

**A STUDY ON ANXIETY, DEPRESSION AND STRESS AMONG WOMEN DURING
PRENATAL AND POSTNATAL PERIOD IN ALAPPUZHA DISTRICT**

Dissertation submitted to Kerala University

In partial fulfilment of the requirements for the award of the Degree of

M. Sc. Counselling Psychology

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CERTIFICATE



This is to certify that the Dissertation entitled "A STUDY ON ANXIETY, DEPRESSION AND STRESS AMONG WOMEN DURING PRENATAL AND POSTNATAL PERIOD IN ALAPPUZHA DISTRICT ,, is an authentic work carried out by Parvathy Madhukumar Reg. No. 60421115018 under the guidance of Dr. Ammu Lukose during the fourth semester of M.Sc. Counselling Psychology programme in the academic year 2021- 2023.

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I, Parvathy Madhukumar , do hereby declare that the dissertation titled” A STUDY ON ANXIETY, DEPRESSION AND STRESS AMONG WOMEN DURING PRENATAL AND POSTNATAL PERIOD IN ALAPPUZHA DISTRICT,, submitted to the Department of Counselling Psychology, Loyola College of Social Sciences, Sreekariyam, under the supervision of Dr Ammu Lukose Assistant professor of the Department of Counselling Psychology, for the award of the degree of Master’s in Science of Counselling Psychology, is a bonafide work carried out by me and no part thereof has been submitted for the award of any other degree in any University.

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Abstract

The purpose of the present study was to understand anxiety stress and depression among women during prenatal and postnatal period. The data were collected from 80 participants (40 prenatal and 40 postnatal) using purposive sampling method. The tool used for the study was Anxiety depression stress scale. The collected data were analyzed using appropriate statistical techniques such as 't' test, ANOVA and correlation method. The findings showed a relation between anxiety depression and stress among women during prenatal and postnatal period.

Key words: *Anxiety, Depression, Stress, Prenatal period, Postnatal period*

Chapter I

Introduction

Pregnancy is a beautiful period a women experiences in her life. Many physiological and psychological changes may occur during and after pregnancy. This research is an attempt to understand certain psychological factors such as anxiety, stress and depression in women during prenatal and postnatal period.

Anxiety

Anxiety is a mental health disorder characterized by feelings of worry anxiety or fear they are a group of mental illness, and the distress they cause can keep you from carrying on with your life normally

Anxiety is a feeling of unease, such as worry or fear that can be mild or severe. Everyone has feelings of anxiety at some point in their life. Anxiety disorders develop as the result of the interaction of genetic (inherited) and environmental factors. Neurologically speaking, increased amygdala reactivity is correlated with increased fear and anxiety responses. Low levels of GABA (a neurotransmitter in the brain that reduces central nervous system activity) can contribute to anxiety, and serotonin, glutamate, have also all been implicated in the development of anxiety disorders .In addition to biological factors, anxiety disorders can also be caused by various life stresses, such as financial worries or chronic physical illness. Severe anxiety and depression can also be induced by sustained alcohol abuse; with prolonged sobriety these symptoms usually decrease. Even moderate sustained alcohol use may increase Anxiety and depression levels in some individuals. Caffeine, alcohol, and benzodiazepine dependence can worsen or cause anxiety and panic attacks. For example, you may feel worried and anxious about sitting an exam or having a medical test or job interview. During times like these, feeling

anxious can be perfectly normal. Anxiety is the main symptom of several conditions, including panic disorder, phobias, post-traumatic stress disorder and social anxiety disorder (social phobia). A brief history of anxiety reveals its Latin roots, through the increased interest in 'nervous illnesses' in the 18th and 19th centuries, to the German term 'angst' used by Sigmund Freud and Danish philosopher Søren Kierkegaard. Scientists generally agree that anxiety is a basic emotion affecting our thoughts, our bodies, and our behaviour. (Freeman and Freeman 2012).

Anxiety is an emotion that predates the evolution of man. Children, adolescents and adults experience anxiety in different forms; while this is visible in some, it can be inferred in others from their physiological and psychological responses. Anxiety also varies in frequency and intensity in different persons, even in response to the same stimulus (Trivedi & Gupta, 2010).

Anxiety is a generalized state of apprehension or foreboding. There is much to be anxious about. Our health, social relationships, examinations, careers and conditions of the environment are but a few sources of possible concerns. It is normal, and even adaptive, to be somewhat anxious about these aspects of life. Anxiety serves us when it prompts us to seek regular medical checkups or motivates us to study for tests. Anxiety is an appropriate response to threats, but it can be abnormal when its level is out of proportion to a threat. In extreme forms, anxiety can impair our daily functioning. Sigmund Freud (1895) coined the term anxiety neurosis, which he believed resulted from dammed-up libido: a physiological increase in sexual tension leads to a corresponding increase in libido, the mental representation of physiological event. The normal outlet of such tension, in Freud's view, is sexual intercourse; sexual practices such as abstinence and coitus interruptus prevent tension release and produce neuroses. The

conditions of heightened anxiety related to libidinal blockage include neurasthenia, hypochondriasis, and anxiety neuroses. The word anxiety has as its root *angst*, German for fear. According to Hallam (1992) anxiety is a word used in every day conversation and refers to a complex relationship between a person and his situation. Anxiety is often a diffuse, unpleasant and uncomfortable feeling of apprehension, accompanied by one or more bodily sensations that characteristically recur in the same manner in the person. It is an alerting signal that warns an individual of imminent danger and enables him to take measures to deal with it. Anxiety and fear may exist simultaneously or follow each other. Anxiety or fear-arousing stimulus may be internal or external, immediate or future, definite or vague, and conflictual or non- conflictual in nature. One can, however, differentiate anxiety from fear, in that in fear no conflict is involved and the threat is known. (Beck 1967)

In 1917, Watson and Morgan theorized that Pavlov's (1927) conditioning paradigm could account for much emotional behavior in humans. In subsequent studies Watson and Rayner (1920) and Jones (1924) supported the classical conditioning interpretation of human fear behavior. These efforts provided the first conceptual foundation for that part of behavior therapy concerned with anxiety and the neuroses (e.g., Wolpe, 1958). Hence the Pavlovian model of conditioned emotionality became part of the early behavioral orthodoxy. As interest in behavior therapy for the neuroses has evolved, a good deal of conceptual diversification has taken place. This trend has included several attempts to extend and/or modify the orthodox analysis of fear behavior. (Delprato and McGlynn, 1984)

In a literary sense anxiety is usually taken to mean "eagerness." Sometimes it is used as a synonym for worry or fear. The German word *angst* is the word used for anxiety by Freud and Goldstein. Karen Horney uses the term *urangst der kreatur* to refer to normal anxiety which

reflects the human situation in the face of nature, death, and the contingencies of life. It is important that fear, normal anxiety, and neurotic anxiety be clearly defined and differentiated. Fear is always directed to a specific object, situation, or danger. Fear can be rational or irrational. Rational fear would exist if one who was inexperienced had to enter a lion's cage in order to retrieve something or if one had to enter a burning house to rescue its occupants. Irrational fear borders on a type of anxiety in which an object or situation is feared, but without good reason. This includes phobias, such as fear of darkness, heights, basements, and so on. Freud, Goldstein, and Horney all agree that rational fear is a "reaction to a specific danger" (Crosby, 1976).

Normal anxiety does not in itself constitute a pathological problem. Normal anxiety was called real or objective anxiety by Freud. It is a reaction to an external danger and as such it is a natural, normal, and useful function. Normal anxiety is not disproportionate to the objective threat, does not involve a repression or other mechanism of intrapsychic conflict, and does not require neurotic defense mechanisms for its management. It can be confronted constructively on the level of conscious awareness or can be relieved if the objective situation is altered (Crosby, 1976).

Neurotic anxiety is often termed subjective in contradistinction to objective anxiety. When a person is thrown into anxiety by situations which are, in themselves, not considered to be objectively threatening, it is referred to as neurotic anxiety. Neurotic anxiety is a reaction to a threat which is disproportionate to the objective danger, involves repression (dissociation) and other forms of intrapsychic conflict, and is managed through various forms of retrenchment of activity and awareness, such as inhibitions, the development of symptoms, and the varied neurotic defense mechanisms. (John F. Crosby, 1976)

Anxiety Disorders

Anxiety disorders are the most common and debilitating among the psychological disorders. Often chronic in nature, anxiety disorders are associated with severe impairments across interpersonal and occupational domains. The symptoms are varies from person to person. Some people have only one or two symptoms, while others have many more. (Antony M et.al 2008). Anxiety includes different types of disorders and these disorders are panic attack, panic disorder, social phobia and specific phobia. (Antony M et.al 2008)

Panic attack is a period of intense fear or discomfort in which the individual experiences at least four of the following symptoms (peaking in intensity within 10 minutes or less): racing or pounding heart, sweating, trembling, shortness of breath, choking sensations, chest pain or tightness, nausea or stomach upset, dizziness, derealization or depersonalization, fear of losing control or going crazy, fear of dying, numbness or tingling sensations, and chills or hot flushes. Panic attacks are not specific to any one anxiety disorder. For example, individuals with panic disorder, specific phobia, and social phobia may experience panic attacks during the course of their illness. (Antony M et.al 2008)

An individual with panic disorder experience recurrent and unexpected panic attacks that are followed by a period of at least 1 month of marked worry about having additional attacks, anxiety about the implications of the attacks (e.g., having a heart attack, going crazy), and/ or a significant change in behavior. Although they frequently co-occur, panic disorder with/without agoraphobia; the intentional avoidance of situations/places from which it might be difficult to escape or receive help in the event of a panic attack (e.g., being away from home, crowds, public transportation, shopping malls. (Antony M et.al 2008)

The essential feature of social phobia (or social anxiety disorder) is marked fear and anxiety about being negatively evaluated in social or performance-based situations (e.g., public speaking, meeting strangers or maintaining conversations). Fearful of being judged, criticized, or embarrassed, individuals with social phobia often avoid social situations or endure them with considerable distress. For individuals whose fears are related to multiple situations (e.g., formal speaking, eating in front of others, dating situations, etc.), the diagnostic specifies generalized type may be added. Common in the general population (lifetime prevalence rates range from 7% to 13%). The disorder typically begins in early adolescence. (Mark, 2002 and Ruscio et al., 2008),

A specific phobia is any kind of anxiety disorder that amounts to an unreasonable or irrational fear related to exposure to specific objects or situations. As a result the affected person tends to avoid contact with the objects or situations and in severe cases any mention depiction of them. The five main types of specific phobia include animal type (e.g., fear of snakes, spiders, dogs), natural environment type (e.g., fear of heights, storms, water), blood-injection-injury type (e.g., fear of blood, needles, surgery), situational type (e.g., fear of enclosed places, driving, flying), and other (p. 6) type (e.g., fear of vomiting, choking, or other specific objects or situations). Although specific phobia is among the most commonly occurring anxiety disorders, with a recent lifetime prevalence estimate of 12.5%, only a small proportion of sufferers (12% to 30%) are estimated to seek treatment for their symptoms.

(Antony M et.al 2008)

Generalized Anxiety Disorder (GAD) is characterized by persistent and excessive worry about a number of different things. People with GAD may anticipate disaster and may be overly concerned about money, health, family, work, or other issues. Individuals with GAD find it difficult to control their worry. They may worry more than seems warranted about actual

events or may expect the worst even when there is no apparent reason for concern. GAD is diagnosed when a person finds it difficult to control worry on more days than not for at least six months and has three or more symptoms. Learn more about symptoms. This differentiates GAD from worry that may be specific to a set stressor or for more limited period of time.

Women are twice as likely to be affected. The disorder comes on gradually and can begin across the life cycle, though the risk is highest between childhood and middle age. Although the exact cause of GAD is unknown, there is evidence that biological factors, family background, and life experiences, particularly stressful ones, play a role. (Antony M et.al 2008)

Causal factors of anxiety disorders

There are a variety of factors affecting anxiety disorders. The main causal factors of anxiety disorders are psychological factors. A variety of psychological causal factors have been implicated in the origins of specific phobias ranging from deep-seated psychodynamic conflicts to relatively straight forward traumatic conditioning of fear and a multitude of individual differences in who is at risk for such conditioning. According to the psychoanalytic View, phobias represent a defense against anxiety that stems from repressed impulse from the id. Because it is too dangerous to know the repressed id impulse, the anxiety is displaced on to some external objects or situations that has some symbolic relationship to the real objects or situations that has some symbolic relationship to the real objects of anxiety phobias are acquired was long criticized as being too far speculative and an alternative, simpler account from learning theory was first proposed by Wolpe and Rachman which has now been further refined (Antony M et.al 2008)

Treatment

Both pharmacotherapy and psychotherapy is used to treat anxiety disorders.

Stress

The term stress has been used to describe a variety of negative feelings and reactions that accompany threatening or challenging situations. However, not all stress reactions are negative. A certain amount of stress is actually necessary for survival. For example, birth is one of the most stressful experiences of life. The high level of hormones released during birth, which are also involved in the stress response, are believed to prepare the newborn infant for adaptation to the challenges of life outside the womb. These biological responses to stress make the newborn more alert promoting the bonding process and, by extension, the child's physical survival. The stress reaction maximizes the expenditure of energy which helps prepare the body to meet a threatening or challenging situation and the individual tends to mobilize a great deal of effort in order to deal with the event. Both the sympathetic/adrenal and pituitary/adrenal systems become activated in response to stress. The sympathetic system is a fast-acting system that allows us to respond to the immediate demands of the situation by activating and increasing arousal. The pituitary/adrenal system is slower-acting and prolongs the aroused state. However, while a certain amount of stress is necessary for survival, prolonged stress can affect health adversely (Bernard & Krupat, 1994).

Stress has generally been viewed as a set of neurological and physiological reactions that serves an adaptive function (Franken, 1994). Traditionally, stress research has been oriented toward studies involving the body's reaction to stress and the cognitive processes that influence the perception of stress. However, social perspectives of the stress response have noted that different people experiencing similar life conditions are not necessarily affected in the same manner (Pearlin, 1982). Research into the societal and cultural influences of stress may make it necessary to re-examine how stress is defined and studied.

There are a number of definitions of stress as well as number of events that can lead to the experience of stress. People say they are stressed when they take an examination, when having to deal with a frustrating work situation, or when experiencing relationship difficulties. Stressful situations can be viewed as harmful, as threatening, or as challenging. With so many factors that can contribute to stress it can be difficult to define the concept of "stress". Hans Selye (1982) points out that few people define the concept of stress in the same way or even bother to attempt a clear-cut definition. According to Selye, an important aspect of stress is that a wide variety of dissimilar situations are capable of producing the stress response such as fatigue, effort, pain, fear, and even success. This has led to several definitions of stress, each of which highlights different aspects of stress. One of the most comprehensive models of stress is the Biopsychosocial Model of Stress (Bernard & Krupat, 1994). According to the Biopsychosocial Model of Stress, stress involves three components: an external component, an internal component, and the interaction between the external and internal components.

The external component of the Biopsychosocial Model of stress involves environmental events that precede the recognition of stress and can elicit a stress response. A previously mentioned, the stress reaction is elicited by a wide variety of psychosocial stimuli that are either physiologically or emotionally threatening and disrupt the body's homeostasis (Cannon, 1932). We are usually aware of stressors when we feel conflicted, frustrated, or pressured. Most of the common stressors fall within four broad categories: personal, social/familial, work, and the environment. These stressful events have been linked to a variety of psychological physical complaints. For example bereavement is a particularly difficult stressor and has provided some of the first systematic evidence of a link between stress and immune functioning. Bereavement research generally supports a relationship between a sense of loss and lowered immune system functioning. Health problems and increased accidents are also associated with stressful work

demands, job insecurity and changes in job responsibilities (Bernard & Krupat, 1994). Stressors also differ in their duration. Acute stressors are stressors of relatively short duration and are generally not considered to be a health risk because they are limited by time. Chronic stressors are of relatively longer duration and can pose a serious health risk due to their prolonged activation of the body's stress response. (Cordon .m 1997)

Psychological stress is a popular term denoting processes believed to contribute to a variety of mental and physical conditions. Despite widespread interest in the construct and its consequences for health and well-being, there is little consensus on definitions for psychological stress. Three perspectives for defining and studying psychological stress are reviewed with respect to their history, development, and current status. The three perspectives on psychological stress differ in terms of the relative emphasis each places on the environment, the organism, and the interaction between organism and environment over time. Conceptual and methodological considerations and implications of the three perspectives are reviewed.

Promising leads for future inquiry are addressed. (Munroe, 2001)

Stress has both physiological and psychological components. We respond to external events or even imagined events with a generalized set of responses called General Adaptation Syndrome or the stress response, but our responses are to some degree tailored to the nature of the event. The term the "Fight or flight" response that is commonly used to describe the way in which our body reacts to stress. First stage of the fight or flight response is activation of the sympathetic nervous system. This causes a system-wide response. Adrenaline and nor-adrenaline are released leading to increased alertness. Blood is diverted from the internal organs and the skin to skeletal muscles. The heart-rate, force of heart contractions, and respiratory rate are increased. The body begins to convert stored glycogen into glucose. All of these changes allow the body to exert a large amount of energy over a short period of time so that the

individual may either fight effectively, or run away effectively. One well-known phenomena which has its roots in the fight or flight response is the reporting of people lifting cars off their loved ones after a car accident. The amount of energy that such a task demands seems inconceivable to most people, and indeed it would be without the fight or flight response.

(Quillan m.c2008)

General Adaptation Syndrome

The first stage of the model is the alarm phase. This is where the fight or flight response is activated causing the organism's ability to resist the stressor to increase. In the resistance phase, the body starts to adapt to the existence of a chronic stressor. In the exhaustion phase the body's resources become depleted, and body systems start to deteriorate. The relaxation response is mediated by the parasympathetic nervous system, which is also called the resting and digesting system. It works in opposition to the fight or flight response by decreasing heart rate, force of contraction, rate of respiration, and diverting blood away from skeletal muscles to the internal organs, therefore stimulating digestion.

The Autonomic Nervous System

Both the fight or flight response and the relaxation response are mediated by the autonomic nervous system which is composed of the sympathetic nervous system and the parasympathetic nervous system. These branches of the nervous system are like the yin and the yang of our being. Their relative levels of stimulation dictate whether we are alert or lethargic, and an appropriate balance between the two systems is essential for our good health and functioning.

When your stress response is triggered, you process information differently and you can feel physically and emotionally taxed. If this state is prolonged, it can escalate to chronic stress. One useful tip to calm yourself is to go to a quiet place and take deep, long breaths. Breathe in, hold for five seconds, and then exhale slowly. Repeat several times. This exercise can help

soothe your nerves and slow a racing heart. For other ideas, try these strategies to calm down quickly, or these 5-minute stress relief strategies for some quick coping strategies. Calming strategies include the following: Meditation, Breathing exercises, Aromatherapy There are two main types of coping strategies: emotion-focused coping strategies and solution-focused coping strategies. These include coping strategies like maintaining a sense of humor and cultivating optimism, where the situation doesn't change, but your perception of it does. These strategies are great to use in many of the situations you've mentioned where you have little ability to control what happens, and you need to see your stressors as a challenge instead of a threat or change the way you respond to your circumstances in order to diffuse some of the stress involved. See this article on coping with stress for more on emotion-focused coping strategies. The following techniques are examples of emotion-focused coping. Sometimes there's nothing you can do to change a situation, but often you'll find an opportunity to take action and actually change the circumstances you face. These types of solution-focused coping strategies can be very effective for stress relief; often a small change is all that's required to make a huge shift in how you feel. For one thing, one change can lead to other changes, so that a chain reaction of positive change is created, opportunities are opened up, and life changes significantly. Also, once an h no options—a recipe for stress—can dissipate quickly. It's important to be thoughtful about which actions to take, as each situation may call for a unique solution, but a less-stressed mind can more easily choose the most beneficial course of action.

While these techniques can be time-consuming, reducing your stress is necessary to improve your well-being and mental and physical health. If you're feeling overwhelmed, work through these strategies in order to calm your nerves and allow yourself to relax. If your stress levels do not decrease, it may be a good idea to talk to a therapist or your primary healthcare provider. They can help you identify ways to minimize your stress and develop nutrition and

exercise plans to maintain your health as you handle your other obligations. Through coping strategies and good self-care with exercise, good food and plenty of sleep, you can manage your stress healthfully without long-term problem (Scott, 2018).

Stress and DSM

The relationship between stress and psychopathology is considered so important that the role of stress is recognized in diagnostic formulation now where this is more apparent than this diagnosis of PTSD—a severe disorder. PTSD was classified as an anxiety disorder in DSM 5 introduced a new diagnostic category called trauma and stressor related disorder PTSD is now included in there some others disorder in new category are adjustment disorder and acute stress disorder these disorders involve pattern of psychological and behavioral disturbances that occur in response to identifiable stressors the key differences among them lie not only in the severity of the disturbances but also in the nature of the stressors and time frame during which the disorders occur (URSIN H et al;2006) **Factors predisposing a person to stress**

People perceive and interpret similar situations differently and also because objectively and two people are faced with exactly the same pattern of stressors. Some individuals are more likely to develop long term problems under stress than others this may be linked in part to coping skills. Researchers also suggest that adolescents with parents who are depressed are more sensitive to stressful events these adolescents are more likely to have depression

themselves after experiencing stressful life events than those who do not have parents with depression

These stable factors are linked to reduced levels of distress in the face of life events as well as more favorable health outcomes there is also some evidence from twin studies that differences in coping styles may be linked to underlying genetic difference even more recent research has clarified that the interaction between the carrier genotype and life events is most marked for interpersonal events rather than for non-interpersonal life events that do not involve relationships. Evidence from animal studies shows that being exposed to a single stressful experience can enhance responsiveness to stressful events that occur later rats that were exposed to stressful tail shocks produced more of the stress hormone cortisol

The term "stress" is used for four aspects of "stress", stress stimuli, stress experience, the nonspecific, general stress response, and experience of the stress response. These four meanings may be measured separately. The stress response is a general alarm in a homeostatic system, producing general and unspecific neurophysiological activation from one level of arousal to more arousal. The stress response occurs whenever there is something missing, for instance a homeostatic imbalance, or a threat to homeostasis and life of the organism. Formally, the alarm occurs when there is a discrepancy between what should be and what is-between the value a variable should have (set value and the real value (actual value) of the same variable. The stress response, therefore, is an essential and necessary physiological response. The unpleasantness of the alarm is no health threat. However, if sustained, the response may lead to illness and disease through established pathophysiological processes ("all static load"). The alarm elicits specific behaviors to cope with the situation. The level of alarm depends on expectancy of the outcome of stimuli and the specific responses available for coping. Psychological defense is defined as a distortion of stimulus expectancies. Response outcome

expectancies are defined as positive, negative, or none, to the available responses. This offers formal definitions of coping, hopelessness, and helplessness that are easy to operationalize in man and in animals. It is an essential element that coping is defined as positive outcome expectancy does the concept predicts relations to health and disease. (Ursin et.al, 2006) Theories that focus on the specific relationship between external demands (stressors) and bodily processes (stress) can be grouped in two different categories: approaches to 'systemic stress' based in physiology and psychobiology (among others, Selye 1976) and approaches to 'psychological stress' developed within the field of cognitive psychology. (Butcher 2008).

As a model of stress, the General Adaption Syndrome (GAS) is focused primarily on the bodies' physiological response to stress. It does not take into account other factors influencing an individual's response to stress such as their thoughts, perceptions or feelings and how these cognitive and psychological factors impact upon them itself (Garysturt, 2004).

Nonetheless the GAS was a hugely influential model which generated a lot of further study. . (Ursin H ET .al, 2006).

DEPRESSION

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life. (Marcus et al, 2012) In the United States, it is often called "The

common cold of mental health.” Most people occasionally are affected and in most cases it is self-limiting. But sometimes it is not self-limiting and requires psychological or psychiatric treatment and it is certainly more serious than a cold. (Dowd, 2000)

According to Beck (1974), individuals encounter many problems daily that prevent them from achieving their goals. That is, the way individuals interpret and see things can help them adapt to different life situations. Therefore, every positive outcome, or negative feeling, experienced by an individual is based on his or her cognitive structure, belief system, and pattern of thoughts. If an individual's thought and thinking pattern are positive and undistorted, his or her emotion and behavior would be positive. This in turn would reflect on his or her level of psychological adjustment. According to Burns (2000), depression was the first health problem in the world. Depression is a mental disorder that can ultimately lead to suicide.

Depression:

- (1) Biological factors: These factors include an individual's genetics, nervous system and biochemical change that lead to depression.
- (2) Social learning: This includes the family and school factors that can contribute to the occurrence
- (3) Stress and environmental crises: These are social factors that lead to distress and depression such as, disasters, divorce and death of loved ones.

Beck (1988) introduced two theories of depression. The first theory suggests that social relationship problem is the main cause of depression. Based on this, Beck named the first personality type as socially stereotypical character; while the second personality type is the independent character. These independent people appreciate their freedom, but they become depressed when they cannot accomplish things by themselves, without depending on others. In his second theory, Beck (1988) attempted to identify whether depressive thoughts are distorted

or undistorted, whether they are negative underestimate self. According to Beck et al, (1979), depression activate three main cognitive patterns, which are called cognitive trinity. These cognitive patterns are negative attitudes towards self, the world, and future. These are manifested in four Areas:

- (1) Emotional aspects: These comprise depressive mood, and sadness.
- (2) Cognitive aspects: These include low self-esteem and misconception.
- (3) Motivational aspects: These consist of negativism and suicidal tendency.
- (4) Physical aspects: These include loss of appetite, and insomnia.

Positive reinforcement, individuals can have their level of psychological adjustment increased. Such a positive support is based on three sources:

- (1) Psychological support: This kind of support is associated with an individual's personal or physical traits and characteristics such as age, level of attractiveness to others, and sense of belonging.
- (2) Environmental support: This occurs as an individual grows and matures in a secured, friendly and democratic family.
- (3) Social and professional support: This kind of support is related to the high social skills an individual acquire and having the kind of profession that helps him psychologically to resist stress and depression.

Moreover, Burns (2000) points out that depression is not an emotional disorder as claimed by psychologists; it is the change in emotion and feeling that results from the distorted attitudes adopted by an individual. Distorted thoughts are always accompanied by depressive sequences or painful emotions. These cognitive distortions include:

- (1) All or nothing: This cognitive distortion is referred to as an individual's tendency to radicalize things, either to get everything or lose everything.
- (2) Overgeneralization: The tendency of an individual to make absolute judgments and extreme generalizations.
- (3) Mental purging: One's focus on the bad aspects in any situation.
- (4) Underestimating positive events: The depressive tendency of an individual to turn positive experiences into negative ones.
- (5) Random conclusion: In many cases of depression, behaviour is the result of misinterpretation of an incident.

According to Ellis and Dryden (1987), there are multiple approaches to Cognitive Behaviour Therapy (CBT). However, there is a general consensus that for the therapy process to be effective and successful, thought, emotion and behaviour cannot be separated because they are all interrelated. Cognitive therapy is a skill-building model, and not a healing model. With it, patients are taught to acquire skills to deal more effectively with their irrational thoughts and behaviours. Beck's cognitive behavioural therapy is a process through which patients' behaviours can be modified by influencing their thought processes; it involves knowing how individuals think and how to change their distorted thoughts and negative beliefs. (Beck 1988)

Depression is a mood disorder which prevents individuals from leading a normal life, at work socially or within their family. Seligman (1973) referred to depression as the 'common cold' of psychiatry because of its frequency of diagnosis. Depending on how data are gathered and how diagnoses are made, as many as 27% of some population groups may be suffering from depression at any one time.

Everyone has days where they feel blah, down, or sad. Typically, these feelings disappear after a day or two, particularly if circumstances change for the better. People experiencing the temporary "blues" don't feel a sense of crushing hopelessness or helplessness, and are able, for the most part, to continue to engage in regular activities. For people dealing with depressive disorders, negative feelings linger, intensify, and often become crippling. With normal sadness, people are still able to experience pleasure when positive events happen. With depressive disorders, the hopelessness and failure stay even when good things are happening. Other, more intense sorts of symptoms, such as suicidal thoughts and cinations (e.g., hearing voices), are also often present. These symptoms suggest that serious varieties of depression may be present.

A person who has a parent or sibling with depression is almost three times more likely to develop Major Depression than someone with no history of depression in their parents or siblings, which suggests that genetics play a role in the causes of depression.

Long-term stress that lasts for a year or more can affect the body's immune system and lead to an increased risk of developing physical illnesses and an increased likelihood of becoming depressed.

Psychological factors influencing depression include negative patterns of thinking, low coping skills, judgment problems, and difficulty in understanding and expressing emotions. Personality factors, history and early experiences; and relationships with others are seen as important factors in causing depression.

People can also become depressed as a result of social factors such as: experiencing traumatic situations (a family death, divorce, job loss, abusive relationship, etc.), lack of social support/relationships, or harassment (bullying).

and expanded as discussed below Wolpe and Rachman developed an account based on learning theory which sought to development of phobic behaviour through classical conditioning the fear response can readily be conditioned to previously neutral stimuli when these stimuli are paired with traumatic or painful events we would also expect that once acquired phobic fears would generalise to other similar objects or stimulations.

Causes factors affecting anxiety

A variety of psychological causal factors have been implicated in the origins of specific phobias ranging from deep-seated psychodynamic conflicts to relatively straight forward traumatic conditioning of fear and a multitude of individual differences in who is at risk for such conditioning. According to the psychoanalytic View, phobias represent a defence against anxiety that stems from repressed impulse from the ID. Because it is too dangerous to know the repressed id impulse, the anxiety is displaced on to some external objects or situations has some symbolic relationship to the real objects or situations that has some symbolic relationship to the real objects of anxiety phobias are acquired was long criticized as being too far speculative and an alternative, simpler account from learning theory was first proposed by Wolpe and Rachman which has now been further refined.

PREGNANT WOMEN

According to the American College of Obstetricians and Gynaecologists, between 14% and 23% of women will struggle with some symptoms of depression during pregnancy (1) Depression in pregnancy may diminish one's capacity for self-care, precipitating inadequate nutrition, drug or alcohol abuse, and poor antenatal clinic attendance, all of which may compromise a woman's physical and mental health, may reduce optimal fetal monitoring, and might restrict the growth and development of the fetus. Performing antenatal screening is

justified and seems reasonable since most postnatal depressive disorders begin during or before pregnancy. Anxiety during pregnancy has been found to be associated with depression as well as adverse pregnancy outcomes. Various studies have shown a link between antenatal maternal stress and cognitive, behavioural, and emotional problem in a child. An in-depth community-based query has to be made during the antenatal period as most of the past studies have been hospital-based and postnatal centric. The importance of mental health in pregnancy can be emphasized by the fact that even the best obstetric care cannot give a desirable outcome of the pregnancy if the mental health issues of the expectant mother are not addressed at the right time and in the right manner.

To generate local evidence to fill up the knowledge gap about the mental health problems faced by the antenatal females and to assess the prevalence of depression, anxiety, and stress in antenatal females, a cross-sectional community-based descriptive enquiry was conducted from January to October 2014 in Ghazipur, an urbanized village in East Delhi which is the field practice area of our institute. One hundred and sixty-five antenatal women who gave consent to participate in the study and residing in the area for 6 months or more were included in the study. The study participants who needed immediate medical attention and/or participant with chronic mental illness were not included in the study. The tool used for the study included the depression, anxiety, and stress scale

The increased vulnerability for mental illness in pregnancy can be explained by the “Biopsychosocial Model, which integrates the biological, psychological, and social factors to explain the occurrence of mental illness. Pregnant females have increased biological vulnerability due to the hormonal maladjustment, psychological vulnerability due to apprehension for new life of motherhood, and social vulnerability due to the added demands of family support and care during this critical phase of her life. More community-based studies

need to be done to increase the database of similar bigger epidemiological studies to be conducted in different social and cultural settings in India. Our study provided a quantitative descriptive enquiry, but some sensitive issues can be picked up only by qualitative study such as in-depth interviews or focus group discussion. There is now a need to move toward quality comprehensive antenatal services. The findings of our study indicate the need to incorporate mental health components in RCH (Reproductive & Child health) program. At the present junction, universal screening may not be a suitable strategy, but surely, it is a desirable and achievable goal in the future. Longitudinal prospective research is needed to establish the temporality of the onset of depression, anxiety, and stress in pregnancy. A control group of non-pregnant women with a similar sociodemographic profile may be a good estimate of the actual burden of mental health morbidities in pregnancy. Repeated probing on several occasions can build up the rapport and gain the confidence of the victim, so antenatal care visits are an ideal option as there are multiple chances of contact with the healthcare delivery system. Our study provided scoping bit in the base of these hitherto less explored and less examined and underappreciated issues related to pregnancies, on which further studies can be planned on a larger constructive framework and better-resourced methodologies (Priya A et al).

Postpartum depression (PPD)

Postpartum depression (PPD), also called postnatal depression, is a type of mood disorder associated with childbirth, which can affect both sexes. Symptoms may include extreme sadness, low energy, anxiety, crying episodes, irritability, and changes in sleeping or eating patterns. Onset is typically between one week and one month following childbirth. PPD can also negatively affect the newborn child.

While the exact cause of PPD is unclear, the cause is believed to be a combination of physical, emotional, genetic, and social factors. These may include factors such as hormonal

changes and sleep deprivation. Risk factors include prior episodes of postpartum depression, bipolar disorder, a family history of depression, psychological stress, complications of childbirth, lack of support, or a drug use disorder. Diagnosis is based on a person's symptoms. While most women experience a brief period of worry or unhappiness after delivery, postpartum depression should be suspected when symptoms are severe and last over two weeks. Depression is a serious condition that negatively affects how a person thinks, feels, and behaves. In contrast to normal sadness, clinical depression is persistent, often interferes with a person's ability to experience or anticipate pleasure, and significantly interferes with functioning in daily life. Untreated, symptoms can last for weeks, months, or years; and if inadequately treated, depression can lead to significant impairment, other health-related issues, and in rare cases, suicide.

Anxiety is a feeling of uneasiness and worry, usually generalized and unfocused as an overreaction to a situation that is only subjectively seen as menacing. It is often accompanied by muscular tension, restlessness, fatigue, inability to catch one's breath, tightness in the abdominal region, nausea and problems in concentration. Anxiety is closely related to fear, which is a response to a real or perceived immediate threat (fight or flight response); anxiety involves the expectation of future threat including dread. People facing anxiety may withdraw from situations which have provoked anxiety in the past. Stress is a feeling of emotional or physical tension. It can come from any event or thought that makes you feel frustrated, angry, or nervous. Stress is your body's reaction to a challenge or demand. In short bursts, stress can be positive, such as when it helps you avoid danger or meet a deadline. But when stress lasts for a long time, it may harm your health. Stress is a normal human reaction that happens to everyone. In fact, the human body is designed to experience stress and react to it. When you experience changes or challenges (stressors), your body produces physical and mental

responses. That's stress. Stress responses help your body adjust to new situations. Stress can be positive, keeping us alert, motivated and ready to avoid danger. For example, if you have an important test coming up, a stress response might help your body work harder and stay awake longer. But stress becomes a problem when stressors continue without relief or periods of relaxation. The postpartum (or postnatal) period begins immediately after childbirth as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state. The terms puerperium, puerperal period, or immediate postpartum period are commonly used to refer to the first six weeks following childbirth. The World Health Organization (WHO) describes the postnatal period as the most critical and yet the most neglected phase in the lives of mothers and babies; most maternal and newborn deaths occur during this period.

The postpartum period can be divided into three distinct stages; the initial or acute phase, 8–19 hours after childbirth; subacute postpartum period, which lasts two to six weeks, and the delayed postpartum period, which can last up to eight months. In the subacute postpartum period, 87% to 94% of women report at least one health problem. Long-term health problems (persisting after the delayed postpartum period) are reported by 31% of women. Postpartum depression is linked to chemical, social, and psychological changes that happen when having a baby. The term describes a range of physical and emotional changes that many new mothers experience. PPD can be treated with medication and counseling. The chemical changes involve a rapid drop in hormones after delivery. The actual link between this drop and depression is still not clear. But what is known is that the levels of estrogen and progesterone, the female reproductive hormones, increase tenfold during pregnancy. Then, they drop sharply after delivery. By 3 days after a woman gives birth, the levels of these hormones drop back to what they were before pregnancy. (Priya A et al).

Need and significance of the study

Anxiety stress and depression is widely prevalent among women in the child –bearing age, especially during the prenatal and postnatal period .attention should be given to this period as this time of intense change physiologically, socially and mentally for women this is a serious public health issue, which essentially requires continuous support to eventually benefit not only the women, but also the family.This study focuses on comparison of anxiety depression and stress among women during their prenatal and postnatal period .By finding out the level of these in both period adequate care can be provide to reduce anxiety depression and stress they undergo. Through understanding both period can carry on precautionary measures during postpartum.

Aim

- To compare anxiety, stress and depression among women during prenatal and postnatal period.

Hypothesis

- There will be no significant difference in anxiety among women during prenatal and postnatal period.
- There will be no significant difference in stress among women during prenatal and postnatal period.

- There will be no significant difference in depression among women during prenatal and postnatal period.
- There will be no significant difference in anxiety among women during prenatal and postnatal period based on their age • There will be no significant difference in depression among women during prenatal and postnatal period based on their age
- There will be no significant difference in stress among women during prenatal and postnatal period based on their age
- There will be no significant relationship between anxiety, depression and stress among women during prenatal and postnatal period.

Objectives

- To compare anxiety among women during prenatal and postnatal period.
- To compare depression among women during prenatal and postnatal period.
- To compare stress among women during prenatal and postnatal period.
- To compare anxiety among women during prenatal and postnatal period based on their age.
- To compare depression among women during prenatal and postnatal period based on their age.
- To compare stress among women during prenatal and postnatal period based on their age.
- To find out the relationship between anxiety depression and stress among women during prenatal and postnatal period.

CHAPTER II

REVIEW OF LITERATURE

A literature review discusses published information in a particular subject area, and sometimes information in a particular subject area within a certain time period. And depending on the situation, the literature review may evaluate the sources and advise the reader on the most pertinent or relevant information.

Leung, Martison and Arthus in (2014) conducted a study on postpartum depression and women. The study was conducted to identify correlations between PPD (prediction of

postpartum depression) and demographic variables, and antenatal depression and psychosocial variables, and also to determine which of the variables as predictors of postpartum depression. A sample of 385 Hong Kong postpartum woman were taken. The scale used for the study was Edinburgh Postnatal Depression Scale (EPDS). The results revealed that 19.8% of participants had postnatal depressed. Fifty-six percent of the variance in PPD was explained by social support and stress factors. However, social support factors accounted for only a small percentage of that variance. The major predictors were antenatal depression, postnatal perceived stress, and childcare stress. HK women may benefit from a culturally appropriate intervention focused on reducing stress in the postpartum period.

In 2001 February Annam Georgiopolous ,Tonyal, Bryan Peter Wollan and Barabarapyawn conducted study on postpartum depression EPDS scale was used for the study Edinburg postnatal depression scale 342 women's wear taken for the study out of 342 women only 68(20%) women's medical records wear reviewed had been given a documented diagnosis of postpartum depression resulting in an estimated population rate of(10.7%)depression was diagnosis of postpartum depression resulting in an estimated population rate of (10.7%)depression was diagnosed in 35%of the women with EPDS scores compared with 5%of the women with low EPDS scores in the first year postpartum . treatment was provided for all women wear hospitalised for depression some degree of suicidal ideation was noted on the EPDS by 48 women but acknowledged in the chart of only 10 women including one with in an immediate hospitalisation .the state of diagnosis of postpartum depression is this community increased from 3.7%before the routine use of EPDS score was predictive of a diagnosis of postpartum depression and the implementation of routine EPDS screening at 6 weeks postpartum was associated with an increase in the rate of diagnosed postpartum depression in this community

Renee L Miller ,Julie F Pallant & Lisa M Negri (2006) conducted a study on postnatal depression have received considerable research and clinical attention Edinburg postnatal depression scale (EPDS)was used for the study As part of a larger cross-sectional study, the EPDS and DASS-21 were administered to a convenience sample of 325 primiparous mothers, who ranged in age from 18 to 44 years Recruited through mother's groups and health centres in Melbourne Australia, inclusion was limited to mothers whose babies were aged between 6 weeks and 6 months. Analyses included comparisons between the classifications of women according to the EPDS and the DASS-21, and an exploration of the extent to which the EPDS identified anxious-depressed women The EPDS identified 80 women (25%) as possibly depressed (using a cut-off of over 9), of which the DASS-21 corroborated 58%. In the total sample, 61 women (19%) were classified by the DASS-21 to be depressed. Using broader criteria for distress, it was revealed by the DASS-21 that a further 33 women (10%) showed symptoms of anxiety and stress without depression. A total of 41 women (13%) had symptoms of anxiety either in isolation or in combination with depression. The DASS-21 identified 7% of the sample as being both anxious and depressed. This at-risk sub-group had higher mean EPDS and DASS-depression scores than their depressed-only counterpart's .The aim of the study was to access the prevalence of postnatal distress using (EPDS) and the depression anxiety stress scale.

Jane Yelland ,Georgina Sutherland \$Stephanie J Brown (2010) conducted a study on postpartum anxiety depression and social health findings from a population based survey of Australian women Whilst the prevalence and correlates of postpartum depression are well established, far less is known about postpartum anxiety. Studies have described the association between socio-demographic factors and postpartum depression, yet few have explored the association between stressors in women's lives around the time of having a baby and maternal

psychological morbidity. This study aimed to describe the population prevalence of postpartum depression, anxiety, co-morbid anxiety and depression and social health issues; and to examine the association between postpartum psychological and social health issues experienced in the six months following birth. Population-based survey of all women who gave birth in Victoria and South Australia in September/October 2007. Women were mailed the survey questionnaire six months following birth. Anxiety and depression were measured using the Depression Anxiety Stress Scales (DASS-21). Questionnaires were completed by 4,366 women. At six months postpartum the proportion of women scoring above the 'normal' range on the DASS-21 was 12.7% for anxiety, 17.4% for depression, and 8.1% for co-morbid depression and anxiety. Nearly half the sample reported experiencing stressful life events or social health issues in the six months following birth, with 38.3% reporting one to two and 8.8% reporting three or more social health issues. Women reporting three or more social health issues were significantly more likely to experience postnatal anxiety (Adj OR = 4.12, 95% CI 3.0-5.5) or depression (Adj OR = 5.11, 95% CI = 3.9-6.7) and co-morbid anxiety and depression (Adj OR = 5.41, 95% CI 3.8-7.6) than women who did not report social health issues. Health care providers including midwives, nurses, medical practitioners and community health workers need to be alert to women's social circumstances and life events experienced in the perinatal period and the interplay between social and emotional health. Usual management for postpartum mental health issues including Cognitive Behavioural Therapy and pharmacological approaches may not be effective if social health issues are not addressed. Coordinated and integrated perinatal care that is responsive to women's social health may lead to improvements in women's emotional wellbeing following birth.

Marie Paule Austin, Dusan Hadzipavlovic, leoleader, Karen saint (2005) conducted a study on maternal trait anxiety, depression and life events stress in pregnancy relationship with infant

temperament Women in the third trimester of pregnancy returned psychological self- report questionnaires; infant temperament was evaluated at 4 and 6 months by maternal and paternal report, while depression (concurrent Edinburgh scale) was also assessed at four and six months. As data were returned inconsistently at 4 and 6 months, we combined these two time points for simplicity of reporting and optimisation of numbers. Univariate logistic regressions on 970 subjects indicated that the pregnancy STAI (>40) scores were associated with 2.56- and 1.57fold increases (maternal and paternal, respectively), in the odds of “difficult” infant temperament at 4 or 6 months. Concurrent Edinburgh scores (OR of 3.06 and 2.64 for maternal reports, respectively) were also predictive of infant temperament. Age, education, income, marital status, obstetric complications, infant gender and prematurity were not predictive of infant temperament. In stepwise multiple logistic regression analyses, the antenatal trait STAI (odds ratio 1.96) significantly predicted maternal reports of “difficult” temperament at 4 or 6 months independent of both antenatal and postnatal depression scores.

There were similar trends for paternal reports of “difficult” temperament but these were not significant. Antenatal depression and perceived LE stress were not predictive of temperament. Finally, women (N=14) reporting domestic violence (DV) in pregnancy had highly significant increased Edinburgh and STAI scores. Maternal trait anxiety was predictive of “difficult” infant temperament, independent of “concurrent” depression and key socio-demographic and obstetric risk factors. These findings, while needing replication using objective measures of infant temperament, suggest that antenatal psychological interventions aimed at minimising anxiety may optimize infant temperament outcomes. There may be some benefit in shaping specific interventions to women reporting specific risk factors such as DV or past abuse.

In (2007)November , Stephen matthey conducted a study on postnatal depression for anxiety disorder Edinburgh Postnatal Depression Scale (EPDS) to detect probable major

depression. Increasingly there is evidence that for many women, and men, anxiety disorders can occur postnatal in the absence of depression. This study therefore examined data on the three EPDS items frequently found to cluster together on an anxiety factor for women (items 3, 4, and 5: EPDS-3A), to determine the optimum cut-off score to screen for specified anxiety disorders. A sample of 238 women and 218 men were administered a diagnostic interview for anxiety and depressive disorders, and completed the EPDS, at 6 weeks postpartum. The receiver operating characteristics show that the optimum cut-off score on the EPDS-3A for women is 6 or more (possible range: 0–9), and for men it is 4 or more, though it appears that the factor structure for men is different than for women. The conclusion is that the EPDS can be used to screen for probable depression in women (using the validated total cut-off score of 13 or more) and also probable anxiety (using the EPDS-3A cut-off score of 6 or more). For men there is already a validated total cut-off score for both depression and anxiety (6 or more)—however, if services are not using this, they can use the EPDS-3A score of 4 or more to screen for probable anxiety disorders in fathers, though further work needs to be undertaken to clarify whether the anxiety factor structure for men is different to that found for women.

Helen reid , Michael power , Katherine Cheshire .on (2013) conducted a study on factors influencing antenatal depression anxiety and stress The purpose of this study was to investigate the prevalence and factors influencing antenatal depression, anxiety and stress symptomatology. The study used a cross-sectional survey design in a sample of 302 antenatal women across the trimesters of pregnancy. The questionnaire collected demographic and pregnancy data, included two measures of emotional distress; the Edinburgh Depression Scale (EDS) and Depression Anxiety Stress Scale (DASS-21), a measure of social support; the Significant Others Scale (SOS), and an adapted measure of distress from life events; the List of Threatening Experiences (LTE). Seventeen per cent were identified as suffering from

depression symptomatology, 25% as having symptoms of anxiety and 25% as having symptoms of stress. Analysis revealed that a lack of support from a partner, mother, and an 'other' (typically a sibling or friend) were significant predictors of symptomatology. There were different predictive factors for antenatal women with children and primiparous women. Information was also obtained about antenatal women's preferences for health-care support with emotional distress. The need to widen the focus from postnatal depression to perinatal mental health was demonstrated. Interventions with an interpersonal focus may prove particularly effective as lack of social support appears to be a significant predictor of antenatal emotional distress.

Veerle Bergink , Henny Wijnen, Robertas Bunevicius , april (2011) conducted a study on Untreated depression during pregnancy may have adverse outcomes for the mother and her child. Screening for depression in the general pregnant population is thus recommended. The Edinburgh Depression Scale (EDS) is widely used for postpartum depression screening. There is no consensus on which EDS cut off values to use during pregnancy. The aim of the current study was to examine the predictive validity and concurrent validity of the EDS for all three trimesters of pregnancy. In a large unselected sample of 845 pregnant women, the sensitivity, specificity, and validity of the EDS were evaluated. The Composite International Diagnostic Interview (depression module) was used to examine the predictive validity of the EDS. The anxiety and somatization subscales of the Symptom Checklist 90 (SCL-90) were used to examine its concurrent validity. Only women with a major depressive episode were considered as cases. The prevalence of depression decreased toward end term: 5.6%, 5.4%, and 3.4%. The EDS scores also decreased toward end term, while the SCL-90 subscale anxiety scores increased. The EDS showed high test-retest reliability and high concurrent validity with the SCL-90 anxiety and somatization subscales. The area under the receiver operating

characteristic curve was high and varied between 0.93 and 0.97. A cut off value of 11 in the first trimester and that of 10 in the second and third trimesters gave the most adequate combination of sensitivity, specificity, and positive predictive value. The EDS is a reliable instrument for screening depression during pregnancy. A lower cut off than commonly applied in the postpartum period is recommended.

Tabssum z insaf(2011) conducted a study on parental stress anxiety and depressive symptoms as predictors of intention to breastfeed among Hispanic women We evaluated this association among 424 participants in Proyecto Buena Salud, an ongoing prospective cohort of pregnant Hispanic women in Western Massachusetts. The Perceived Stress Scale (PSS), the State-Trait Anxiety Inventory (STAI), and the Edinburgh Postnatal Depression Scale (EPDS) were administered by bilingual interviewers in early pregnancy (mean 13.6 weeks gestation) and mid pregnancy (mean 25.7 weeks gestation). Information on sociodemographic, behavioural, and acculturation factors was also collected. Breastfeeding intention was abstracted from medical records. During mid pregnancy were less likely to intend to breastfeed compared to women without depressive symptoms.

According to K. Palamar et. al., (2008), women with untreated postpartum depressive symptoms are 300 times more likely to experience the depressive symptoms during subsequent pregnancies. Also the likelihood of suicide is intensified during the second pregnancy which may account for the highest risk of death for this population (Pallamara, K., et. al., 2008). Further, under diagnosis and mistreatment of the disorder may lead to higher cases of postnatal psychosis (PNP), a much more serious and dangerous form of PND (Abrams & Curran, 2007).

A systematic review of studies that diagnosed depression by clinical structured interview reported that the point prevalence of MDD and minor depression ranged from 6.5–12.9% through the first 6 postpartum months, peaking at 2 and 6 months after delivery.⁵ A large cohort

study that was conducted in Denmark reported that the first 90 days after delivery represented a time of increased risk of new-onset psychiatric disorder (mostly PPD) in new primiparous mothers, but not in new fathers. Other recent studies document an increased risk of MDD during the postpartum period. The prevalence of PPD varies in non-Western countries from 0.5–60%; cultural factors can influence the development and reporting of PPD.

A recent study identified difficulty falling asleep in the first 3 months after delivery as a possible risk factor for PPD. In addition, infant sleep disturbance may be both a risk factor for and an outcome of PPD in the early postpartum period. Studies have suggested that persistent infant and child sleep problems are related to maternal depression. Despite the consistent findings of a relationship between maternal depression and infant and child sleep problems, a causal pathway has not been determined, and few studies have measured infant sleep objectively. Numerous studies have reported on the low rates of screening, diagnosis, and treatment of perinatal depression in medical settings. Clinician discomfort with psychiatric disorders, time constraints, low belief in maternal mental health having an important effect on child development, and lack of knowledge about resources are some of the barriers to clinician screening for psychiatric disorders in medical settings. However, the postpartum obstetric visit and paediatric well-baby visits are opportunities for the clinician to assess the mother's clinical setting

CHAPTER III

METHOD

This chapter describes the research design, the sample, the tools used, the procedure adopted for the data collection and the statistical methods employed for the analysis of the collected data.

Participant characteristics

The sample of present study consisted of eighty (80) women selected from Alppuzha district using purposive sampling method. The age of the women ranged from 21 to 35 years the subjects wear taken from hospitals

Inclusive criteria

- The samplings must be women's.
- Age ranging from 21 to 35 was considered.
- The women's from Alappuzha districts were selected from the study.

Exclusion criteria

- Those who are above 35 years were excluded
- Samples from outside Alappuzha districts were excluded

Tools

Only questionnaire measures wear used in the present study. The measure used is Eysenck personality inventory scale in addition to these a personal data sheet was used to collect information on relevant socio-demographic variables such as age, religion, place of residence, monthly income, education number of siblings.

Personal data sheet;

In addition to the measures described above, a personal data sheet was used to obtain information from the women's on relevant socio-demographic variables such as personal educational and family history **Anxiety, depression and stress scale;**

Anxiety depression and stress scale (ADSS) was used in the study to compare anxiety depression and stress among women during prenatal and postnatal period. The ADSS scale was developed by Pallavi Bhatnagar, Megha Singh, Manoj Pandey, Sandhya and Amitabh. The scale consists of 48 items in which 19 items are based on anxiety, 15 items on depression and 14 items on stress. There were only 2 options; yes or no. Each item is scored 1 if endorsed yes and 0 if endorsed no. The range of score is 0-19 for anxiety subscale, 0-15 for depression subscale and 0-14 for stress subscale. Higher score indicates experiencing greater anxiety, depression and stress and vice-versa. **Research Design:**

The present research was descriptive in nature. Descriptive research involves collecting data in order to answer questions concerning the current status of the subjects of the study. A descriptive research determines and reports the way things are. As explained by Best and Khan (1992), "it is concerned with conditions or relationships that exists, opinions that are held, processes that are going on, effects that are evident or trends that are developing". Among the different methods that are used in the descriptive research, the survey method was used for the present study. A survey is an attempt to collect data from members of the population in order to determine the current status of the population with respect to one or more variables. In the

present study, the relevant data were collected using well established scales. The sample was selected using purposive sampling method. The responses were scored according to the respective manuals, and the data were analysed employing appropriate statistical methods using the SPSS.

Procedure

The research topic was A Comparative study on anxiety stress and depression among prenatal and postnatal women. The main procedure was to approach women and each person was given a questionnaire with 48 questions which was related to stress anxiety and depression in postnatal and prenatal women. Then they were asked to fill the questionnaire personally.

The samples were instructed as follows, ‘the given questionnaire has some statements that pertain to general life outcomes. Please indicate how much you agree or disagree with each statements of two point scale The two points are yes or no you have to put a tick mark on the point which suits you best there is no right or wrong answers. When you answer, mark the answer which comes first to your mind. Do not think too much about your answers answer each questions honestly start answering after understanding the instructions. Later, the filled questionnaires wear collected from women’s promising them that the information provided may be kept confidential.

RESULTS AND DISCUSSION

The present chapter discusses the result of analysis in the two sections the first section contains the sample distributions (frequency tables) in accordance with socio-demographic variables. The second sections contains the result of the comparison of different groups of socio-demographic variables with relationship between prenatal and postnatal in women

Measures and covariates The collected data were analysed using appropriate statistical techniques which included:

- Mean and standard deviation
- Correlation
- 't' test
- Independent t test
- One way ANOVA

In order to test the role of the selected socio-demographic variables the samples was classified into different categories the women's were tested using t test in case where only two are groups one way ANOVA where there are more than two groups

The 't' test

When making comparisons between the means of two samples or between some standard values the mean of one sample 't' tests are commonly used. The 't' test gives two statistics that can be used to conduct test of the mean at 't' value (T) and a p value (P). The 't'

value is not very informative by itself but it is used to calculate the P value. The P values tells you how likely it is that you would obtain your sample, with its mean and standard deviation, if the null hypothesis (H_0) is true, you must decide the P value is required to reject the H_0 before conducting the test. The value that you choose as your criterion is called the alpha level. If the P values are less than or equal to the alpha level, then you can reject H_0 and conclude that 'm' is not equal to the reference value.

ANOVA

An ANOVA test is a way to find out if survey or experiment results are significant in other words they help you to figure out if you need to reject the null hypothesis or accept the alternative hypothesis. One way ANOVA is used to compare two means from two independent group using the f distribution the null hypothesis for the test is that the two means are equal. Therefore a significant result means that the two means are unequal. The one way ANOVA will tell you that at least two groups wear different from each other but it won't tell you which groups were different. If your test returns a significant f-statistic, you may need to run an ad hoc (like the Least Significant Difference test) to tell you exactly which groups had a difference in means.

Correlation

In statistics, correlation or dependence is any statistical relationship, weather casual or not, between two random variables or bivariate data. In the broadest sense correlation is any statistical association, through it commonly refers to the degree to which pair of variables are linearly related in statistics, correlation or dependence is any statistical relationship, weather casual or not, between two random variables or bivariate data in the broadest sense correlation is any statistical association, though it commonly refers to the degree to which pair of variables are linearly related. Familiar examples of dependent phenomena include the correlation

between the physical statures of parents and their offspring, and the correlation between the price of a good and the quantity the consumers are willing to purchase, as it is depicted in the so-called demand curve. Correlations are useful because they can indicate a predictive relationship that can be exploited in practice. For example, an electrical utility may produce less power on a mild day based on the correlation between electricity demand and weather in this example, there is a casual relationship, because extreme weather cause people to use more electricity for heating or cooling. Correlation does not imply causation

Analysis of the background variables

Socio-demographic characteristics are expected to have a relationship between prenatal and postnatal among women. The socio-demographic details were examined and the breakup of the sample based on the variable are discussed in this section.

Table 1

Breakup of sample based on age

Age groups	Frequency	Percentage
21-25	18	22.5
26-30	40	50.0
31-35	22	27.5

Total	80	100.0
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As per the above table, majority of the samples (N=50) come under the age group of 26 to 30 years and its percentage is 50.0. The 22.5 percentage of the total sample are (N=18) belong to the age group of 26 to 30 years and 27.5percentage (of the total sample (N=22) belongs to the age group of 31 to 35.

Table**2**

Mean standard deviation and corresponding t values of the sample on the basis of prenatal delivery and postnatal delivery

Variables	Prenatal delivery (N=80)		Postnatal delivery (N=80)		t values
	Mean	SD	Mean	SD	
Anxiety	7.7750	4.14545	5.8750	5.27300	1.793
Depression	5.4250	3.70646	3.3750	3.40955	2.574*
Stress	6.1250	3.91046	4.6500	4.04811	1.657

As per the above table the t value obtained for anxiety is 1.793, depression is 2.574, and stress is 1.657. The p value for anxiety is 0.077, for depression is 0.012 and for stress is 0.101. Since the p value for anxiety and stress are greater 0.05 the null hypotheses there will be no significant difference in anxiety among women during prenatal and postnatal period and there

Table

will be no significant difference in stress among women during prenatal and postnatal period were accepted. The p value for depression is less than 0.05 and the null hypothesis there will be no significant difference in depression among women during prenatal and postnatal period is rejected.

3

Analysis of variance

		Sum	of	Mean Square	F	Sig.
		Squares	df			
anxiety	Between Groups	97.564	2	48.782	2.176	.120
	Within Groups	1725.986	77	22.415		
	Total	1823.550	79			
depression	Between Groups	110.549	2	55.275	4.421	.015*
	Within Groups	962.651	77	12.502		
	Total	1073.200	79			

Table

stress	Between Groups	110.413	2	55.206	3.638	.031*
	Within Groups	1168.575	77	15.176		
	Total	1278.988	79			

As per the table the 'p' value obtained for depression and stress are .015 and .031 respectively which are less than .05 and are significant. Hence the null hypothesis there will be no significant difference in stress and depression among women based on their age is rejected. The p value for anxiety is .120 which is not significant at .05 level. Hence the null hypothesis there will be no significant difference in anxiety among women based on their age is accepted.

4

Correlation matrix for anxiety, depression and stress

Variable	Anxiety	Depression	Stress
Anxiety	1		
Depression	.727**	1	

Table

Stress	.711**	.834**	1
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**correlation is significant at the 0.01 level (2tailed)

As per the table the relation between anxiety, depression and stress are significant at 0.01 level, hence the null hypothesis there will be no significant relationship between anxiety stress and depression among women during prenatal and postnatal period is rejected.

CHAPTER V

SUMMARY AND CONCLUSION

The objective of the study was to find if there was any role of age in prenatal and postnatal in women the socio demographic detail in this study included age there was equal distributions of the samples on the basis of age 75% of the people belong to the age group between 25-30 and only 20% of sample belong to the other age group .This study also reveals that there is a significance difference in postnatal women on the basis of their age this maybe of their age difference **Tenability of hypothesis**

Hypothesis 1

There will be no significant difference in anxiety among women during prenatal and postnatal period.

The hypothesis is accepted.

Hypothesis 2

There will be no significant difference in stress among women during prenatal and postnatal period.

The hypothesis is accepted.

Hypothesis 3

There will be no significant difference in depression among women during prenatal and postnatal period.

The hypothesis is rejected.

Hypothesis 4

There will be no significant difference in anxiety among women during prenatal and postnatal period based on their age.
The hypothesis is accepted.

Hypothesis 5

There will be no significant difference in depression among women during prenatal and postnatal period based on their age.
The hypothesis is rejected

Hypothesis 6

There will be no significant difference in stress among women during prenatal and postnatal period based on their age
The hypothesis is rejected.

Hypothesis 7

There will be no significant relationship between anxiety, depression and stress among women during prenatal and postnatal period
The hypothesis is rejected.

Implications of the study

- The present study has provided baseline information about anxiety, depression and stress among women during prenatal and postnatal period

- The findings of the study have helped to bring out the factors that are relevant in causing anxiety, depression and stress among women during prenatal and postnatal period

Limitations and suggestions

- Though the study has succeeded well in achieving its stated objectives and verifying the hypothesis formulated, being time bound study it has some limitations which are pointed out below.
- The study was conducted within a short period of time. If the study had been conducted through a long term process, it might have shown better results regarding the anxiety, depression and stress among women during prenatal and postnatal period
- The sample size of the study was small. Increased number of samples might have given a better picture of the study.
- There were many extraneous variables present which affected the results of the experiment.
- The present study was conducted only on the basis of their age. Also, if the study had been conducted on the basis of their quality of life and emotional well-being, it would have been more good and effective.

Conclusion

There is a relation between anxiety depression and stress among women during prenatal and postnatal period.

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APPENDIX 1

Name :

Age :

Sex :

Place :

Literature : Yes /No Education :

Occupation :

Income :

Marital status :

Type of family :

Total no of people :

APPENDIX 2

- 1) **I am aware of the dryness of my mouth**
- 2) **I feel difficulty while breathing (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)**
- 3) **I am not able to feel good**
- 4) **I find it difficult to relax**

- 5) I feel that I get upset easily
- 6) I often feel that I am not able to do anything
- 7) I often to have a feeling of numbness/shakiness in my hands and legs (e.g. legs going to give away
- 8) I find myself getting restless if delayed in any way
- 9) I feel that I have nothing to look forward to
- 10) I often feel down hearted and sad
- 11) I often get the feeling of faintness
- 12) I feel that I am rather touchy
- 13) I am not able to be enthusiastic about anything
- 14) I perspire heavily even in the absence of physical exertion and high temperature (e.g. hands sweaty)
- 15) I get scared without any good reason
- 16) I find as if I am getting more irritable
- 17) I find it hard to calm down after getting upset
- 18) I have difficulty in swallowing
- 19) I find that it is difficult for me tolerate any interruptions in whatever I am doing 20) I am worried about those things in which I might panic and make a fool of myself
- 21) I feel more nervous and anxious than usual
- 22) I have difficulty in taking the initiative for new task

- 23) I find myself getting agitated in everything
- 24) I am bothered about headaches, neck and back pains
- 25) I feel weak and get tired easily
- 26) I feel sad and depressed
- 27) I feel that I am losing interest in almost every thing
- 28) I can feel my heart beating fast
- 29) I am slow to respond
- 30) I feel extremely upset if exposed to events that remind me of similar stressful event
- 31) I feel that I am not worth as a person
- 32) I get feelings of numbness and tingling in my fingers, toes
- 33) I have no expectations/hope from the future
- 34) I am bothered by stomachs and indigestion
- 35) I have to empty my bladder often
- 36) I have repeated unwanted memories of the stressful events
- 37) I feel that my life is meaningless
- 38) I am not able to handle/control my feelings
- 39) I have nightmares
- 40) Often my mind goes blank
- 41) I have heavy pressure in
- 42) I often have crying bouts without any good reason

43) The stressful events goes problems in my relationships with other people

44) Often I want to be alone 45) Sometimes my vision is blurred

46) I have difficulty in concentrating the chest

47) Often I have feelings of nausea

48) I feel unwell