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Study on Psychological Well Being of Pregnant Women in Tamil Nadu

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ABSTRACT
Mental health can be described as the dynamic concept which is modified with time and changing perspective. It is defined as the harmonious and blissful state of being in world with a sense of purpose and growth. The mentally healthy person is the person who is free from internal conflict, who is not at war with herself or her ideal self and real self. Pregnancy is a biological phenomenon and characterized as the process of fertilization and development of one or more eggs. Its common name is gestation in humans. One scientific term for the state of pregnancy is gravity and the female is sometimes referred to as a gravid. Psychosocial models explain gender differences in morbidity and mortality focusing on variables at the intrapsychic and intrapersonal levels, including sex differences in personality, coping behaviors and self-efficacy. Other models postulates that the gender differences in morbidity are due to the differences in psychosocial risk factors, most importantly differences in quantity and quality of chronic stress, social inequality and social isolation. Indian conception of mental health is not only about healthy body but it includes as healthy mind. Health is seen as well-being in its broadest sense, not simply the absence of illness. Well-being is the complex interplay of biological, socio-cultural, psychological, economic and spiritual factors. In classical Indians, health is conceptualized as a state of delight or a feeling of spiritual, physical wellbeing. Drawing from Bhagvadgeeta states that human well-being unfolds at three levels namely, cognitive, conative and affective. It concludes that the women were happier in the third trimester than in the first trimester which has the least psychological Well-being reported by the respondents.

Key words*: mental health, well-being, stress, trimester*

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I. Introduction

Pregnancy is a biological phenomenon and characterized as the process of fertilization and development of one or more eggs. Its common name is gestation in humans. One scientific term for the state of pregnancy is gravity and the female is sometimes referred to as a gravida. Similarly, the term parity is used for the number of times a female has given birth including stillbirths. Medically, a woman who has never been pregnant is referred to as a nulli-gravida, a woman who is pregnant for the first time as a prima-gravida, and a woman in subsequent pregnancies as a multigravida or multiparous. As soon as a woman becomes pregnant, her body starts to change so that it can support both the mother and the unborn baby. During pregnancy, the women undergoes many physiological changes entirely normal, including cardiovascular, hematologic, metabolic, renal and respiratory changes that become very important in the event of complication.

Pregnancy may have adverse physical and psychological health outcomes for the mother as well as for her baby. As far as physical changes are concerned, minute ventilation is increased by 40 per cent in First Trimester. The womb will grow to the size of a lemon by eight weeks. During first trimester, in early weeks, the mother is likely to be more tired. As the uterus begins to grow the bump becomes visible. General health is affected in the form of tiredness, nausea, constipation, frequent urination, food craving, change in the size of breasts, fainting or dizziness, blotted stomach and high emotion. Pregnant women often experience a host of symptoms including extreme fatigue.

Weeks 13 to 28 of the pregnancy are called Second Trimester. The uterus, the muscular organ, that holds the developing fetus, can expand up to 20 times its normal size during pregnancy. The movement of fetus, often referred to as "quickening", can be felt. In second trimester, most of women feel more energized and begin to put on weight as the symptoms of morning sickness subside and eventually fade away. There can be mild swelling in feet, ankles, on hands and face. Constipation, heartburn and indigestion are common. The hormones estrogen progesterone, human placental lactogen, oxytocin, and prolactin prepare body for feeding the baby and cause the breasts to enlarge, become painful and tender. The fetus, placenta and amniotic fluid account for just

over a third of the weight gain during pregnancy. The remaining weight comes from increased blood volume, fluid retention and extra body fat.

In Third Trimester**,** the physical changes like most of weight gain, changes in waistline, widening hips, strong fetal movements, weak bladder control, backache and perpetual sensation of baby fall, and breathing changes occur. The final weight gain takes place, which is the most weight gain throughout pregnancy. In second trimester, the woman's abdomen would have been very upright, whereas in the final trimester of pregnancy it starts drop down quite low. The woman's abdomen will transform in shape as it drops due to the fetus turning in a downward position ready for birth. The navel will sometimes become convex, 'popping out', due to her expanding abdomen. The fetus begins to move regularly. It can become quite strong and be disruptive to the woman. Head engagement, where the fetal head descends into cephalic presentation, relieves pressure on the upper abdomen with renewed ease in breathing. Shortness of breath, tiredness, difficulty in moving and sleeping, and frequent urination may be felt by the pregnant lady. However, it severely reduces bladder capacity, increases pressure on the pelvic floor and the rectum. The baby grows and pushes lower back of the mother. At this stage, mother feels the movement of the fetus. Other sign may be the nipples secreting colostrum, 'Braxton-Hicks' contraction (contraction of uterus usually known as false labour) may begin, and blood flow to the womb is increased tenfold since conception.

Mental Health

Mental health can be described as the dynamic concept which is modified with time and changing perspective. It is defined as the harmonious and blissful state of being in world with a sense of purpose and growth. So it is the state of balance between the individual and the surrounding world, State of harmony between oneself and others, coexistence between the realities of the self and that of other people and that of the environment with a sense of equality and equity with all persons. The mentally healthy person is the person who is free from internal conflict, who is not at war with herself or her ideal self and real self. Further mentally healthy person knows herself; this is to say that, she understands her needs, problems and goals, she has good self-Control, i.e., she is able to balance rationality and emotionality.

Theories of Mental health and well-being

As discussed it is observable that mental health is a dynamic concept, as earlier biomedical model of health where hormonal, structural changes, genes, personal disposition were main focus. Women were acknowledged more vulnerable to mental disorders or illnesses. Considering this model differences between genders widen because specific health protective and damaging factors can affect men and women differently. Later focus shifted to psychological cognitive model where brain and thinking differences were captured but the issue remains the same gender was treated as a variable to be controlled. Half of the human population was continued to be ignored. In researches the social factor were taken in to consideration in mental health pave the way to think about women illness in less biased way. Psychosocial perspective focuses how our social environment directs to cognitive world of human so determine its positive and negative mental health. Here women get some space to express them. There are ample of studies reporting higher anxiety, higher depression and other psychiatric disorders among women. In the field of psychology whenever women's mental health has been discussed, it is always in terms of absence or presence of mental illness. Although there is focus on positive mental health but always in relation to marriage, motherhood etc.

Psychosocial model of mental health

Psychosocial models explain gender differences in morbidity and mortality focusing on variables at the intrapsychic and intrapersonal levels, including sex differences in personality, coping behaviors and self-efficacy. Other models postulates that the gender differences in morbidity are due to the differences in psychosocial risk factors, most importantly differences in quantity and quality of chronic stress, social inequality and social isolation. This model also includes the effect of experiences across the life-span and the social and economic roles, the influence of environment, culture, psychology and social factors have on health.

Indian concept of mental health

Indian conception of mental health is not only about healthy body but it includes as healthy mind. Health is seen as well-being in its broadest sense, not simply the absence of illness. Well-being is the complex interplay of biological, socio-cultural, psychological, economic and spiritual factors. In classical Indians, health is conceptualized as a state of delight or a feeling of spiritual, physical wellbeing. Drawing from Bhagvadgeeta states that human well-being unfolds at three levels namely, cognitive, conative and affective. The cognitive level talks about self with its lustful inclinations, desire and attachments (Asakti). At the conative level wellbeing lies in the performance of one's duty or karma. Lastly at the affective level, well-being lies in the attainment of freedom from " I" and "mine". Being embedded in a socio-cultural context people imbibes beliefs

system that structures the meaning of health and illness. By adopting gender perspectives it is supposed that women are positioned at cognitive level nevertheless affective level, Indian women are rarely imagined thus this area also become defined by male perspective.

Mental health and well-being of women

Gender is socio cultural concept and gender difference are constructed and perpetuated by traditions. Butler (1990) writes: Gender is an identity tenuously constituted in time, instituted in an exterior space through a stylized repetition of acts. The effort of gender is produced through the stylization of the body and, hence, must be understood as the mundane way in which bodily gestures, movements, and styles of various kinds constitute the illusion of an abiding gendered life. Mental health is not solely determined by an individual's characteristics, society law, and family other factors have equal importance. In Indian literature *Mitakshra* states that women must serve her father, then her husband and later her son. She must live in servitude. She deserves no liberty .If we see the definition of mental health it's about liberty, self-actualization, autonomy and these are prohibited to practice for women. It reflects that how women issues were neglected and defined in biased term. Indian constitution provides equality before law and declares discrimination as offence based on gender castes, religion etc. But in practice there is hardly any case which justify discrimination based on gender as offence and traditional role are such as modesty is always appreciated. Gender stereotypes are prevalent in assessing mental health too. Attributes associated with a traditional and predominant version of femininity passive, nurturing, gentle, submissive, yielding, tender, dependent, collaborative, emotional, supportive, fragile, sympathetic, vulnerable and modest etc.

Feminine identity and Well-being

Autonomy: Autonomy is prohibited for a woman in Indian literature. As we have already discussed what *Manusmiriti* says that women should be always subservient to men, she deserves no liberty. Other saying similar to restricting autonomy is:

" Woman is an embodiment of the worst desires, hatred, deceit, jealousy and bad character. Women should never be given freedom. (Manu IX. 17 and V. 47, 147) ".

By the definition of well-being autonomy is primary demand for experiencing well-being. Women in India are aware of their suppression, felt betrayed and rejection of their deep felt true emotion but can't revolt against patriarchal culture. Women are half population, equal contributor in economy but yet not have a say in matters regarding control over their own sexuality and reproduction**.**

STRESS

Stress is defined in a multiple way, such as physiological social and cognitive terms. Stress affect mental health in a various ways as it's not only a negative experience. Positive stress is termed as eustress whereas negative stress as distress. Experience of stress is necessary to develop the sense of efficacy, positive evaluation of self by overcoming it. So stress can be defined as state of imbalance within individual due to interaction with environment. The concept of stress in the modern terms is not easily found in the traditional texts of Indian culture and traditions such as Charak Samhita, Patanjali's Yogasutra and Bhagwad Gita.

Sources of Stress in women's Life

Smith (1993) identified four interesting sources of stress. 1) A Hostile work environment (e.g. discrimination and sexual harassment) Friedman (1988) observes that women who have succeeded to break the glass ceiling have made more personal sacrifices and have had to experience greater psychological conflict and stress. 2) An unsupported home – e.g. the double shift of house work. 3) A disapproving social environment. e.g conflict of values, specially between employment and parenting. 4) Individual's self-concept e.g. conflict between real' and ought selves', the super women syndrome. Thus for the women, the source of stress associated with being employed are multiple and associated with complexity and contradictions of their multiple locations within society.

Coping

Coping is primarily a psychological concept. The coping process in its broadest sense refers to any attempt to deal with stressful situation when a person feels she must something do about it. The word coping is frequently used to describe ways of dealing with stress or to modify or elevate the conditions causing harm, threat or challenge. Coping response can be active in nature and oriented towards confronting a problem, or they can be strategies that entail an effort to reduce tension by avoiding or dealing with problems. Thus coping turns to be significant factor in determining mental health of women by altering making positive or realistic appraisal of their self, relating positively with others, autonomy, harmony and other aspects of mental health.

The main objectives of the Study

I. To understand the mental health, well-being, stress and coping strategies of women, both employed and homemaker in the study area.

II. To investigate if there is any difference between the employed and home makers women and to explore why this difference exit.

III. To study the effect of rural and urban areas on mental health, well-being, stress and coping strategies of women.

Hypothesis of the Study

1. There will be significant difference in and among employed and homemakers of rural and urban areas on the level of mental health and well-being.
2. There will be significant relationships between dimensions of mental health and coping strategies across all groups of subjects under study.
3. There will be significant relationships between well-being and dimensions of daily stress across all groups of subjects under study.

II. Methodology

On the basis of review of studies related to mental health and wellbeing of Indian women following method was adopted to achieve the research objectives. The research design is cross-sectional, descriptive, and co-relational. The study is focused on women's issues of mental health in rural and urban areas in employed women and homemakers. There are several reason behind this division, one of the most important being that the bulk of literature on women in mental health tend to concentrate on one or other area and usually comparison is made with men, ignoring realities of gender inequality, different standard of behaviour in existing society. The chapter represents the methods and procedure adopted for the present investigation which was conducted to measure general health, psychological well-being and depression during pregnancy (first and third trimester) and postpartum periodamong women in Tamil Nadu. A total sample of 100 educated women was selected from various hospitals in Karur district of Tamil Nadu. These hospitals are well-known Maternity Hospital with all nursing home facilities. However, the final sample available for the analysis was substantially lower, i.e., 80 women for several reasons. First, the data was collected during several assessments, two times in the pre-partum and one month postpartum. Five cases could not be traced down or did not wish to complete the questionnaire due to their personal circumstances. Second, some of the participants, i.e., six women had miscarriages and pregnancy related complications which led to abortion, and premature delivery.Third, we excluded nine cases that did not complete the questionnaires given in the allotted time period, i.e., first and third trimester of pregnancy and one month postpartum period only.

TOOLS USED

To assess general health among women, GHQ-28 by Goldberg and Hiller (1979) was used. The GHQ-28 is frequently used as an indicator of general health. Chinese Happiness Inventory (CHI) constructed by Lu and Shih (1997) was used for measuring Psychological Well- Being of the selected sample of women.Happiness was measured by Indian adopted version of CHI. Zung Self-Rating Depression Scale (ZSDS) developed by Zung (1965) was chosen to assess depression because of its accepted clinical value. It covers a broad range of depressive symptomology, dealing with the areas of pervasive affect, physiological equivalents and psychological concomitants. One way repeated measure, correlation and regression analysis were also carried out to analyze the data.

The Postpartum Questionnaire

The postpartum questionnaire which was administered one month postpartum period included questions regarding the delivery details. The details included the data regarding, mode of delivery, gender of the newly born baby, and satisfaction regarding the gender of the baby born. There were some questions or information sought from the women which were repeated during the three time period, i.e., first and third trimester of pregnancy and onemonth postpartum.

Results and Interpretation

From the collected data this study clearly indicate that 100 per cent of the selectedwomen were Hindus since Tamil Nadu is predominantly a Hindu state. Hundred per cent of the respondents belonged to joint family structure. From the data it is observed that a little more than half of the respondents (53.8 per cent) had a family size of 6-10 members and more than one- third (38.8 per cent) represented a family size of up to 5 members. Only 6 women had family size of 11-15 members. It is evident that very little per cent of the respondents belonged to lowest economic status, i.e., below Rs.5,000 (6.3 per cent) and highest economic status, i.e.,

Rs.50,000 and above (10 per cent). Approximately, 42.5 per cent of the sample fell in the range of Rs.5,000-Rs.15,000 and 21.3 per cent fell in the rangeof Rs.15,000- Rs.25,000, while 20.0 per cent of the sample was in the range of Rs.25,000 – Rs.50,000 of economic strata. This study revealed that all the women were literate. Most of the women (37.5 per cent) had attained average level of education, i.e., matriculate to senior secondary educational level. Further, this analysis revealed that about 28.8per cent of the respondents were graduates, while 30 per cent were post graduate and having higher level of education. Furtherly, this study evealed that a little less than two- third of the women were prima parous (60 per cent). Adding to it, 30 per cent of the women were pregnant the second time. Further, it is evident that about 8.8 per cent of the respondents were having 3rd pregnancy. The table also indicate that only 1.3 per cent of the women had 6 and above number of pregnancies. The information regarding the use of contraceptive to maintain the gap between two successive pregnancies has been analysed. It is observed from this study that the contraceptives were usedto maintain the time period between two pregnancies by 31.25 per cent of the respondents, while 68.84 per cent didn't use the contraceptives perhaps because 60 per cent of the women were prima-parous. Evident from the data it is showed all the women were healthy (98.75 per cent) with no prior ailment except one (1.25 per cent) who was suffering from thyroid disorder.The table and the figure showed that as far as desired gender of the unborn baby is concerned an overwhelming majority of the women (98.75 per cent) did not give any preference to any particular gender of the baby except one who preferred to have amale child (1.25 per cent).

Information regarding family support was collected from the selected women during first and third trimester and during postpartum period through the questionnairesdesigned separately for the time periods, i.e., the pregnancy (first and third trimester) and the postpartum period. The information for the three time periods has been depicted. It is evident from the sample respondents that all the selected women (100 per cent) had full support from the family (in- laws and parents) and from their partners as well during first trimester. It is clearly stated in this study that all the women (100 per cent) were having family support during postpartum period as well. They were all given proper care by the parents, in-laws and husband during postpartum period which is further depicted in the Figure 5.1.3C. It can be concluded from the results of the above section that joint family holdsa lot of significance in this small hill state bearing the fact that hundred per cent of the respondents were having joint household structure. Very little percentage of the working women (18.18 per cent) were having government and permanent jobs; while rest and a majority of the respondents who were working were engaged in privatesectors and were on contractual basis (81.82 per cent).

According to the labour law Maternity leave and Child care leave to the mothers have been made compulsory and is the liability of the companies or of the employer. The information regarding the leave (maternity and child care leave) entitlement has been presented. It is evident that all the women (18.18 per cent) who were working in government sector had maternity leave facility, while 81.82 per cent of the sample did not have maternity leave facility. This is because these women were working in private sector where they don't seem to be following the labour laws strictly.

This study reveals that all the women felt inadequate to meet the job demands physically during the postpartum period (100 per cent),whichwas followed by first trimester (72.73 per cent) and were least affected physically during third trimester (63.64 per cent). Only 36.36 per cent of the women in third trimester and 27.27 per cent of the women in the first trimester were physically able and adequate to meet their job demands. It can be inferred that all the women (100per cent) during first and third trimester and 77.27 per cent of the women during postpartum period were psychologically capable to perform their duties well. Only 22.73 per cent of the respondents were not able to meet their job demands psychologically particularly during the postpartum period.

More than half of the respondents (54.54 per cent) were emotionally strong enough to meet their job demands during first trimester. On the other hand, 45.46 per cent of the women felt most inadequate to meet the job demands emotionally during first trimester. Furthermore, it is interesting to note from the results that none of the respondents felt emotionally inadequate to meet their job demands during third trimester and postpartum period. It can be concluded from the results of this section that most of the working women were physically inadequate to meet their job demands during the postpartum period as compared to first and third trimester of pregnancy. The women showed more physical inadequacy in the beginning of the pregnancy than the later stage of pregnancy. The data analysis also revealed that all working women were psychologically strong enough to meet their job demands during pregnancy. In addition to this, only few working women felt psychological inadequate to meet their job demands during postpartum period. The results also reflected that there was an emotional fluctuation among the women which made them inadequate to their job demands during first trimester of pregnancy only. All of the working women felt adequate to meet their job demands in both the time periods, i.e., third trimester of pregnancy and postpartum period. Out of 80 women 53.8per cent delivered baby boy, while 46.3per cent delivered baby girl, mostly as per the timings doctors apprehended. It is therefore concluded that most of the women had a normal delivery. Majority of them delivered baby boy. All women were happy about the gender of the new born baby.

III. Conclusion

From the above reported results it can be concluded that there was a significant difference in the well-being of the women during all the three time periods i.e. first and third trimester, and the postpartum period. The increasing trend in the mean scores further revealed that the women had highest psychological well-being during the postpartum period than the other time periods i.e. first trimester and the third trimester. The women were happier in the third trimester than in the first trimester which has the least psychological Well-being reported by the respondents.

BIBLIOGRAPHY

[1]. Depression and other common mental disorders: global health estimates. Geneva: World Health organisation ; 2019.
[2]. National Mental Health Survey of India, 2015-2016.Prevalenc e,pattern and Outcomes.
[3]. Maternal mental health and child health and development in low and middle income countries. A report of UNFPA & WHO meeting, 2018.
[4]. Maria Muzik, MD MS and Stefana Borovska. Perinatal depression: implications for child mental health**.** Ment Health Fam Med. 2019 Dec; 7(4): 239–247.
[5]. Charlson FJ, Baxter AJ, Cheng HG, Shidhaye R, Whiteford HA. The burden of mental, neurological, and substance use disorders in China and India: a systematic analysis of community representative epidemiological studies. Lancet. 2020 ;388:376–89.
[6]. Teixeria JM, Fisk NM, Glover V. Association between maternal anxiety in pregnancy and increased uterine artery resistance index: cohort based study.BMJ 1999; 318(7193) : 1288- 1289
[7]. Christine Rubertsson, Ulla Waldenström & Birgitta Wickberg. Depressive mood in early pregnancy: Prevalence and women at risk in a national Swedish sample. Journal of Reproductive and infant psychology 2017; 21 (2):113-123.
[8]. K. A. Mariam, Krishnamachari Srinivasan. Antenatal psychological distress and postnatal depression: A prospective study from an urban clinic. Asian Journal of Psychiatry June 2009.
[9]. Shaunak Ajinkya, Pradeep R. Jadhav, and Nimisha N. Srivastava. Depression during pregnancy: Prevalence and obstetric risk factors among pregnant women attending a tertiary care hospital in Navi Mumbai. Ind Psychiatry J. 2018.
[10]. L Manikkam, J K Burns.Antenatal depression and its risk factors: An urban prevalence study in KwaZulu-Natal.The South African medical journal 2019;Vol 102(12): 940-94.