

# PSYCHOLOGICAL PROBLEM OF PREGNANT WOMEN

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## Abstract

**Background:** Pregnancy is a special and joyful period of life. It is the time for great responsibilities and emotional attachment with the pregnant women. But many pregnant women may suffer confusion, fear, sadness, stress, depression or other psychological problems. **Aims:** To assess the different psychological problems such as anxiety and depression among pregnant women and the association of anxiety and depression with socio-demographic data of pregnant women. **Material and Method:** It was ex facto non experimental design conducted among 100 pregnant women in government hospital, were assessed with Hospital Anxiety and Depression scale, consisting 14 items. **Result :** out of 100 Pregnant females 47% of the woman were no anxiety, 25 % were mild ,17 % were moderate and 11 % were severe.and other side 48% of the woman were no depression , 37% were mild depression,12 % were moderate and 3% were sever depression

**Conclusion:** This study finds a prevalence of 53 % of anxiety and 52% of depression among pregnant women.

**Key words:** Anxiety, Depression, Pregnant women.

## INTRODUCTION

Depression is a leading cause of morbidity and disability. In women, the incidence of depression peaks during the reproductive years, which increases the likelihood of symptom onset or relapse during or after pregnancy. Major depression during the peripartum (MDP) period, defined by the Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> edition as a depressive episode occurring during pregnancy or within 4 weeks following delivery, warrants empirical attention due to the high prevalence and the negative sequelae for women, their children, and their familie. Up to 20% of women may experience depressive symptoms during their pregnancy, and 10% of pregnant women have symptoms which qualify as a major depressive disorder/episode. Similarly, up to 20% of women experience major depressive episodes in the postpartum period. Despite recent recommendations to screen for depressive symptoms in pregnancy, depressive symptoms continue to be underidentified and undertreated in pregnant women. This lack of recognition has serious implications, as it is now widely recognized that maternal depression, anxiety and stress during pregnancy have powerful long-term effects on both mother and bab. The underlying biological mechanisms have not been fully understood but it has been suggested that a decrease in blood flow to the foetus and/or an increased exposure of the foetus to cortisol may be some of the possible mediating factors. Maternal increased levels of cortisol that have been associated with depression, anxiety and stress, can cross the placenta and be transferred to the foetal environment and affect the developing foetus. Antenatal depression and anxiety have also been associated with inadequate nutrition and weight gain, increased alcohol consumption, substance abuse and smoking moreover, mothers with antenatal anxiety and depression are more likely to access perinatal services late, to attend antenatal appointments less frequently, and to fail to have regular scans Some studies have found that these women have more visits to the obstetrician, mainly related to the fear of childbirth, and show a preference for an elective caesarean section Moreover,

depression and anxiety have been linked to stillbirth, premature birth, low birth weight, low Apgar scores, smaller head circumference and major congenital anomalies

## METHODOLOGY

**Objectives of the Study :** To assess the different psychological problem such as anxiety and depression among pregnant women and socio-demographic profile associated with it.

**Sampling:** The sample selected for the study consists of 100 pregnant women from different educational and socio-economic background attending different Gynecology and Obstetric clinics were include. The purposive sampling technique will be used to collect data.

### Inclusion Criteria

Gestational period 12 to 35 weeks, Married, Age 18 to 40 yrs. subject were able to read and write and consenting for the study.

### Exclusion criteria:

Subject with the history of psychiatric disorder, or serious medical illness, Subject with the history of mental retardation.

### Tool of assessment:

**The socio-demographic and clinical information sheet:** included the socio-demographic information of respondent like: age, education, religion, employment status of pregnant women, occupation of husband, marital status. The second part of this sheet comprised the gynaecological information of respondent: No of children, abortion history, family history of any significant illness, Any other associated chronic diseases of pregnant women like (hypertension, diabetes, T.B, HIV etc). hyperemesis, preference of mother, preference of father, preference of mother in low, physical and sexual harassment.

**Hospital Anxiety and Depression Scale:** It was originally developed by Zigmond and Smith (1983) Hospital Anxiety and Depression Scale (HADS) [12]: this is very well validated scale to assess anxiety and depression among hospital based patients. It consists 14 questions, 7 scoring anxiety and 7 scoring depression. Patients were asked to read each question and place a tick against the reply that came closest to how they had been feeling that day. Each answer was scored 0, 1, 2 or 3. The possible range of scores was therefore 0 to 21, with higher scores indicating greater levels of anxiety. Score of 0-7 is considered normal, scores of 8-10 is borderline abnormal and scores of 11-21 is abnormal case.

### Procedure:

All the pregnant women were contacted individually for description of the study and consent. These respondents given the questionnaire in brief about the purpose of investigation and after that they were requested to respond honestly according to the given instruction. they were administered the Hospital anxiety and depression scale as per standard procedure. There are no time limit fixed for filling-up the questionnaire.

## STATISTICAL ANALYSIS

Statistical analysis were performed using the SPSS. Descriptive statistics (percentage, mean and standard deviation) were used to describe various sample characteristics.

## RESULT

Result of the present study show that socio demographic and clinical characteristics of sample of pregnant women.

**Table-1: Showing socio-demographic characteristics of the sample with psychological problems like anxiety and depression.**

Variable	Mean $\pm$ SD	Min	Max
Age	24.22 $\pm$ 4.03	18	36
Education	9.98 $\pm$ 4.86 Years	0	19
Duration of Preg (weeks)	21.80 $\pm$ 10.18	12	37
	Variables	Frequency	Percentage
Religion	Hindu	84	84
	Others	16	16
Employment status of Pregnant women	House wife	87	87
	Job	13	13
Occupation of Husband	Job/Business	42	42
	Others	58	58

Socio-demographic and occupational data (Table-1) reveal that respondents were within the age of 18-36 and mean score was 24.22 with SD of 4.03 and education of mean was 9.98 with SD 4.86. Sample consisted of pregnant women from all religions, though the majority was Hindus (84%). All Pregnant women were married. It is obvious that only 13% of the study sample were employed and 58% of the sample were having husband as a service man.

**Table-2: Showing Clinical characteristics of the sample**

	Variables	Frequency	Percentage
No. of Children	Multigravida	51	51
	Primigravida	49	49
Abortion	No	63	63
	Yes	37	37
Family history of any significant illness	NO	88	88
	Yes	12	12
Any other associated chronic Disease	No	93	93
	Yes	7	3

Hyperemesis (Vomiting)	No	42	42
	Yes	58	58
Preference of mother	Daughter	42	42
	Son	46	46
	Any	12	12
Preference of Father	Daughter	45	45
	Son	39	39
	Any	16	16
Preference of Mother in low	Daughter	25	25
	Son	55	55
	Any	20	20
Physical and sexual Harrasment	No	71	71
	Yes	29	29

Table shows that current study 49% of the women were having their first child and 51% were being having their second, third or fourth child. Out of hundred women 63% were not having among history of abortion before the pregnancy. 88% women reported no significant family history of any illness such as hypertension, diabetes, HIV and TB etc. 93% of the women had no chronic history of any illness. Common problem of vomiting found that 58% and most of the mother in low prefer son child 55% and also father prefer for daughter 45%. No significant history found in any sexual and physical harassment of pregnant women in after marriage.

**Table 3 : Showing frequency and distribution of anxiety and depression across severity.**

variables	Anxiety (%)	Depression (%)
Normal	47	48
Mild	25	37
Moderate	17	12
Severe	11	3
Total	100	100

Table 3: shows that current study 47% of the woman were no anxiety, 25 % were mild ,17 % were moderate and 11 % were severe.and other side 48% of the woman were no depression , 37% were mild depression,12 % were moderate and 3% were sever depression.

**Table-4: Association between History of victimization and hospital anxiety and depression scale**

	History of victimization	No history of victimization	Df	$\chi^2$	P
No Anxiety	49	6	1	5.199	.023
Anxiety present	32	13			
No Depression	55	8	1	4.393	.036
Depression present	26	11			

Note: There is a significant relationship between victimization and Hospital Anxiety and Depression scale  $P= 0.05$

**Table-5: Difference among groups between presence or absence history of Abortion on HADS ratings.**

	No abortion N=63 Mean (SD)	History of Abortion N=37 Mean (SD)	Df	T	P
Anxiety Score	7.31(3.92)	10.08(4.54)	98	-3.20	.002
Depression Score	636.85 (3.37)	378.16 (3.27)	98	-1.88	.062

Table shows higher level of depression and anxiety was found with history of pregnant women then those who never had history of abortion.

**Table-6: Association between Gravida and Hospital and Anxiety Depression scale**

	Primi Gravida	Multi gravida	Df	$\chi^2$	P
No Anxiety	27	28	1	0.00	0.484
Anxiety present	22	23			
No depression	33	30	1	.779	.377
Depression present	21	16			

Table shows there is no significant association between Gravida condition and presence of hospital anxiety depression scale.

**Discussion:**

.. In our study, (52%) were suffering from anxiety and 53% depression during early-to-mild pregnancies. Almost similar findings were observed (55.7%) were suffering from pregnancy-related anxiety during early-to-mid pregnancies determined by using the PRT scale in India and the reported prevalence rates using differing scales from other countries seem to be much lower- 23.6% in Saudi Arabia using the State Anxiety scale, 26.8% in Brazil using the Hospital Anxiety Subscale, 23% in South Africa using the Mini-International Neuropsychiatric Interview diagnostic interview and 25% in Tanzania using the Pregnancy-related anxiety questionnaire. HADS is a self-administered instrument. The rates vary depending upon the types of instrument used for measuring antenatal anxiety and depression, self-reported nature of the responses which might be a reason for high frequency of anxiety and depression and for other variables like satisfaction with current life, noninclusion of some important variables like heavy household work, and pregnancy symptoms in our study. Clinical characteristics show that frequency of abortion was high 37% among depressed and anxious pregnant women. Most of the mothers in low prefer son child. Vomiting is a common problem among pregnant women 58%... There is a significant relationship between victimization and HADS. Domestic violence in the form of sexual/physical as well as verbal abuse was strongly associated with antepartum depression/anxiety and higher level of depression and anxiety was found with history of pregnant women than those who never had history of abortion. Our study highlights that anxiety and depression are common during pregnancy. Therefore, there is a need to incorporate screening for anxiety and depression in antenatal programs and providing practical support to women during pregnancy, particularly those with a previous history of depression and who have poor family relationship.

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