



TO DETERMINE IF PROGRESSIVE RELAXATION TREATMENT DECREASES STRESS IN PREGNANT WOMEN

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ABSTRACT

Pregnancy is one of the hardest times in the life of a woman. The stress linked with the birth of the first child is classified as severe among psychosocial stress. Global studies show that 10-15% of pregnant women are affected by anxiety and sadness at different levels. Antenatal and depressive diseases are so widespread and significant in pregnancy that over half of all women who are pregnant suffer from prior anxiety. Studies have shown the connection between pregnancy and pregnancy among women's mental health. The above proportion varies with the incidence correspondingly in the second or third trimester of 12 to 15 per cent and 14 per cent. One study shows that 50% of women are pregnant in their 3rd quarter. Many studies have shown that progressive muscle relaxation in the treatment of a number of diseases, including multiple sclerosis pain relief, pulmonary disease anxiety in patients and anxiety, depression, nausea and vomiting in cancer patients, is effective. Moreover, multiple studies have shown that progressive muscle relaxation training may increase QOL, reduce pain and minimise stress for pregnant women with low back pain. However, no research has been done into the impact on prenatal mental health of progressive muscular relaxation. The purpose of this survey is to assess the overall health effect of pregnant women's progressive muscle relaxation, a non pharmacological approach. A combined test comparison showed that there was a significant difference (P 0.001, P 0.001) in the experimental group, but not in the control group, between the mean difference in physical symptoms, angst and sleeplessness, the social functioning and depression before and after intervention. The study demonstrated a significant difference between women's general health in experimental groups in the field of physical, psychological and social components. The data mostly confirmed the hypothesis of the study regarding the effect of relaxation on the overall health of pregnant women. It is therefore proposed, because of its effectiveness, lack of bad effects, especially during pregnancy, or cost-efficacy, that the medication is used by pregnant women.

Key words: Progressive Relaxation Therapy, Stress In Pregnant Women, Stress Management, Complications During Pregnancy.

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INTRODUCTION:

Pregnancy is one of the hardest times in the life of a woman. The stress linked with the birth of the first child is classified as severe among psychosocial stress. Global studies show that 10-15% of pregnant women are affected by anxiety and sadness at different levels. Antenatal and depressive diseases are so widespread and significant in pregnancy that over half of all women who are pregnant suffer from prior anxiety [1]. Studies have shown the connection between pregnancy and pregnancy among women's mental health [2]. The above proportion varies

with the incidence correspondingly in the second or third trimester of 12 to 15 per cent and 14 per cent. One study shows that 50% of women are pregnant in their 3rd quarter. All possible results of psychological pressures in pregnancy, delivery, breastfeeding, abortion, vomits, diarrhea, preeclampsia, weight loss, premature delivery, immune suppression and subsequent increases in the level of episiotomy and neonatal infections, as well as postpartum psychological disturbance. The decreased quality of life (QOL) is also linked to the disorders indicated above, for example depression and general



health problems. Relaxation is a behavioural strategy, frequently referred to as behavioural aspirin [3]. It is a new strategy that will probably become the cornerstone of anxiety & treatment with mental stress and a disciplinary approach that can be integrated into practice [4]. Relaxation techniques such as muscle relaxation and breathing are among the physiological mechanisms that link both the mind and the body and have a favourable influence on stress management as a non-medicinal procedure for the physical, mental and social aspects of overall health [5]. It is often used in research to alleviate the stress of detecting and managing muscle tension. Different research studies examined the impacts of the approach on different groups, but just a few examined the impact on pregnant ladies, one of the most vulnerable groups in society. Urach et's research on the effects of mental health relaxation during pregnancy showed that relaxation methods have positive effects on the physical & psychological systems. Mother's mind and body relaxing practises throughout pregnancy[6]. This has been said to contribute to small and common pain and soreness. Several other research have produced similar results on the psychological advantages of progressive muscle rest. A study investigating the effect of progressive muscle relaxation on anxieties among nursing students showed a considerable difference between the mean anxiety rates of the experimental and control groups after a muscle relaxation exercise[7]. Furthermore, studies showed that progressive muscle asthma relaxation in women with bronchial asthma is an effective way to improve blood pressure, pulmonary and heart rate parameters and to reduce the level of state-trait wrath; this has led to an improvement in bronchial asthma quality in pregnant women. This has resulted in a better QOL. Many studies have shown that progressive muscle relaxation in the treatment of a number of diseases, including multiple sclerosis pain relief, pulmonary disease anxiety in patients and anxiety, depression, nausea and vomiting in cancer patients, is effective. Moreover, multiple studies have shown that progressive muscle relaxation training may increase QOL, reduce pain and minimise stress for pregnant women with low back pain. However, no research has been done into the impact on prenatal mental health of progressive muscular relaxation. Embryonic women have less pregnancy and neonatal difficulties with good mental health. Nurses should evaluate and develop programmed coping for women during pregnancy[8]. Community-based programmes, which foster healthy coping, can improve maternal and neonatal health. According to Lufenuron, health care providers and other health professionals can impact coping mechanisms throughout the prenatal time, according to Borcher Ding (2009). More work can be done to evaluate cope and to incorporate appropriate cope techniques in the care plan during pregnancy[9].

AIM AND OBJECTIVE:

The purpose of this survey is to assess the overall health effect of pregnant women's progressive muscle relaxation, a non-pharmacological approach [10].

MATERIAL AND METHODS:

Sixty women who matched the study criteria of inclusion and were sent to a prenatal clinic in a designated hospital in Ragolu were in the group of this clinical experiment. The study included They were aged 18 to 35 and they were pregnant during the first quarter (up to 12 weeks). In the first quarter, primi gravida, individual pregnancy and no high-risk pregnancy, such as diabetes, hypertension, mental disorder and anti-depressant uses were used to pick the following criteria. There were two split groups: control (n = 30) and experimental (n = 30). The overall health of participants were first evaluated using the Health Questionnaire 28 (GHQ28), and the Progressive Muscle Relaxation Technique (PMRT), used since the launch by Edmond Jacobson in 1938, was then taught to experimental group subjects. PMRT training was held theoretical and practical every other day of the week, divided into three sessions of 1.5 to 2 hours each[11]. During the sessions, both the role and the value of the relaxation approach were introduced by the pregnant women or the research units were then asked to use it step by step. The training CD was prepared after the course and the participants received the material of the aforementioned technique to listening in the house during practise. After the training the participants comprehended the practise. At least twice a day the participants performed at home for eight weeks and reported their findings in a daily checklist. During this period, the researcher contacted the participants over the telephone and answered their queries to confirm that the exercise was performed properly. We had eighteen occurrences of sample attrition, based on criteria for exclusion, for example, pregnant women's discontent with the study, lack of training in more than one session, frequent practise failure for eight weeks or failure to complete the checklist. During this time, the control group received no treatment. Finally, the overall health of the two groups was examined by GHQ 28 eight weeks after the intervention. The data were collected using the GHQ28 demographic and survey data. GHQ is a self-screening questionnaire of 28 subjects, four subdivisions[12]. The articles are classified on a Likert scale of 4 (0-3). The sum of their four subscale scores ranging from 0 to 84 are the total value of each competitor. The lower score represents the highest level of general health. This questionnaire has been scientifically reliable and valid and utilised in various studies as a standard tool. Input was provided with the software SPSS15. The information was evaluated and analysed using descriptive statistics including standard and average variation, pair- and independant tests and Chi-square testing as well as inferential statistics (P 0.05)[13-14]. After the necessary research and objectives were received,



all participants filled informed written consent forms and were evicted who did not choose to continue the study [15-18]. The study was approved by the Committee for Ethics of the University of Ayatollah [19-22]. The pregnant women were told of the aims of the study and their ability at any stage to withdraw. In addition, only

standard training and care was provided to the control group in this study. For ethical considerations, relaxation training and training notes were provided by the end of the trial, or the training CD was also delivered following the test to the control group [23-26].

Table 1: Distribution of control and experimental groups based on demographic information

Group variable	N (%)		P value
	Control	Experimental	
Age, years			0.2
18 -23	6 (20%)	13 (43.33%)	
24 -29	12 (40%)	9 (30%)	
30 - 35	12 (40%)	10 (33.3%)	
Gestational age, weeks			0.13
1 – 4	4 (13.33%)	10 (33.33%)	
5 – 8	11 (36.66%)	5 (16.66%)	
9 – 12e	15 (50%)	14 (46.66%)	
Educational degree			0.14
Diploma	12 (40%)	11 (36.66%)	
BS or higher	18 (60%)	19 (63.33%)	
Employment status			0.48
Employer	8 (26.66%)	9 (30%)	
Housewife	24 (80%)	23 (76.66%)	
Regularly referring to prenatal clinic			0.06
Yes	21 (70%)	28 (93.3%)	
No	9 (30%)	2 (6.66%)	

Table 2: Comparison of mean scores before and after the intervention in the experimental group

Subscale stage	Mean (SD)				
	Physical symptoms	Anxiety and insomnia	Social functioning disorder	Depression	Total score
Before intervention	10.06 (35.33%)	10.89 (36.3%)	11.01(36.7)	4.00 (14.1%)	35(3.67)
After intervention	5.12 (17.06%)	5.79 (19.3%)	6.92 (23.02%)	1.96(6.53%)	19.7(4.9)
P value	<0.001	<0.001	<0.001	<0.001	<0.001

RESULTS AND DISCUSSION:

The majority of the survey participants had a high school or higher education and according to the findings were housewives[27-29]. They also referred regularly to the prenatal clinic for prenatal routinal care and the functionalities of the control and experimental groups were statistically not substantially different [Table 1].

A combined test comparison showed that there was a significant difference (P 0.001, P 0.001) in the experimental group, but not in the control group, between the mean difference in physical symptoms, angst and sleeplessness, the social functioning and depression before and after intervention[30-32].

The disadvantages of the study included time consumption due to the large number of samples of women followed after training, and considerable samples attrition after obstetric intervention[33]. There were

additional constraints on individual variances in the mental and emotional components of the training that could influence the relaxation of the muscle[34]. The lack of research topics in training sessions, which required individual repeated training and a lack of reaction to the eight week after the training, was also caused by the exclusion and relocation of select individuals. The lack of generalisation of results and the existence of only a few relevant studies, limiting the ability to compare results with other study, were significant constraints of this study. Further research in the future is required[35-39].

CONCLUSION:

The study demonstrated a significant difference between women's general health in experimental groups in the field of physical, psychological and social components. The data mostly confirmed the hypothesis of



the study regarding the effect of relaxation on the overall health of pregnant women. It is therefore proposed, because of its effectiveness, lack of bad effects, especially

during pregnancy, or cost-efficacy, that the medication is used by pregnant women.

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