behavioral responses. Relaxation exercises, breathing techniques, and stress management strategies were also introduced to strengthen participants' coping abilities. The final session was devoted to reviewing the content covered throughout the program, evaluating homework assignments,

assessing progress toward individual counseling goals using scaling questions, and completing the final counseling evaluation.

The effectiveness of the intervention was assessed at baseline, immediately after completion of the counseling program, and again two months later using the Cambridge Worry Scale. Compared with routine prenatal care alone, solution-focused group counseling produced significant reductions in pregnancy-related worries, particularly concerns associated with childbirth, maternal and fetal health, and family relationships (Karrabi et al., 2019).

Further evidence for the effectiveness of the Solution-Focused Approach was provided by Mortazavi et al. (2021), who conducted a randomized controlled trial to evaluate its effects on pregnancy-related anxiety and fear of childbirth. The study included 132 nulliparous women between 28 and 32 weeks of gestation who reported moderate to severe fear of childbirth. Participants were randomly allocated to either an intervention group or a control group. While both groups received routine antenatal care, women in the intervention group additionally participated in solution-focused group counseling (Mortazavi et al., 2021).

The counseling program consisted of five weekly sessions of approximately 60 minutes, all facilitated by a midwife trained in Solution-Focused Brief Therapy. Throughout the intervention, participants were encouraged to recognize their existing strengths, reflect on positive pregnancy-related experiences, establish realistic future goals, and generate individualized strategies for managing their fears and concerns. Homework assignments were incorporated into each session and reviewed during subsequent meetings to reinforce behavioral changes, strengthen coping skills, and support continuous progress throughout the counseling process (Mortazavi et al., 2021).

The first session introduced participants to the counseling model, established collaborative counseling goals, and provided an opportunity for women to openly discuss their concerns regarding pregnancy and childbirth. During the second session, homework assignments were reviewed while participants explored their personal strengths and existing coping resources in greater depth. Women were encouraged to adopt more constructive perspectives toward pregnancy and childbirth and to identify practical strategies for managing their concerns. The third session concentrated on strengthening positive perceptions of pregnancy and childbirth. Constructive feedback was provided throughout the counseling process to reinforce adaptive thinking, and participants collaborated in identifying realistic solutions that could reduce childbirth-related fear while increasing confidence in their ability to

cope with labor and delivery (Mortazavi et al., 2021). During the fourth session, participants learned relaxation exercises, controlled breathing techniques, and stress management strategies designed to reduce pregnancy-related anxiety. Women were encouraged to replace maladaptive cognitive and behavioral patterns with more effective coping strategies that could support emotional regulation throughout pregnancy. The final counseling session focused on reviewing the content of previous meetings, evaluating participants' progress toward their individual goals, discussing the influence of solution-focused strategies on pregnancy anxiety and fear of childbirth, and completing the post-intervention assessments (Mortazavi et al., 2021).

The findings of both randomized controlled trials suggest that solution-focused counseling may be an effective psychosocial intervention for reducing pregnancy-related anxiety and fear of childbirth. By emphasizing women's personal strengths, encouraging the development of adaptive coping strategies, and fostering confidence in their own abilities, the Solution-Focused Approach appears to improve emotional well-being while promoting more positive attitudes toward pregnancy and childbirth.

The effectiveness of the intervention was evaluated before and after completion of the counseling program using the Pregnancy Anxiety Scale (ASP) and the Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ). Women who participated in solution-focused counseling demonstrated significantly lower levels of pregnancy-related anxiety and fear of childbirth across all measured dimensions than those receiving routine prenatal care alone ($p < .001$). In addition to these psychological benefits, participants in the intervention group expressed a stronger preference for vaginal birth and reported greater satisfaction with their pregnancy experience, suggesting that solution-focused counseling positively influenced both emotional well-being and childbirth-related decision-making (Mortazavi et al., 2021).

Further evidence regarding the effectiveness of solution-focused interventions was provided by Kaya and Güler (2022), who conducted a randomized controlled trial during the COVID-19 pandemic to examine the impact of online solution-focused psychoeducation on fear of childbirth and childbirth self-efficacy. The study enrolled 119 primigravid women at 28 weeks of gestation who reported severe fear of childbirth. Participants were randomly allocated to one of three groups: a solution-focused psychoeducation group ($n = 39$), a childbirth preparation education group ($n = 40$), and a control group receiving routine prenatal care ($n = 40$). Women assigned to the intervention group participated in six consecutive weeks of individual online solution-focused psychoeducation, while the childbirth preparation group received conventional antenatal education.

The psychoeducation program was developed according to the principles of Solution-Focused Brief Therapy and incorporated a range of core solution-focused techniques, including collaborative goal setting, the miracle question, scaling questions, exception questions, the EARS technique (Eliciting, Amplifying, Reinforcing, and Start Again), constructive feedback, consultation breaks, and structured homework assignments. Alongside these counseling strategies, individualized antenatal education addressing pregnancy, childbirth, the postpartum period, and newborn care was provided according to each participant's learning needs. Throughout the intervention, women were encouraged to identify their existing strengths, recall previous successful experiences, strengthen their coping abilities, and build confidence in managing childbirth-related concerns.

Intervention outcomes were evaluated using the Childbirth Attitude Scale (CAS) and the Self-Efficacy Scale (SES). Compared with both the childbirth preparation group and the routine care group, women who received solution-focused psychoeducation experienced significantly greater reductions in fear of childbirth together with marked improvements in childbirth self-efficacy ($p < .001$). Significant gains were also observed across all dimensions of self-efficacy, including initiating behavior, maintaining behavior, completing behavior, and overcoming obstacles. These findings suggest that the solution-focused intervention not only reduced childbirth-related fear but also strengthened women's confidence in their ability to cope successfully with pregnancy and labor.

Based on these findings, Kaya and Güler (2022) concluded that online solution-focused psychoeducation represents a feasible, safe, and effective counseling intervention, particularly under circumstances where face-to-face services may be limited, such as during the COVID-19 pandemic. The authors proposed that this evidence-based approach could be incorporated into routine prenatal care as an effective strategy for reducing fear of childbirth, enhancing childbirth self-efficacy, and supporting maternal psychological well-being.

Taken together, the randomized controlled trials conducted by Sharifzadeh et al. (2018), Karrabi et al. (2019), Mortazavi et al. (2021), and Kaya and Güler (2022) consistently support the effectiveness of the Solution-Focused Approach in reducing fear of childbirth and pregnancy-related anxiety. Despite differences in study populations and intervention formats, the findings demonstrate a common pattern: interventions that encourage women to recognize their strengths, identify existing coping resources, and develop individualized solutions contribute to meaningful reductions in childbirth-related fear while simultaneously strengthening childbirth self-efficacy. These consistent findings provide growing evidence for

incorporating solution-focused counseling into routine antenatal care and childbirth education programs as an evidence-based psychosocial intervention.

The current evidence indicates that the Solution-Focused Approach is an effective counseling model for improving the psychological well-being of pregnant women experiencing fear of childbirth. Randomized controlled trials conducted by Sharifzadeh et al. (2018), Karrabi et al. (2019), Mortazavi et al. (2021), and Kaya and Güler (2022) consistently demonstrate that solution-focused counseling reduces pregnancy-related anxiety and fear of childbirth while enhancing childbirth self-efficacy, promoting more positive expectations regarding labor, and encouraging favorable attitudes toward vaginal birth. These findings suggest that the benefits of the Solution-Focused Approach extend beyond symptom reduction by supporting women's confidence, resilience, and ability to cope with the challenges associated with pregnancy and childbirth.

The philosophy of contemporary midwifery is founded on woman-centered care, empowerment, respect for individual preferences, and the active involvement of women in decisions related to pregnancy and childbirth. These principles closely parallel the theoretical foundations of the Solution-Focused Approach, making it particularly compatible with modern midwifery practice. Because midwives maintain continuous contact with women throughout pregnancy, they are ideally positioned to identify fear of childbirth at an early stage, recognize women at increased psychological risk, and provide appropriate solution-focused counseling interventions. Through this approach, women can be supported in recognizing their personal strengths, developing greater confidence in their ability to cope with labor, strengthening childbirth self-efficacy, and approaching childbirth with increased emotional preparedness. Accordingly, incorporating solution-focused counseling into routine antenatal care, childbirth education programs, and standard midwifery practice represents an evidence-based strategy that has the potential to reduce fear of childbirth while simultaneously improving maternal psychological well-being and contributing to more favorable maternal and neonatal outcomes.

Traditional and Complementary Medicine Approaches in Premenstrual Syndrome: A Holistic View of Women's Health ³

Premenstrual syndrome (PMS) is a common women's health condition characterized by physical, psychological, and behavioral symptoms that emerge during the luteal phase of the menstrual cycle and decrease or disappear completely with the onset of menstruation. PMS affects a substantial proportion of women of reproductive age and may negatively impact quality of life, work performance, academic achievement, and social relationships (Modzelewski et al., 2024; Siminiuc & Țurcanu, 2023). The global prevalence of PMS has been reported to be approximately 47.8%, while 30–50% of women experience clinically significant PMS symptoms. Premenstrual dysphoric disorder (PMDD), a more severe form of PMS, is estimated to affect 3–8% of women (Modzelewski et al., 2024).

Although the etiology of PMS has not been fully elucidated, hormonal fluctuations, dysregulation of neurotransmitter systems, inflammatory processes, genetic predisposition, stress, and lifestyle-related factors are believed to contribute to its development (Modzelewski et al., 2024). In particular, the effects of allopregnanolone, a progesterone metabolite, on GABA-A receptors and alterations in the serotonergic system have been reported to play a significant role in the manifestation of PMS symptoms (Modzelewski et al., 2024). Furthermore, even when hormone levels remain within normal physiological ranges, increased sensitivity to hormonal fluctuations in certain women is considered one of the key mechanisms underlying the development of PMS (Modzelewski et al., 2024).

PMS symptoms encompass a broad spectrum of manifestations. Physical symptoms include breast tenderness, abdominal bloating, edema, weight gain, headache, back pain, muscle and joint pain, fatigue, gastrointestinal disturbances, and sleep disorders. Psychological symptoms include irritability, anxiety, depressed mood, anger, crying spells, difficulty concentrating, forgetfulness, and social withdrawal (Siminiuc & Țurcanu, 2023). While these symptoms may be mild in some women, they can significantly impair daily activities and social functioning in others (Modzelewski et al., 2024).

Pharmacological treatment approaches for PMS include selective serotonin reuptake inhibitors (SSRIs), hormonal therapies, and combined oral contraceptives. However, these

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treatments may be associated with adverse effects such as nausea, headache, weight changes, sleep disturbances, and alterations in libido (Modzelewski et al., 2024). Consequently, increasing numbers of women have turned to complementary and traditional medicine (CTM) practices. Aromatherapy, acupuncture, homeopathy, phytotherapy, yoga, meditation, reflexology, and nutritional interventions are among the most commonly used complementary approaches for alleviating PMS symptoms (Siminiuc & Turcanu, 2023).

Acupuncture is one of the fundamental practices of Traditional Chinese Medicine and is based on the insertion of fine needles into specific energy points on the body. It is among the most extensively studied complementary therapies for the treatment of premenstrual syndrome (PMS). Acupuncture is believed to reduce pain by increasing endorphin release, regulate the autonomic nervous system, and alleviate psychological symptoms through its effects on serotonergic activity (Armour et al., 2018).

A Cochrane systematic review evaluating acupuncture and acupressure reported that these interventions may improve both physical and psychological symptoms of PMS. Significant reductions were observed in pain, breast tenderness, abdominal bloating, irritability, and depressive symptoms (Armour et al., 2018). Similarly, a systematic review and meta-analysis conducted by Kim et al. (2011) concluded that acupuncture may be beneficial in alleviating PMS symptoms. Furthermore, the meta-analysis by Yang et al. (2018) demonstrated that acupuncture reduced PMS symptom scores and improved quality of life. Nevertheless, researchers emphasized the need for higher-quality studies due to the limited sample sizes of existing trials (Armour et al., 2018; Yang et al., 2018).

Aromatherapy is a complementary treatment method that utilizes essential oils derived from plants through inhalation or topical application. Aromatherapy is known to exert beneficial effects on stress, anxiety, and mood disturbances.

In a randomized controlled trial conducted by Uzunçakmak and Ayaz Alkaya (2018), inhalation aromatherapy with lavender essential oil significantly reduced PMS symptoms after three menstrual cycles. Marked improvements were observed particularly in irritability, anxiety, depressed mood, and pain symptoms. Similarly, Heydari et al. (2018) demonstrated that aromatherapy using *Rosa damascena* essential oil effectively reduced physical, psychological, and social symptoms associated with PMS. In addition, studies involving *Citrus aurantium* and saffron have suggested that aromatic plants may be beneficial in alleviating PMS symptoms (Beiranvand et al., 2016).

Homeopathy is a complementary therapeutic approach based on the principle of “*similia similibus curentur*” (“like cures like”) and emphasizes individualized treatment. Homeopathic remedies used in PMS management are selected according to the individual's symptom profile.

Studies conducted by Yakir and colleagues have suggested that individualized homeopathy may improve PMS symptoms. More recently, Sahoo et al. (2024) reported that women receiving individualized homeopathic treatment experienced significantly greater reductions in overall PMS symptom scores compared with those receiving placebo. Notable improvements were observed particularly in pain, fluid retention, and emotional symptoms. However, the evidence base remains moderate because most studies involve small sample sizes and individualized treatment protocols (Rahman, 2024; Mabena, 2024).

Homeopathic remedies used in the treatment of PMS are individualized according to the patient's physical, emotional, and behavioral symptoms. One of the most frequently prescribed remedies reported in the literature is *Natrum muriaticum*, which is commonly used for emotional sensitivity, social withdrawal, depressive symptoms, and headaches. *Cyclamen europaeum* is utilized for mood changes, dizziness, and various premenstrual complaints, whereas *Lachesis mutus* is preferred in cases characterized by irritability, nervousness, hot flashes, and premenstrual tension (Rahman, 2024; Sahoo et al., 2024).

For PMS-associated abdominal bloating, flatulence, and emotional instability, *Lycopodium clavatum* may be prescribed. Another frequently reported remedy, *Sepia officinalis* (*Sepia succus*), is particularly indicated for irritability, emotional exhaustion, pelvic heaviness, and symptoms related to hormonal imbalance. *Nux vomica* is commonly used in women experiencing tension, anger, hypersensitivity, and digestive complaints (Rahman, 2024; Sahoo et al., 2024).

Another homeopathic remedy used for PMS symptoms associated with hormonal fluctuations is *Folliculinum*, which has been reported in several studies to be effective in alleviating symptoms. Other less frequently prescribed homeopathic remedies include *Arsenicum album*, *Causticum*, *Kali phosphoricum*, *Pulsatilla nigricans*, *Staphysagria*, and *Thuja occidentalis*. Among these, *Kali phosphoricum* is particularly preferred for mental fatigue and nervous symptoms, whereas *Pulsatilla nigricans* is commonly prescribed in cases characterized by emotional instability and a tendency to cry. Although *Staphysagria* and *Thuja occidentalis* have been prescribed in a more limited number of PMS cases, they remain treatment options depending on the individual symptom profile (Sahoo et al., 2024).

Phytotherapy refers to the use of medicinal plants and herbal products for therapeutic purposes. It is one of the most widely utilized complementary approaches in the management of PMS. Herbal products are believed to alleviate PMS symptoms through their anti-inflammatory, antispasmodic, antioxidant, and anxiolytic properties.

In a randomized, double-blind, placebo-controlled trial conducted by Jafari et al. (2021), women who consumed 400 mg of garlic daily for three menstrual cycles experienced a significant reduction in PMS symptom severity. A systematic review on chamomile demonstrated that its anti-inflammatory and antispasmodic properties may reduce pain, cramps, and emotional symptoms (Khalesi et al., 2019). Furthermore, saffron, *Vitex agnus-castus*, lemon balm (*Melissa officinalis*), and ginger have also been reported to exert beneficial effects on PMS symptoms (Beiranvand et al., 2016).

Various plant-derived essential oils, including lavender (*Lavandula angustifolia*), damask rose (*Rosa damascena*), bitter orange blossom (*Citrus aurantium*), saffron (*Crocus sativus*), and geranium (*Geranium*), have been investigated for their effects on PMS symptoms. Systematic reviews and meta-analyses have suggested that aromatherapy may be effective in reducing PMS symptoms (Es-Haghee et al., 2020; Kolivand et al., 2021). In particular, a randomized controlled trial conducted by Heydari et al. (2018) demonstrated that aromatherapy using *Rosa damascena* essential oil significantly reduced the physical, psychological, and social symptoms associated with PMS (Heydari et al., 2018).

A recent study protocol was developed to evaluate the effects of peppermint (*Mentha piperita* L.) essential oil on PMS. In this protocol, participants were scheduled to inhale peppermint oil at a 10% concentration twice daily, starting seven days before menstruation and continuing until the fourth day of menstruation. Menthol and other monoterpenes contained in peppermint oil have been reported to possess analgesic, antispasmodic, anti-inflammatory, and anxiolytic properties. In addition, they may improve mood by influencing neurotransmitter systems such as serotonin and GABA (Lagzian et al., 2025). However, because the results of this study have not yet been published, there is currently insufficient evidence to draw definitive conclusions regarding the effectiveness of peppermint aromatherapy in the management of PMS (Lagzian et al., 2025).

Nutrition plays a fundamental role in the management of premenstrual syndrome (PMS) symptoms and has increasingly been recognized as an important non-pharmacological approach to symptom control. Current evidence suggests that dietary patterns rich in vegetables, fruits,

whole grains, legumes, and dietary fiber may contribute to a reduction in PMS symptoms, whereas excessive consumption of refined sugars, caffeine, alcohol, processed foods, and high-fat diets may exacerbate symptom severity (Siminiuc & Ţurcanu, 2023). Nutritional interventions are thought to influence PMS through multiple mechanisms, including modulation of inflammatory pathways, regulation of hormonal balance, stabilization of blood glucose levels, and optimization of neurotransmitter synthesis. Furthermore, adequate intake of essential micronutrients such as calcium, magnesium, vitamin D, and B-complex vitamins has been associated with improvements in both physical and psychological PMS symptoms. These nutrients may contribute to neuromuscular function, mood regulation, and hormonal homeostasis, thereby reducing symptom burden and improving overall well-being (Siminiuc & Ţurcanu, 2023).

In addition to nutritional interventions, several complementary and traditional medicine approaches have been explored for the management of PMS. Among these, yoga, meditation, breathing exercises, reflexology, and massage therapy are commonly utilized to alleviate symptoms and improve quality of life. These interventions are generally aimed at reducing stress, promoting relaxation, improving emotional regulation, and enhancing physical functioning. Since psychological stress is recognized as an important factor that may worsen PMS symptoms, strategies targeting stress reduction are considered particularly valuable. Research has demonstrated that regular physical activity and structured stress-management practices can contribute to reduced symptom severity, improved emotional well-being, and enhanced quality of life among women experiencing PMS (Siminiuc & Ţurcanu, 2023).

Yoga is a holistic mind-body practice that promotes harmony among physical, mental, and emotional dimensions of health. Several studies investigating the effects of yoga on PMS have reported significant improvements in both physical and psychological symptoms. Women participating in regular yoga programs have demonstrated reductions in pain intensity, fatigue, irritability, anxiety, and depressive symptoms. Yoga is believed to exert these beneficial effects through mechanisms involving autonomic nervous system regulation, stress reduction, improved circulation, enhanced muscular relaxation, and increased production of neurotransmitters associated with positive mood states. Moreover, yoga encourages mindfulness and body awareness, which may help women develop more effective coping strategies for managing premenstrual symptoms. Studies conducted by Kamalifard et al. (2017), Tsai (2016), and Vaghela et al. (2019) consistently reported that regular yoga practice contributes to significant improvements in PMS-related outcomes and overall quality of life.

Meditation and breathing exercises represent another group of relaxation-based interventions used in the management of PMS. These practices aim to reduce physiological and psychological stress responses by regulating breathing patterns, promoting mindfulness, and facilitating relaxation. Controlled breathing techniques may influence autonomic nervous system activity by enhancing parasympathetic function and reducing sympathetic arousal, thereby decreasing stress levels and improving emotional stability. Meditation practices have been associated with reduced anxiety, improved emotional regulation, enhanced concentration, and decreased perception of pain. Women who engage in regular meditation and breathing exercises often report greater emotional resilience and improved ability to cope with PMS-related mood disturbances. Consequently, these interventions are considered valuable supportive approaches, particularly for women experiencing significant psychological symptoms during the premenstrual period.

Massage therapy is another complementary intervention frequently used to manage PMS symptoms. This therapy involves the manual or mechanical manipulation of soft tissues, muscles, and connective structures to promote relaxation and improve physiological functioning. During massage therapy, stimulation of peripheral receptors activates neurological pathways that contribute to muscle relaxation, reduced stress hormone production, and enhanced circulation. Research has demonstrated that massage therapy may decrease muscle tension, anxiety, irritability, and depressive symptoms among women with PMS. Furthermore, massage may contribute to pain reduction by improving blood flow and reducing muscular discomfort. Women frequently report feelings of relaxation, improved mood, and enhanced physical comfort following massage sessions. Studies have also indicated that massage therapy is among the commonly preferred self-care strategies used by women to cope with PMS symptoms (Sarı Çetin & Erbil, 2020).

Reflexology is a complementary therapeutic approach based on the application of pressure to specific reflex points located on the feet, hands, and ears. According to reflexology theory, these reflex points correspond to different organs and systems within the body. By stimulating these areas, reflexology is believed to promote physiological balance and facilitate the body's natural healing processes. Research examining reflexology in women with PMS has shown promising results, including reductions in premenstrual distress scores, symptom severity, and perceived stress levels. Reflexology may also improve relaxation, sleep quality, and emotional well-being. Furthermore, some studies suggest that longer treatment durations and repeated sessions may enhance therapeutic effectiveness. Findings reported by

Bolsoy (2008) and Hasanpour et al. (2019) support the potential role of reflexology as a complementary intervention for alleviating PMS symptoms and improving quality of life.

Overall, yoga, meditation, breathing exercises, massage therapy, and reflexology appear to be valuable supportive interventions for women experiencing PMS. These approaches may contribute to reductions in pain, stress, anxiety, depressive symptoms, emotional distress, and overall symptom severity. Additionally, they may improve psychological well-being, physical functioning, and quality of life. However, despite the encouraging findings reported in the literature, the current evidence base remains limited by methodological variability, small sample sizes, and differences in intervention protocols. Therefore, healthcare professionals should consider these therapies as complementary rather than replacement treatments and guide women regarding their appropriate and safe use. Further high-quality research is required to establish standardized protocols and strengthen the evidence supporting these interventions in PMS management (RCOG, 2017).

Conclusion

Premenstrual syndrome (PMS) is a prevalent and multifaceted health condition that affects women physically, psychologically, emotionally, and socially, often resulting in a substantial reduction in quality of life. The growing interest in complementary and integrative healthcare approaches reflects the need for effective, accessible, and patient-centered strategies for managing PMS symptoms. The literature reviewed in this paper indicates that complementary and traditional medicine interventions—including acupuncture, acupressure, aromatherapy, homeopathy, phytotherapy, reflexology, yoga, meditation, breathing exercises, and nutritional interventions—may provide beneficial effects in reducing the severity of PMS symptoms and improving overall well-being.

Evidence suggests that these approaches may contribute to reductions in pain, breast tenderness, bloating, fatigue, irritability, anxiety, depressive symptoms, emotional distress, and impairments in daily functioning and quality of life. Among the reviewed interventions, aromatherapy, acupuncture, reflexology, and yoga appear particularly promising due to the consistency of positive findings reported across multiple studies. Likewise, nutritional modifications and selected herbal therapies may support hormonal regulation, reduce inflammation, and improve psychological and physical symptoms. Individualized homeopathic treatments have also demonstrated potential benefits in some women, particularly when tailored to specific symptom profiles.

Despite these encouraging findings, several limitations remain within the existing body of evidence. Many studies have been conducted using relatively small sample sizes, short follow-up periods, heterogeneous intervention protocols, and varying methodological quality. These factors limit the generalizability of findings and make it difficult to draw definitive conclusions regarding the efficacy and safety of individual interventions. Consequently, the strength of evidence varies considerably among different complementary and traditional treatment modalities.

Future research should focus on conducting large-scale, multicenter, randomized controlled trials with rigorous methodological designs to better evaluate the effectiveness, safety, and long-term outcomes of these interventions. In addition to symptom reduction, future investigations should assess broader outcomes such as quality of life, psychological well-being, occupational and academic performance, treatment adherence, patient satisfaction, cost-effectiveness, and long-term safety. Such comprehensive evaluations would provide stronger evidence to support clinical decision-making and healthcare policy development.

As scientific evidence continues to expand, the role of complementary and traditional medicine in PMS management is likely to become more clearly defined. Integrating evidence-based complementary therapies into conventional healthcare frameworks may provide women with more holistic, individualized, and patient-centered treatment options. Ultimately, a multidisciplinary approach that combines conventional medical treatments with appropriately selected complementary interventions may offer the greatest potential for improving the health, well-being, and quality of life of women affected by premenstrual syndrome.

Result

Midwifery is a fundamental health profession that, in accordance with the Ministry of Health Midwifery Regulation, provides care, support, education, and counseling to women, infants, children, and families, beginning from the preconception period and extending through pregnancy, childbirth, the postpartum period, newborn care, and child health processes.

Midwives are professionals who are responsible for protecting, promoting, and monitoring the health of women and newborns; providing care, counseling, and education; identifying risks at an early stage; and referring individuals to appropriate health services when necessary. In this respect, midwifery is not merely a profession that accompanies childbirth, but a holistic care profession with a central role in sustaining the health of women, newborns, children, and families.

In this process, the duties and responsibilities of midwives are not limited to providing care. Midwives are professionals who assess women's needs holistically, inquire about the traditional and complementary practices they use, identify potential benefits and risks, provide reliable information, raise awareness about incorrect or unsafe practices, and refer women to appropriate health services when necessary. At the same time, listening to women's concerns during pregnancy, childbirth, and breastfeeding, helping them recognize their strengths, supporting their coping skills, and guiding them in making informed decisions are among the fundamental responsibilities of midwives.

Therefore, when integrating Traditional and Complementary Medicine practices and the solution-focused approach into midwifery care, scientific evidence, ethical principles, patient safety, legal regulations, and professional scopes of practice should be taken into consideration. As key health professionals who protect and promote the health of women, newborns, and families, provide counseling, undertake advocacy roles, and monitor the care process, midwives have an indispensable role in the implementation of holistic care.

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