Emotional state of primigravid women with pregnancy susceptible to prolongation

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Objective. This study sought to know the perception of the emotional state of women with pregnancy susceptible to prolongation. **Methodology.** The research was conducted with qualitative descriptive methodology, founded on in-depth individual interviews of 7 gestants susceptible to prolongation, with ages between 21 and 32 years and duration of the pregnancy comprised between 40+5 and 41+4 weeks. **Results.** The emotional state varies throughout the pregnancy; once the probable date of delivery has passed, the emotional well-being is altered by fear of pain during delivery, possible complications, and caring for the newborn, presenting a state of nervousness due to the imminent delivery. In addition, the women described the need for the presence of a companion during and after the delivery. **Conclusion.** Fear can affect negatively the subjective experience of the pregnancy during its final phase, the delivery process, and the transition to maternity in gestants with pregnancy susceptible to prolongation. These women need support and specific education from the midwife according to their individual needs.

Keywords: qualitative research; pregnancy; midwifery; emotions.

Estado emocional de mujeres primigestas con embarazo en vías de prolongación

Objetivo. Conocer la percepción del estado emocional de las mujeres con embarazo en vías de prolongación. **Metodología.** Se llevó a cabo una investigación con metodología cualitativa descriptiva, fundamentada en entrevistas individuales en profundidad a siete gestantes en vías de prolongación, con edades entre los 21 y 32 años y una duración del embarazo comprendida entre 40+5 y 41+4. **Resultados.** El estado emocional varía a lo largo del embarazo, una vez pasada la fecha probable de parto. En este sentido, el bienestar emocional se ve alterado por el miedo que es genera el dolor del parto, a las posibles complicaciones y al cuidado del recién nacido, por lo que presentan un estado de nerviosismo por el parto inminente. Las mujeres, además,

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necesitan de la presencia de un acompañante durante el parto y después del mismo. **Conclusión.** El miedo puede afectar negativamente la experiencia subjetiva del embarazo en la fase final del mismo, al proceso de trabajo del parto y a la transición hacia la maternidad en las gestantes con embarazo en vías de prolongación. Estas mujeres necesitan el apoyo y educación específica por parte de la enfermera matrona según sus necesidades individuales.

Palabras clave: Investigación Cualitativa, embarazo; matrona; emociones.

Estado emocional de mulheres primigestas com gravidez em via de prolongamento

Objetivo. Conhecer a percepção do estado emocional das mulheres com gravidez em via de prolongamento. **Metodologia.** Levou-se a cabo uma investigação com metodologia qualitativa descritiva, fundamentada em entrevistas individuais em profundidade a 7 gestantes em via de prolongamento, com idades entre os 21 e 32 anos e uma duração da gravidez compreendida entre 40+5 e 41+4. **Resultados**. O estado emocional varia ao longo da gravidez, uma vez passada a data provável de parto, o bem-estar emocional se vê alterado pelo medo à dor do parto, às possíveis complicações e ao cuidado do recém nascido, apresentando um estado de nervosismo pelo parto iminente. As mulheres ademais descrever a necessidade da presença de um acompanhante durante o parto e depois do mesmo. **Conclusão.** O medo pode afetar negativamente à experiência subjetiva da gravidez na fase final do mesmo, ao processo de trabalho do parto e à transição para a maternidade nas gestantes com gravidez em via de prolongamento. Estas mulheres precisam o apoio e educação específica por parte da enfermeira matrona segundo suas necessidades individuais.

Palavras chaves: pesquisa qualitativa; Gravidez; tocologia; emoções.

Introduction

The mean duration of human pregnancy is approximately 265 days, defining term pregnancy as that gestation comprised between 37 weeks (259 days) and 42 weeks (294 days), calculating it since the first day of the last menstrual period.[1] Prolonged pregnancy is also defined as pregnancy post-probable date of delivery and post-term pregnancy. These terms have been used indistinctly in literature, which is why many articles lead to their use indiscriminately, thus, hindering the search and interpretation of information. To confront this lack of uniformity, a work group from the American College of Obstetricians and Gynaecologists[2] recommends for the definition of pregnancy to be the following: pre-term (37 0/7 weeks to 38 6/7 weeks of gestation), full term (39 0/7 weeks to 40 6/7 weeks of gestation), late (41 0/7 weeks to 41 6/7 weeks of gestation), and post-term (as of 42 0/7 weeks). Pregnancy post-probable date of delivery would be that going beyond 40 weeks (280 days) since the date of the last period. Prolonged pregnancy is the object of much discussion, both in the diagnosis as in its management and moment of its interruption, besides having a high rate of dystocia and maternal-infant morbidity.[3]

Different studies have indicated that the perception of maternity and birth of a child will be quite different according to the course of the pregnancy, type of delivery and care and education, like the study by Parcells which found depression and anxiety during pregnancy[4] or Domínguez-Luna *et al.*,[5] in Madrid who manifested that pregnant women with prolonged bed rest due to premature membrane rupture had high levels of anxiety, stress, concern, fear, sadness, and emotional lability because of the situation experienced. The results of a systematic review carried out recently reveal various depression symptoms during

pregnancy, like maternal anxiety, life tension, prior depression, lack of social support, domestic violence, and unwanted pregnancies.[6] Another research concludes that mental health disorders are frequent during pregnancy and puerperium, but that women who are pregnant or in the post-delivery period do not have a higher risk of suffering a mental disease than those who are not pregnant.[7]

Health professionals caring for the gestants need to be prepared to offer comprehensive care and meet all their needs; the midwives, as those responsible for the pregnant women, must assess the mental health needs of the women to conduct adequate interventions in that sense.[8] During pregnancy, important biological, somatic, psychological, and social changes take place that influence upon the individual psychic dynamics, besides influencing, in turn, the pregnant women's social relationships; how they experience those changes impacts directly on their experience of the maternity.[9] Many women when told of the probable delivery date at the beginning of the pregnancy understand that said date means that it is the optimal time
of the duration of a human pregnancy and that that on that day the delivery will take place.[10]

Few studies have been found referring to pregnancy susceptible to prolongation and of the feelings women have at the end of it, which is why the aim of this study was to learn of the perception of the emotional state of the pregnant woman when the probable delivery date has elapsed and she expects her child's birth at any moment, to improve the care offered to them. As specific objectives, we sought to identify the functional patterns intervening in the emotional state of the gestants and know the expectations on the delivery and the perception on the healthcare offered during pregnancy.

Methodology

This research was carried out through qualitative methodology, using as data and information gathering strategy in-depth individual interviews to know the study phenomenon from the point of view of the participants, inquiring on the experience of the emotional state of the first-time mothers with pregnancy susceptible to prolongation. Prior consent was obtained from the ethics committee at the Jaén Hospital Complex and from the Research Committee at Universidad Jaén; likewise, prior written consent was obtained from each of the participants. Each interview was recorded in audio format to make a true transcription of them.

Study participants. Pregnant women with more than 40 weeks of gestation counted as of the date of the last period who had as reference hospital the Jaén Hospital Complex, over 18 years of age, and first-time mothers who were not included in high-risk protocols. To attract the participants, convenience sampling was conducted by selecting available pregnant women who attended fetal well-being control consultation. The sample was homogeneous, given that they shared similar traits. With the seven participants the principle of data saturation was achieved (Table 1).

Information collection. The strategy used to gather the data was the in-depth, semi-structured individual open-question interview. We sought support on observation to collect the gestures and expressions of the women being interviewed by taking notes. The interviews were conducted by two midwives from March to May 2013, after a prior informal contact by the resident from Obstetric-Gynecologic Nursing who invited them to participate in the study. The necessary time was facilitated for the pregnant women to answer what was being asked. The place to hold the interview was agreed upon with the participants, holding them at their homes, with only the gestant and the interviewers present. The interview protocol was previously piloted with a pregnant woman who fulfilled the inclusion criteria to profile the categories and know the adjustment of the interview protocol to the research objectives. Once this was done, the script was modified to fit it better to the objectives of the study.

Table 1. Sociodemographic and obstetric characteristics of women participants

Gestant	Age	Level of formation	Place of residence	Work	Duration of the pregnancy (weeks)	Nationality
E1	32	University	City	Yes	40+6	Spaniard
E2	30	Professional	City	No	41+2	Spaniard
E3	32	University	Town	No	40+6	Spaniard
E4	32	Primary	Town	Yes	40+3	Spaniard
E5	21	Primary	Town	No	41+4	Spaniard
E6	31	University	Town	No	40+6	Spaniard
E7	28	University	City	No	40+5	Spaniard

Data analysis. An analysis was performed of the contents and of the informants' responses. It took place after the literal transcription of the data recorded and from the field notes according to the recommendations by Tusón.[11] Once transcribed, the data was reduced, coded, grouped and then classified into categories with the aid of the analytic memos carried out, presenting the data to make decisions and reach conclusions from the description and interpretation of their meaning.[12,13] To help during the data analysis process, the NVivo program version 8 was used. After performing the analysis, the reports were returned to the participants to find if they felt identified with the report's results.

Results

The experience on the pregnancy from each of the participants is unique. In spite of this perception, the data analysis found common results among all of them.

Representations of themselves, support individuals, and the future descendant

All the participants wanted to have a child and classified the experience as positive. On the question: "How do you think you will be as a mother?" We noted in the gestural language that the participants became emotionally altered, revealing a certain amount of nervousness regarding the idea of not being able to fulfill the maternity role, although they showed self-confidence and confidence on the support network during the delivery process and on the subsequent upbringing of the child, mentioning that they would be getting help from their relatives. The stated that their lifestyles had not changed because of the pregnancy: … *they say they will help me with everything they can with whatever I don't know how to do* (E6).

Another of the issues addressed in this category was the partner's role during the pregnancy and upbringing of the future child. The women highlighted that their partners also saw the pregnancy as positive and each woman described the father's qualities and positive attitudes for caring: *…alright! …he will surely be better than me [laughter], hmmm, he is more communicative than I am, so I know – perhaps I am wrong – but I think he is will understand this better…* (E2). About the future child, there were different perceptions; three of the participants received 3D ultrasound on the sixth month of pregnancy. When they saw, through the ultrasound procedure, the physical features of the face, they found a likeness with the father or with themselves. This could be interpreted as a feeling of belonging of the fetus and its early social incorporation, along with the desire for the child to have traits that would identify him or her with the partner. A perception not felt in other forms of maternity like adoption or during assisted reproduction techniques with

donor semen. Other women, who did not have that information, believed the newborn would have a physical likeness shared from both parents and described the future child from different aspects of their own personality; in addition, a certain difficulty was noted by the mother to generate a specific representation of the child. Regarding the behavioral sphere in function of how fetuses behaved in the maternal womb they described these as being nervous or tranquil, although their biggest concern was their health: *E3 –Physically, I think the child looks like me based on what we saw on the 3D ultrasound and, additionally, right now she seems at ease*… (E3). *I hope he arrives healthy and we don't have problems, the rest does not matter much. Yes, it does not matter much; I just want everything to turn out well and for the baby to arrive well, that´s all* (E4).

Emotional well-being

Once the probable delivery date passed, they expressed fear for three reasons: first for the delivery, given that they ignored the dynamics and the physical setting of the delivery service and had no prior experience, but did have a preconceived idea of what their delivery would be in function of stories from relatives or from friends who had gone through that moment, besides, they preferred it to be a quick process and with epidural anesthesia. They considered it positive for a relative, in this case their partner, to accompany them during labor and delivery, given that they said it could provide security and above all tranquility, being that they were their principal source of support: *I expect for the delivery to also go well, which is what scares me the most, especially now that I know what it is about* (E7). *Well, I think it is rather important, because you are alone, it is your only – at that moment – I think it is your only support…* (E4). *Well, tranquility, assurance, company* (E6).

The participants expressed how the professionals could help them during delivery; for this they claimed information, specific explanations about the moment they would be in and the time to end the process in function of their experience. It is a demand that transmits the importance of the information received and the concern for the time of labor and delivery to be short. They also requested support and help on how things would be developing. This is why it may be deduced that safety during the delivery process rests upon the healthcare professional, revealing a lack of trust upon themselves: *With information, relaxing, getting a bit more explanations on how, given that at the start no matter how much they tell you, you have no idea where you are going, you don't know what it is...* (E4). *I like to help, I like to feel active, and what's more, I think everything improves that way, not only me and the child but the team works better* (E1).

In the second place, they reported fear of caring for the newborn, which they justified by their lack of experience. Although all the participants attended the sessions of the maternal education program and recognized that they learnt a lot, and felt supported during the pregnancy and satisfied with the treatment received, they expressed fear of the time they would get home not knowing how to care for the child: *I am afraid of what is coming. I was more afraid of the delivery, but now I am more afraid of getting home and finding that ballot* (E6). *Yes, I have been treated well everywhere, by the midwife, the physician, everyone...* (E5).

Fears related to themselves as mothers can be related with failing in their care and with not being good mothers.

In the third place, they described fear of how the process would unfold; they wished their child to be born without malformations and at the same time for no complications during delivery. A fear that accentuated as the gestation was prolonged, given that since the fourth or fifth month they could not perceive fetal movements: *Because I do not know if she is well in there and you wonder what could be happening there... did something happen? Is it moving or not? If it moves its bad, if it doesn't its worse …* (E2). *I don't know, that it won't arrive well, or when it is born although I've been told that everything is okay, but perhaps there is something*

that can't be seen in the ultrasound or something and it is not coming well… (E7).

An *in-vivo* category that emerged from the analysis was that of the altered emotional state they represented as a nervous state. All the participants when asked of the current emotional state expressed verbally and through non-verbal behavior the nerves caused by the moment; they felt uneasy because the delivery could start at any moment. Family and friends influenced upon this emotional state; they stated that the fact of making constant phone calls and being always concerned with the pregnant women intervened negatively in their emotional well-being. This social behavior that denotes concern by the family implies in the gestant emotional distress, given that it is not perceived as positive: *I was nervous, in constant tension; I have two bags ready, mine and theirs. You get nervous because you see that it has to be from one moment to another* (E3). *Perhaps I get more nervous in that sense because they call you so much and always ask how you are doing. How are you? And, how are you doing?…* (E4). *They always end up arguing; I am keeping them from coming over because they want to come over now and what I do is keep them away. I don't want burdens in my house!* (E1).

The emotional state could also be influenced by the lack of rest during the night; this functional pattern is altered as of the 38th week of gestation, according to what the participants describe due to increased nighttime urination and because of the pain in the hips and lower part of the abdomen and increased weight of the uterus. Likewise, it could be affected due to the lack of peace in them upon learning that at any moment the delivery could start: *But now this last month and above all this last week, bad, because I wake in the middle of the night to go to the bathroom and then it's hard to fall asleep again; I lie on one side and it bothers me, and the same thing when I lie on the other side...* (E3). *No, these last two weeks, since the 38th week, I don't rest at night. I get up as if I had not slept* (E1).

Another of the functional patterns that could influence upon the emotional well-being of pregnant women was physical activity, but in this case positively, all of them followed the recommendations from the healthcare professional that cared for them, walking for at least one hour daily: *I have circulatory problems; I started walking since the second month. Additionally, I notice that the day I go out to walk I feel I have more energy…*(E4).

Discussion

Parents-child-family interrelation

Parents must bear in mind a series of personal, socio-economic, interpersonal, and temporal constraints to decide on conceiving a child,[14] but once immersed in the gestation, support from the family and friends is fundamental.[15] Relatives of the participants shared their own experiences and provided information that could help them during the pregnancy phase, as well as during labor and delivery and during the subsequent care of the newborn. With respect to the future child, research describes that the representations of the child in gestants with an ambivalent relationship correspond to a combination of both parents' personalities and which are not based on the fetus' behavior in the womb, rather, gestants with a secure relationship do describe the future descendant in function of fetal movements.[16] In our study, gestants do refer to aspects from the behavioral sphere in function of the fetal movements perceived, while representing them with physical and personality characteristics from both parents, a sign of attachment present in the mothers. The quality of the mother-child relationship is related to how the mother recalls her own experiences from infancy;[17] this attachment is associated to the progressive adaptation produced in the woman to her pregnancy and to the practices of prenatal education.[18]

Influences on the emotional well-being

Fear during this stage of pregnancy for the future mothers can be influenced by several factors. Upon delivery, the role of the companion for

the participants is that of providing support and tranquility; a reference exists that indicates that, in many cases, prenatal education is not focused on the companion, they do not feel as part of the process, their role is scarce and that creates unease and distrust in the partner during the whole pregnancy. Help from the companion and from the family for the interviewees mitigates the fear and nervousness present at the end of the pregnancy, but excessive and persistent support from relatives intervenes negatively upon the emotional state.[19] Fear of the delivery influences upon the experience of pregnancy, during the labor process and the transition to maternity. The pregnant women from this research report being satisfied with the care and information provided by the health professionals who have cared for them during their pregnancy; in this respect, some studies reflect the positive experiences of the mothers regarding their care based on good collaboration with the health professionals.[20] Research describes that gestants state a certain degree of concern for the health and well-being of their children,[21] which is why nursing interventions can help to improve positivity and comfort in pregnant women.[22]

Table 2. Categories of information analysis

Category	**Representations on themselves, support individuals, and the future descendant**	
Subcategory	On themselves: Ideas, expectations and beliefs about their future role as mothers	-Role as mother -Maternity perception
Subcategory	On the support personnel: Thoughts and expectations about the paternal role and on the support received from relatives and friends	-Role of the father -Parental relationship -Support from friends -Support from the family
Subcategory	On the future descendant: Thoughts and expectations related to the child that will be born	-Physical -Psychological
Category	**Emotional well-being**	
Subcategory	Fear: Emotional reaction against a danger recognized as such during a state of awareness	-Delivery -Complications -Newborn care
Subcategory	Frame of mind: Generalized and persistent emotion that influences upon the perception of the world	- Emergent: Nervousness
Subcategory	Functional patterns: configuration of behaviors, more or less common to all people, which contribute to their health, quality of life, and achievement of their human potential	-Sleep-rest --Activity–Exercise --Elimination
Subcategory	Support and information offered by the midwife during prenatal visits	-Broad and detailed information

The mother's attachment to the child starts when she learns of her pregnancy,[23] during this period the emotional bond begins and at the end of the pregnancy the concern is greater. Pregnancy planning exists by the participants that, together with their bond with their child, lead them to express concern for their child's health during pregnancy and fear the delivery process. The couple's planning of the pregnancy leads to less concern, an adequate relationship, in addition to having fewer psychological symptoms.[24] Care of women with fear of delivery is emotionally demanding and takes up much time from the health personnel caring for them, which is why they need support from a companion during delivery and after such. This situation invites to

early care of women with fear of delivery, with individual care and adequate preparation for it.[25] Along with all these emotions, the participants also express the fear of caring for the newborn; the first contact between the parents and the baby is characterized by turbulent emotions,[26] but once home some difficulties and fears emerge due to lack of experience with health or nutrition.[27]

Some of the functional patterns altered in the gestants may intervene in their mood. During the night, there is increased urination in the participants as of the 38th week and this influences upon rest, a product of the changes in the urinary and hematological systems due to hormonal and postural factors that modify the renal function and also because of the increased pressure exerted by the womb on the bladder; this produces a more frequent need to urinate[1] and is related to sleep. It is well known that rest is related to the emotional well-being, given that restful sleep is fundamental to confront situations with emotional equilibrium; without sleeping or resting the concentration capacity, judgment, and participation in daily activities diminishes, while irritability increases. Mood disorders are related to the amount and quality of sleep.[28]

To help in getting some sleep, physical exercise is a factor to bear in mind. In healthy pregnant women, engaging in physical exercise regularly, even low intensity, can be a potentially effective low-cost method to improve psychological well-being, besides, helping to get some sleep and maintain it.[29] The interviewees followed the health indications and engaged in daily exercise, given that it is currently recommended for pregnant women to practice 30 minutes or more of moderate exercise most days of the week, barring medical or obstetric complications.[30]

Conclusion

During the pregnancy of the women in this research images, expectations, fears, and desires were developed of their future descendant, as well as of themselves as mothers, projecting the responsibility of the delivery upon the health personnel caring for them, while their inner world is reorganized for the future changes. Awareness of the whole pregnancy process provides them tranquility. The main source of support for these women is their partner, expressing that their role during delivery is fundamental; they believe wholeheartedly on the need for a person to accompany them during labor and delivery. Support from the family and friends, along with the expectations deposited upon the future descendant mediate on this emotional alteration, as long as that support by the family is not excessive.

The women in our study show concern associated to fears, independent of their age, level of formation, place of residence, and work. Upon the arrival of the post probable delivery date, they describe that the emotional well-being is influenced by two feelings: the first is fear, both of the delivery and of the complications that may occur. This fear becomes more evident with each passing day that their expectations are not fulfilled; one of the influencing factors is lack of knowledge of the delivery services because they are first-time mothers. When looking beyond the delivery, during an immediate future, their fear is represented in caring for the newborn, even when all the participants have attended the classes on maternal education, which leads us to think that prenatal classes are not sufficient for the gestants to feel confident upon getting home with the newborn and health education would have to be established in function of the needs expressed by the gestants. Another fear present is insipient nervousness because of the delivery that is about to begin and which affects them emotionally from what is perceived through the non-verbal behavior and through the declarations of the participants.

Several functional patterns intervene on the mood, like physical activity performed during pregnancy that has a protective effect of it and its daily practice is recommended of all pregnant women. Lack of nightly rest, along with excessive

support from the family, influences negatively upon the emotional well-being. In this aspect, it is important to have a balance between the demand and the response to signals by relatives and close friends of the gestant, given that increased excessive support produces emotional distress and may produce a non-adaptive response from the pregnant women to the delivery process and future care of their child.

To end, strategies of emotional support would have to take place by the midwives and other health professionals during this final phase of the pregnancy to offer comprehensive care, like organized visits to the delivery services in their zone to have a prior contact and help them when the delivery process starts, along with the puerperal education, like the puerperal home visit upon release from the hospital, where health education takes place on the aspects requested most by the women such as hygiene, sleep, and breastfeeding; for this, the incorporation of the midwife would be necessary, give that it is the figure in all healthcare centers and the presence of the midwife in the hospitalization puerperal units.

Limitations. It would have been enriching for the study to have discussion groups, but due to time limitations, this possibility was discarded. Another limitation was the losses during the data collection phase: four women began their delivery process after contacting them to conduct the interview.

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