

## ANXIETY DURING CHILDBIRTH AMONG PRIMI GRAVIDAE

Ruth Joshila Philips<sup>1\*</sup> and Dr. Josephine Little Flower<sup>2</sup>

<sup>1</sup>Government College of Nursing, Hyderabad, Telangana, India.

<sup>2</sup>Former Nursing Advisor, Government of India.

### ABSTRACT

Pregnancy and child birth is intriguing, especially for a primi gravida. As many as 30 percentage of pregnant women will experience some level of anxiety, this is seen more in first time mothers. A quasi experimental study was conducted with an overall aim to evaluate the impact of birth preparedness programme on maternal and foetal out comes among primi gravidae. Anxiety was one of the maternal outcomes that was measured. The study group comprised of 110 primi gravidae mothers each in the control group and the experimental groups. The inclusion criteria include primi gravidae who have completed 28 weeks, but not more than 34 weeks of gestation, at the time of induction into the study. The research design adopted for the study was post-test only design. The primi gravidae who were in the experimental group underwent three sessions of Birth preparedness programme. Anxiety was measured using Visual Analog Scale for Anxiety (VAS-A) to measure women's self-reported level of anxiety during labour. Mean anxiety of primi gravidae in the control group was  $49.91 \pm 3.9$  and in the experimental group was  $28.49 \pm 9.79$ . Mean difference between the groups was 21.42. The calculated 't' value was 21.31 with  $p < 0.001$  which was a statistically highly significant difference between groups. Thus it could be concluded that the Birth Preparedness Programme was effective in reducing the anxiety of primi gravidae in the experimental group when compared to that of primi gravidae in the control group.

### Key words: .

#### Corresponding Author

**Ruth Joshila Philips**

Email:- [joshila1974@yahoo.co.in](mailto:joshila1974@yahoo.co.in)

#### Article Info

Received 02/07/2020; Revised 20/08/2020

Accepted 12/09/2020

### INTRODUCTION

Pregnancy is a developmental challenge, a turning point in a woman's life. For a mother to be for the first time, pregnancy is the transition period from childlessness to motherhood. The journey of pregnancy to motherhood is usually through labour. It is a powerful physiologic function that makes a lasting effect on the woman and her family, often a positive effect. Labour is threatening in many respects. Pain, disfigurement, disruption of bodily function and even death are the potential threats for the woman who is in labour [1].

Pregnancy and child birth is intriguing, especially for a primi gravida. Many primi gravidae have little idea what pregnancy and labour entails for them. Their information about labour and child birth is frequently based on experiences related to them by family members or friends. These tales are often fraught with myths and exacerbation of reality. Thus the labour process that was

initially viewed with confidence and happiness may provoke fear and anxiety in the women. These extravagant scenarios about labour, narrated to them influences the women's emotional state and intellectual process leading to anxiety and fear about the "dreaded" but inevitable labour. Lack of personal experience further causes concern in these women [2].

As many as 30 percentage of pregnant women will experience some level of anxiety, this is seen more in first time mothers. A smaller number of women will have more severe symptoms and will be diagnosed with an anxiety disorder. Anxiety disorders are categorized according to their symptoms. These include:

- Generalized anxiety disorder
- Obsessive compulsive disorder (OCD)
- Post-traumatic stress disorder (PTSD)
- Panic disorder



- Agoraphobia
- Social phobia.

Most women have symptoms or a diagnosis of a particular disorder before they get pregnant. Some women will develop symptoms for the first time during pregnancy. Some symptoms will worsen with pregnancy. Symptoms that are common to each disorder include:

- Worry, stress or being on edge most of the time
- Muscle tension and difficulty staying calm
- Difficulty sleeping
- Recurring worrying thoughts that will not go away
- Panic attacks.

### What causes anxiety?

Women may be genetically predisposed to worry and anxiety or may have been subject to a stressful event or both. When the anxiety is pregnancy-related it is likely that the women have an anxious temperament and a general tendency to worry. The anxiety will be focused on the baby's health, fear of the birthing experience or concern about weight gain and body shape.

Women who are victim/survivors of sexual assault may also have particular anxieties during pregnancy. For this group of women there is also likely to be anxiety in the lead up to the birth and further anxiety about being a parent. Women who have been sexually assaulted can find it very difficult to be touched. Medical check-ups can be very stressful, especially check-ups that involve the vagina. This group of women can also be very fearful of the birth process; they can suffer from muscle tension during the birth, which in turn can impact on their ability to manage the pain of labour [3].

Women who have different kinds of pre-existing anxiety disorders can find pregnancy challenging for any number of reasons. Pregnancy and the birth experience can put women into situations outside their comfort zones, which can induce anxiety. There are also symptoms that women may have in late pregnancy such as shortness of breath, dizziness, an increased heart rate and feeling hot and sweaty which can be mistaken for panic attacks or, in some instances, can lead to a panic attack. It is important to seek treatment early during pregnancy so that the experience of pregnancy and motherhood is positive rather than filled with dread, and also so that the woman can get quality antenatal and postnatal care [3].

Anxiety is effectively treated with psychological therapies. These include relaxation training, cognitive behavioral therapy, and mindfulness practice. Lifestyle modifications such as stress reduction and exercise are also helpful. Sometimes in more severe illnesses, medication may

be needed, preferably in conjunction with psychological therapies. While a certain amount of anxiety during pregnancy may be inevitable, there is growing evidence that high levels can affect children long after birth.

In fact some studies show a strong link between maternal anxiety levels early in pregnancy and a child's susceptibility to attention deficit hyperactivity disorder (ADHD) years later. The association was stronger than that seen for any other predictor of behavioral problems during childhood, including smoking during pregnancy, low birth weight, or a mother's current stress level [3].

The findings support the somewhat controversial idea that exposures in the womb play a critical role in predisposing people to a host of diseases and emotional disorders later in life. Known as the "fetal programming hypothesis." The theory suggests that at certain points during pregnancy environmental exposures to the fetus in the womb significantly influence brain development, which, in turn, can impact future health. It is well known that stress and anxiety during pregnancy can increase a woman's risk of miscarriage, preterm delivery, and giving birth to a baby that is low birth weight [3].

What effects can anxiety have on labour

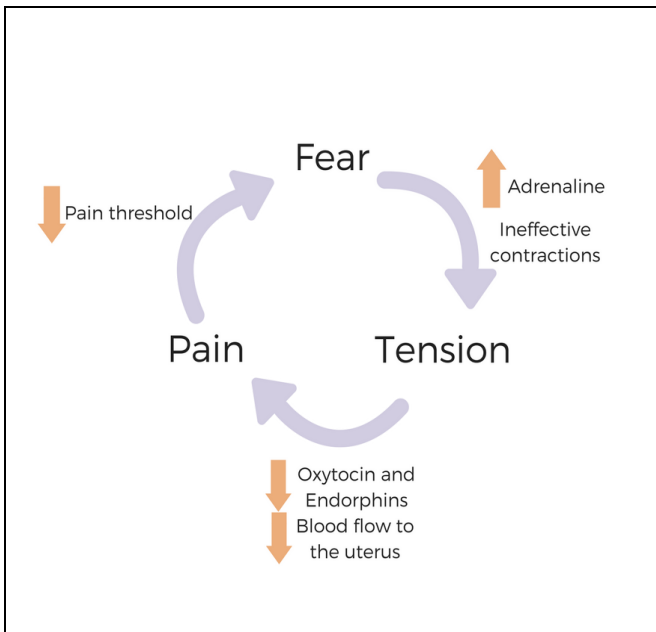
In the 1920s, Grantley Dick-Read described what has become known as the "Fear-Tension-Pain" cycle. He suggested that fear causes a woman to become tense, and that tension increases pain. The increased pain, in turn, increases fear, and the cycle repeats. Dick-Read suggested interrupting this cycle in two ways:

- Reduce fear by educating women about what is happening during childbirth
- Reduce tension by promoting relaxation, thus reducing the pain.

Given that stress can interfere with the process of parturition, it is reasonable to expect that stress reduction might bring about a facilitation of the birth process. This is the foundation philosophy of most childbirth education methods. The bulk of the literature supports the contention that childbirth education is beneficial in several respects. No disadvantages to childbirth education have been demonstrated [3].

A quasi experimental study was conducted with an overall aim to evaluate the impact of birth preparedness programme on maternal and foetal outcomes among primi gravidae, at Modern Government Maternity Hospital Hyderabad, Telangana India. The study was performed on a sample of 220 primi gravidae who met sample selection criteria; Anxiety was one of the maternal outcomes that was measured. Ethical clearance was obtained from the concerned authorities, and informed written consent was obtained from the primi gravidae. The study group comprised of 110 primi gravidae mothers each in the control group and the experimental groups. The inclusion criteria include primi gravidae who have completed 28 weeks, but not more than 34 weeks of gestation, at the





time of induction into the study, and attending the antenatal clinic at the selected hospital, who are aged between 19 and 35 years, without any complications and willing to participate in the study. Exclusion criteria include primi gravidae who are posted for elective LSCS due to complications of pregnancy, primi gravidae who have preterm/post term labours, or with malpresentations, malposition or multiple fetuses or primi gravidae who have delivered babies with congenital anomalies.

The research design adopted for the study was post-test only design. The primi gravidae who were in the experimental group underwent three sessions of Birth preparedness programme, that helped them to understand, brief anatomy and physiology of female reproductive tract, the stages of labour, process of birth, ambulation, diet and anxiety was measured using Visual Analog Scale for Anxiety VAS-A (a scale of 0 to 100) to measure women's self-reported level of anxiety during labour. Anxiety of the primi gravidae was measured at each stage of their labour. A total of four observations were taken and the mean anxiety score was calculated among primi gravidae. Mean anxiety of primi gravidae in the control group was  $49.91 \pm 3.9$  and in the experimental group was  $28.49 \pm 9.79$ . Mean difference between the groups was 21.42. The calculated 't' value was 21.31 with  $p < 0.001$  which was a statistically highly significant difference between groups. 96.4% control group and 90.9% in the experimental group, belonged to the age group of 19 to 24 years, and all (100%) of them were married [4].

Majority of the primi gravidae, i.e. 70.9% in control and 61.8% of them in experimental group were living in urban area. The groups were not homogenous in relation to education, as 65.4% in control group and only 26.4% in experimental group had studied up to secondary education. Only 2.7% primi gravidae in control group and 11.8% in experimental group had studied upto primary

education, and a meagre 0.9% in control group and 22.7% of the experimental group had degree and above education. 40.9% primi gravidae in control group and 57.3% in experimental group measured 151-155 cms in height. Whereas, 27.3% in control group and only 4.5% in experimental group were 156-160 cms tall. Hence, the groups were heterogeneous according to their heights ( $p < 0.001$ ).

Majority of the primi gravidae, 84.5% in control group and 60.9% in experimental group were 51 to 60 kg in weight. Nine percentage in control group and 24.6% in experimental group weighed 61-70 kg. The groups were heterogeneous ( $p < 0.001$ ) in relation to the hemoglobin percentage of the primi gravidae, the highest percentage 80% of them in control group had 10 to 12.5 gm/dl whereas 73.6% in experimental group had haemoglobin level of 12.6 to 13.0 gm/dl. Regarding the type of pelvis, almost all of them had gynaecoid pelvis in control group (99.1%) and in experimental group (96.3%). The groups were homogenous in relation to the gestational age at the time of enrollment into the study ( $p = 0.361$ ), the highest percentage 36.4% and 40% in control and experimental respectively, were enrolled into the study at 31-32 weeks of gestation. In relation to the gestational age at the onset of labour, the highest percentage 69.1% and 74.5% in control and experimental groups respectively were in 37<sup>th</sup> week of gestation. Whereas, 3.6% and 7.3%, in control group and in experimental group respectively were in 39 week of gestation.

The primi gravidae, 43.6% in control group and 90.9% in experimental group (i.e. more than double percentage) had natural/spontaneous onset of labour, and the remaining, 56.4% of primi gravidae in control group and only 3.6% in the experimental group needed induction of labour. In regard to the weight of the newborn, 53.6% and 44.6% of the subjects in control and experimental respectively gave birth to babies weighing 2.5 kg to 2.8 kg. Hence, homogeneity was presented across groups according to the weight of the new born ( $p = 0.176$ ). Regarding sex of the new born at birth was more or less similarly distributed in control and experimental hence, homogeneity was present in both the groups ( $p = 0.499$ ). Analysis was also done to find the relationship between the selected demographical and biophysical variables but, there was no statistically significant relationship found. Thus it could be concluded that the Birth Preparedness Programme was effective in reducing the anxiety of primi gravidae in the experimental group. The study findings are consistent with the research that Childbirth education or birth preparedness has shown to reduce anxiety<sup>4</sup> during labor or child birth. Low levels of anxiety have been associated with women in labour reporting of a more positive birth experience [5] whereas high anxiety enhances pain perception.



## CONCLUSION

The benefits of childbirth education have been demonstrated to various degrees. One of the many benefits is reduction of anxiety or tension during labor, leading to a more positive birth experience. Fear and anxiety are

associated with the unknown. If every pregnant woman is taught about the facts of pregnancy and labour before motherhood can be realized these issues can be promptly addressed.

## REFERENCES

1. Fabian HM, Rådestad IJ, Waldenström U, Childbirth and parenthood education classes in Sweden. Women's opinion and possible outcomes [Abstract] Acta Obstet Gynecol Scand. 2005 May;84(5):436-43.
2. Deave T, Johnson D, Ingram J, Transition to parenthood: the needs of parents in pregnancy and early parenthood, [Abstract] BMC Pregnancy Childbirth. 2008 Jul.
3. <https://www.thewomens.org.au/health-information/pregnancy-and-birth/mental-health-pregnancy/anxiety-pregnancy>
4. Klusman LE: Reduction of pain in childbirth by the alleviation of anxiety during pregnancy. J Consult Clin Psychol 43: 162.
5. Walker B, Erdman A: Childbirth education programs: The relationship between confidence and knowledge. Birth 11: 103.



This work is licensed under a Creative Commons Attribution-NonCommercial 3.0 Unported License.

