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ORIGINAL ARTICLE

ANXIETY IN PUERPERAE IN HIGH RISK MATERNITY HOSPITAL

ANSIEDADE EM PUÉRPERAS EM MATERNIDADE DE ALTO RISCO

ANSIEDAD EN PUÉRPERAS EN MATERNIDAD DE ALTO RIESGO

Karina Fardin Fiorotti[1], Jordana Marques Goulart[2], Bruna Lígia Ferreira de Almeida Barbosa[3], Cândida Caniçali Primo[4], Eliane de Fátima Almeida Lima[5], Franciéle Marabotti Costa Leite[6]

ABSTRACT

Objective: to identify the mean of the trait and the state of anxiety among puerperae and verify their relation with the sociodemographic, reproductive characteristics and the experience of violence. ***Method:*** this is a quantitative, descriptive, cross-sectional study of 302 women with at least 24 hours postpartum. The data was obtained through interviews with a questionnaire. Data were analyzed by Stata 13.0. Results were presented in the form of tables. ***Results:*** it was observed that the average anxiety trait was higher among puerperal women who did not have a partner, had less schooling, had no paid work, had a family income of 1100.00 reais or less, did not plan or desired pregnancy and suffered physical violence during pregnancy. It is noticed that the state of anxiety had a higher average among the women with lower family income and who did not wish to be pregnant (p <0.05). ***Conclusion:*** it is concluded that the trait and the state of anxiety are present in the puerperal period and are higher in the group of women with worse socioeconomic conditions, who did not plan / wanted gestation and experienced violence during this period. ***Descriptors:*** Postpartum period; Women's Health; Women; Anxiety; Epidemiological Factors; Cross-Sectional Studies.

RESUMO

Objetivo: identificar a média do traço e o estado de ansiedade entre puérperas e verificar sua relação com as características sociodemográficas, reprodutivas e a experiência de violência. ***Método:*** trata-se de estudo quantitativo, descritivo, tipo transversal, com 302 mulheres com, pelo menos, 24 horas de pós-parto. Obtiveram-se os dados por meio de entrevistas, a partir de um formulário. Analisaram-se os dados pelo Stata 13.0. Apresentaram-se os resultados em forma de tabelas. ***Resultados:*** nota-se que a média do traço de ansiedade foi maior entre as puérperas que não apresentam companheiro, com menor escolaridade, não possuem trabalho remunerado, têm renda familiar igual ou inferior a 1100,00 reais, não planejaram ou desejaram a gravidez e sofreram violência física na gestação. Percebe-se que o estado de ansiedade teve maior média entre as mulheres de menor renda familiar e que não desejaram a gravidez (p<0,05). ***Conclusão:*** conclui-se que o traço e o estado de ansiedade estão presentes no período puerperal e são maiores no grupo de mulheres com piores condições socioeconômicas, que não planejaram/desejaram a gestação e vivenciaram a violência nesse período. ***Descritores***: Período Pós-Parto; Saúde da Mulher; Mulheres; Ansiedade; Fatores Epidemiológicos; Estudos Transversais.

RESUMEN

Objetivo: identificar el promedio del trazo y el estado de ansiedad entre puérperas y verificar su relación con las características sociodemográficas, reproductivas y la experiencia de violencia. ***Método:*** se trata de un estudio cuantitativo, descriptivo, tipo transversal, realizado con 302 mujeres con al menos 24 horas de postparto. Se obtuvieron los datos a través de entrevistas, a partir de un formulario. Se analizaron los datos por el Stata 13.0. Se presentaron los resultados en forma de tablas. ***Resultados:*** se nota que el promedio del trazo de ansiedad fue mayor entre las que habían tenido compañero, con menor escolaridad, no tienen trabajo remunerado, tienen ingresos familiares igual o inferior a 1100,00 reales, no planificaron o desearon el embarazo y sufrieron violencia física en la gestación. Se percibe que el estado de ansiedad tuvo mayor promedio entre las mujeres de menor renta familiar y que no desearon el embarazo (p <0,05). ***Conclusión:*** se concluye que el trazo y el estado de ansiedad están presentes en el período puerperal y son mayores en el grupo de mujeres con peores condiciones socioeconómicas, que no planificaron / desearon el embarazo y vivenciaron la violencia en ese período. ***Descriptores***: Periodo Posparto; Salud de la Mujer; Mujeres; Ansiedad; Factores Epidemiologicos; Estudios Transvesales.

[1]Master, Federal University of Espírito Santo / UFES. Vitória (ES), Brazil. Email: karinafiorotti@gmail.com ORCID iD: https://orcid.org/0000-0001-8461-2984; [2]Nurse, Federal University of Espírito Santo / UFES. Vitória (ES), Brazil. Email: jordanagoulart.12@gmail.com ORCID iD: https://orcid.org/0000-0002-7763-1439; [3]Master (PhD student). Federal University of Espírito Santo / UFES. Vitória (ES), Brazil. Email: brunalfalmeida@yahoo.com.br ORCID iD: https://orcid.org/0000-0002-0085-049X; [4,5,6]PhDs, Federal University of Espírito Santo / UFES. Vitória (ES), Brazil. Email: candidaprimo@gmail.com ORCID iD: https://orcid.org/0000-0001-5141-2898; E-mail: elianelima66@gmail.com ORCID iD: https://orcid.org/0000-0001-5128-3715; Email: francielemarabotti@gmail.com ORCID iD: https://orcid.org/0000-0002- 6171-6972

INTRODUCTION

It is known that the arrival of a child implies changes in different aspects, such as physiological, psychic and socio-familial, because it represents a transition that is part of the definition of a new role for women. This period is between childbirth and up to six weeks afterwards, known as the puerperium, as a delicate phase for the binomial mother and newborn.[1]

It is understood that, due to the changes undergone, the woman may present fears, doubts and anxieties about her ability to care for the baby, whether or not she wants to be pregnant. For the transformations that occur with women in the pregnancy-puerperal period, conditions for the development of postpartum anxiety and other psychiatric conditions in the mothers are provided, and in addition, maternal depression and anxiety may have implications in child care.[2-3]

It becomes, at that moment, the fundamental social support and, if this support is not enough, the bond of the mother-baby dyad can be difficult, both in the sense of being insufficient and in the exacerbation, generating shocking symptoms in the life of the couple and of the children that may be revealed in the pre- and postnatal phases.[4]

Some factors contribute to the increase in the probability of the woman experiencing anxiety, such as: stress situations, psychiatric comorbidities, low financial condition, abortion history, fetal death, premature delivery or early neonatal death, situations of violence, history of mental illness and a history of psychiatric treatment during the previous pregnancy or at any time of life.[5-8]

It is reported that there is increasing evidence that mothers with anxiety histories have difficulty responding adequately to their babies, and these difficulties may negatively influence a child's subsequent development, including problems in child learning, attention, language, and emotional regulation.[9]

It should be discussed and discussed during the puerperal period by health professionals, so that it can be carried out through an integral vision that considers the socio-cultural and family context, allowing professionals, more attention and availability to perceive and attend the real needs presented by each woman, qualifying the care provided.[10]

OBJECTIVE

- To identify the mean of the trait and the state of anxiety among puerperae and verify their relation with the sociodemographic, reproductive characteristics and the experience of violence.

METHOD

This is a quantitative, descriptive, epidemiological, observational, cross-sectional study carried out in a high-risk maternity unit linked to the Unified Health System (UHS), in the city of Vitória, Espírito Santo. The sample was composed of women who were hospitalized between June and September 2016 and who met the following inclusion criteria: at least 24 hours postpartum, of a live fetus above 500 grams, regardless of the type of delivery. The presence of a deficit that hindered or prevented the interview from being performed was adopted as exclusion criteria.

The entire team of interviewers was duly trained to conduct the survey. Initially, the pilot study was carried out, where 32 women were approached, and in the collection of data, 314 puerperae were invited to participate in the study, of which 12 refused, totaling 302 participants at the end.

It should be noted that, prior to the interview, the participant was educated about the research objectives, ethical issues, confidentiality and the right to withdraw from participating in the research at any time. Data collection was initiated only after the signing of the Free and Informed Consent Term (FICT). The interviews were carried out in a private place where only the interviewer and the puerpera, with or without the newborn, were found, with an average duration of 30 minutes.

It is reported that the first instrument used in data collection was a questionnaire with socio-demographic and reproductive questions, and the demographic questions addressed: age (up to 19 years and 20 years or more); marital status (with partner or without partner); years of study (<= eight years of study or> eight years); paid work (yes or no) and family income (<= R$ 1,100.00 or above R$ 1,100.00). For the reproductive variables, the questionnaire related to the planning of gestation (yes or no); desired pregnancy (yes or no); history of abortion (yes or no); age of cohabitation (<= 16 or> 16 years); number of antenatal visits (<= six and seven or more) and birth weight (<= 2,500 grams or above 2,500 grams).

The Trait-State Anxiety Inventory (IDATE) was used to identify the Trait / State of anxiety of the puerperal woman. Two scales, each composed of 20 affirmations and scored from 1 to 4, are presented in the IDATE in order to evaluate anxiety as a state (IDATE-E) or as a trait (IDATE-T), with total scores of each scale may vary from 20 points (minimum) to 80 points (maximum).[11] It should be noted that the categories of the anxiety-state trait were based on a theoretical reference according to the characterization: "20 to 40 points = low level of anxiety"; "41 to 60 points = moderate level of anxiety"; "61 to 80 points = high level of anxiety".[12]

The Abuse Assessment Screen (AAS), developed in 1989 in the United States by the Nursing Research Consortium or Violence and Abuse and translated and validated in Brazil by Reichenheim, was used for the tracking of violence. It is understood that this instrument is specific to the tracking of cases of violence in pregnancy and consists of five issues that identify experiences of maltreatment throughout life, physical violence in the last year, physical violence in pregnancy, sexual abuse in the last 12 months and current fear of their partner or someone close to them.[13] The subject of physical violence in pregnancy was discussed in this study.

Data was analyzed by the statistical program Stata, 13.0, presenting them by means of gross and relative frequencies and confidence interval. It is added that the comparisons by sociodemographic, reproductive characteristics and physical aggression during pregnancy were made by Student's t test for unequal variances. The study was approved by the Research Ethics Committee under the number of CAE 55247716.5.0000.5071.

RESULTS

In the study, the mean of the anxiety trait among postpartum women was 43.1 (SD = 9.9); whereas the anxiety state had a slightly lower mean: 41.3 points (SD = 11.6) (data not shown in the table).

As regards the sociodemographic profile, Table 1.

Table 1. Sociodemographic and reproductive profile of postpartum women admitted to a high-risk maternity hospital. Vitória (ES), Brazil, 2016.

Variables	N	%	CI95%
Age			
Up to 19 years	51	16.9	13.0-22.0
20 years and over	251	83.1	78.4-86.9
Marital status			
With partner	208	68.9	63.4-73.9
Without partner	94	31.1	26.1-36.6
Years of study			
<=8	165	54.6	48.9-60.2
>8	137	45.4	39.8-51.0
Paid work			
Yes	122	40.4	35.0-46.1
No	180	59.6	53.9-65.0
Family income (reais)			
<= 1.100	136	45.0	39.5-50.7
Above 1,100	166	55.0	49.3-60.5
Planned pregnancy			
Yes	97	32.1	26.8-37.4
No	205	67.9	10.2-18.0
Desired Pregnancy			
Yes	260	86.1	
No	42	13.9	10.4-18.3
History of abortion			
Yes	74	24.5	20.0-29.7
No	228	75.5	70.3-80.0
Family age			
< = 16	181	60.3	54.6-65.7
> 16	119	39.7	34.3-45.3
Number of prenatal consultations			
<= 6	73	24.4	19.9-29.6
7 or more	226	75.6	70.4-80.1
Infant weight at birth (grams)			
<= 2.500	49	16.3	12.5-21.0
Above 2,500	251	83.7	79.0-87.5

Physical violence during pregnancy			
Yes	14	4.6	2.7-7.7
No	288	95.4	92.3-97.2

Table 2 shows the difference between the mean of the trait and the state of anxiety according to the sociodemographic characteristics. A higher average of the anxiety trait is observed among puerperae without companion, with less schooling, who do not have paid work and those with family income equal to or less than 1,100.00 reais; already in the anxiety state, there was only a difference in the comparison with the income, and the group of women with lower family income presented higher mean anxiety state when compared to the higher income group (p = 0.016).

Table 2. IDATE-trait / status scores distributed according to socioeconomic characteristics. Vitória (ES), Brazil, 2018.

Variables	N (%)	IDATE-trait Average (SD)	P Value	IDATE-status Average (SD)	P Value
Age					
Up to 19 years	51 (16.9)	43.6 (9.8)	0.697	42.5 (18.3)	0.598
20 years and over	251 (83.1)	43.0 (10.0)		41.1 (9.7)	
Marital status					
With partner	208 (68.9)	42.3 (9.9)	0.028	41.5 (12.2)	0.609
Without partner	94 (31.1)	45.0 (10.0)		40.8 (10.3)	
Years of study (years)					
<=8	165 (54.6)	44.8 (9.9)	0.001	42.2 (13.2)	0.126
>8	137 (45.4)	41.1 (9.7)		40.2 (9.3)	
Paid work					
Yes	122 (40.4)	41.0 (9.7)	0.002	40.1 (9.5)	0.123
Not	180 (59.6)	44.6 (9.9)		42.1 (12.8)	
Family income (reais)					
Up to 1,100	136 (45.0)	45.6 (10.1)	0.000	43.1 (13.5)	0.016
Above 1,100	166 (55.0)	41.1 (9.5)		39.8 (9.6)	

Student's t test with uneven variance

Table 3 shows the difference in the mean of the trait and the state of anxiety according to the reproductive characteristics. A higher mean of the anxiety trait was observed among postpartum women whose pregnancies were not planned and desired and who suffered physical violence during pregnancy (p <0.05); whereas the anxiety state had higher mean values in the group that did not desire pregnancy when compared to the one who desired (p = 0.030).

Table 3. IDATE scores-trait / status distributed according to reproductive traits and physical aggression experience during pregnancy. Vitória (ES), Brazil, 2016.

Variables	N (%)	IDATE-trait Average (SD)	P Value	IDATE-status Average (SD)	P Value
Planned pregnancy					
Yes	97 (32.1)	41.5 (9.6)	0.040	41.0 (9.7)	0.731
No	205 (67.9)	43.9 (10.1)		41.4 (12.4)	
Desired Pregnancy					
Yes	260 (86.1)	42.2 (9.9)	0.000	40.7 (11.6)	0.025
No	42 (13.9)	48.9 (8.9)		44.9 (10.7)	
History of abortion					
Yes	74 (24.5)	42.2 (10.3)	0.342	40.8 (9.9)	0.667
No	228 (75.5)	43.5 (9.9)		41.4 (12.1)	
Coitus					
< = 16	181 (60.3)	43.5 (9.5)	0.537	40.7 (12.3)	0.243
> 16	119 (39.7)	42.7 (10.7)		42.2 (10.6)	
Number of prenatal consultations					
Up to 6	73 (24.4)	43.4 (10.7)	0.835	39.3 (9.0)	0.089
7 or more	226 (75.6)	43.0 (9.8)		41.5 (9.8)	
Infant weight at birth (grams)					
Up to 2,500	49 (16.3)	42.9 (9.9)	0.857	40.3 (9.5)	0.456
Above 2,500	251 (83.7)	43.2 (9.9)		41.5 (12.0)	
Physical violence					

during pregnancy					
Yes	14 (4.6)	49.8 (9.5)	0.022	46.9 (11.0)	0.069
No	288(95.4)	42.8 (12.0)		41.0 (11.6)	

Student's t test with robust variance

DISCUSSION

The trait and maternal anxiety status in the postpartum period in a high-risk maternity hospital were evaluated in this study. In the findings, the mean of the anxiety trait among the puerperae of 43.1 points and the state of anxiety with a mean of 41.3 points were shown, showing moderate anxiety, data close to those found in a national survey carried out in the city of Ribeirão Preto / SP, where the mean score for the anxiety trait was 39.1 and the mean score for the anxiety state was 42.5.[14] The results indicate that the presence of anxiety is one of the most common mental disorders in the puerperium, with different levels of maternal health impairment.[15]

The interaction of the mother with her children is one of the main effects of puerperal anxiety, making her less responsive, tending to emit hostility or isolation behaviors with her children, generating a less stimulating and restricted environment to the child's development; [16] In addition, the woman shows decreased coping capacity, reactivity and sensitivity, increasing feelings of ineffectiveness in maternal care.[17]

In relation to the associations found between anxiety and the socioeconomic characteristics of the woman, the highest average of the anxiety trait was found among those who declared that they did not have a partner. It is noteworthy that studies have shown that women who receive support from their partners, within a satisfactory relationship, have lower levels of anxiety.[18,19]

It is ensured by an adequate social support, including the support of the woman's partner, also, support at different times during the delivery and puerperium periods, as well as providing the pregnant women and puerperas with greater control of the environment and autonomy, providing hope, support and protection.[20]

It becomes this social support, as well as family support, very important for the maintenance of mental health and coping with stressful situations, as well as the adequacy of maternal behaviors in relation to the children.[20]

There was no paid employment, low maternal schooling and family income of less than 1,100 reais, as well as the highest mean of the anxiety trait, a result that corroborates other national and international studies that relate lower levels of schooling and socioeconomic structure with higher levels of maternal anxiety.[14,21,22]

In this study, a higher average anxiety trait among puerperae whose pregnancy was not planned and desired, and the higher anxiety state among those who did not wish to be pregnant was observed. In a recent study, maternal unintended desire for pregnancy is associated with a higher prevalence of anxiety in pregnancy, and this is due to unwanted gestation to contribute to a poor psychological adaptation of the woman, triggering anxiety during pregnancy.[23]

It is believed, in this scenario, that it is important to consider that maternal desire in relation to pregnancy may be related to the higher propensity to trigger emotional disturbances, such as feelings of anguish and unhappiness, which, together with other factors, may promote the development of mental disorders in the pregnant woman, which points out the negative impact of an unwanted pregnancy on women's mental health.[23]

It was also found an important association between the higher average anxiety trait among women who reported physical violence in pregnancy, and previous studies bring the violence during the gestational period strongly linked to puerperal anxiety and other types of common mental disorders.[24]

Violence, whether physical, sexual, psychological or emotional, becomes even more serious when the woman is pregnant, since it has significant consequences for the health of the mother-child dyad, such as low birth weight, abortion, childbirth and premature birth and until maternal and fetal death.[25]

It is understood that the violence experienced by the pregnant woman is still difficult to approach in personal and professional relations, and women who experience these situations are restrained in declaring the aggressions of partners and relatives and also some acts of violence are not recognized for them, neither by these women nor even by health professionals.[26]

It is of fundamental importance to associate care with the woman to the family, evaluating their socio-cultural context, involving the approach of the relationships between their members and the understanding that the existence of particular individual, family and

collective conditions increases the risk of violence. It should be noted that in this study there was no statistical relationship between maternal age and postpartum anxiety, but other studies showed a significant relationship between anxiety in the puerperal period and younger women.[14,27] It is believed that potentially older women have an emotional support from the life experience accumulated with the years[17] and, in this sense, in consonance with similar publications, there was no association between the birth weight of the child and maternal anxiety.[28]

Another aspect of the study was not to have found differences in the average anxiety among postpartum women with or without a history of abortion, however, it is worth considering that research conducted with women who experienced abortion, whether spontaneous or provoked, shows a relationship from anxiety to abortion, and in this context, anxiety can be a consequence of guilt over the loss of the child, whether it is real, desired and imagined, or the potential child, or even by deviations from the pattern of socially expected behavior, since motherhood is seen as intrinsic to women.[29]

It should be noted that, because it is a differentiated period of life, it is important to know what factors can prevent or cushion the stressful events related to pregnancy and the puerperium, such as social support, humanized and prepared care, in order to develop effective psychosocial strategies capable of minimizing the impact of psychological / psychiatric symptomatologies on the mother-baby relationship, as well as on family relationships. It is understood that anxiety may imply inadequate links between mother-infant and intrafamily, and social support, and more specifically, family support, may be very important in order to avoid the development or worsening of depressive symptoms.[30]

CONCLUSION

It is concluded that the level of anxiety (trait/status) is moderate among the puerperal participants and that, in addition, women who do not have a current partner, who have lower schooling, have no paid work, have lower family income, planned or desired pregnancy and suffered physical violence during pregnancy have a higher level of anxiety when compared to the group that did not present these characteristics.

As a limitation of this study, the reduced number of studies addressing puerperal anxiety in the literature is considered. Therefore, new research is suggested that analyze this aggravation, especially studies of longitudinal character, to verify not only the occurrence, but its impact on the health of the mother and the child. This finding is of great relevance, since it allowed the identification of a group of puerperae more vulnerable to the aggravation of anxiety, which may have a negative impact on the binomial.

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Corresponding Address

Karina Fardin Fiorotti
Rua Marechal Campos, 1468
Bairro Maruípe
CEP: 29043-900 – Vitória (ES), Brazil