Quest Journals
Journal of Research in Pharmaceutical Science
Volume 4 ~ Issue 1 (2018) pp: 41-47
ISSN(Online) : 2347-2995
www.questjournals.org

Research Paper

Maternal Distress In Labour: Concept Paper.

Agness Murombedzi, Gladys Mugadza, Christine Mary Kasu, Abigail Kapfunde, Clara Haruzivishe
Corresponding author: Agness Murombedzi.

ABSTRACT:*Pregnant women go through varying adaptations which worsen in labour throughout the post - natal period.*
Objective:*The thrust of the concept analysis was to describe the concept maternal distress in order to clarify meaning among nurse midwives.*
Methodology:*(Walker & Avant, 2011)concept analysis model was used to guide this paper.*
The following search engines, Google Scholar, PubMed and Medline were utilised to select 15 articles relevant to the concept of interest.
Results:*Attributes like transition to motherhood, stress and functioning and control were identified. Antecedents to maternal distress included becoming a mother, role changes, body changes, increased demands and birth experiences. The consequences of maternal distress are compromised mental status maternal, role development, quality of life, relationships and social engagement.*
Conclusion:*Maternal distress interpretation offers a comprehensive approach health ante natally and intra partum. Support on women's experiences would alleviate the struggles and hardships to understanding maternal emotional.*
KEY WORDS:*Maternal distress, pregnancy, labour.*

R*eceived; 13 October. 2018 Accepted; 29 October. 2018;*

I. INTRODUCTION AND BACKGROUND

However historically, regionally and nationally maternal distress in labour has not been looked into hence no rates readily available. Globally maternal distress rates vary between 10% and41% this makes it a public health concern (Fontein-Kuipers et al., 2015).

WHO(2015), 289000 women worldwide died because of consequences related to pregnancy and child birth maternal distress included representing 800 maternal deaths daily(Murtaja & Thabet, 2017). However presence of maternal distress and its association with pregnancy and maternal mortality is not well understood.

In a study conducted in the Netherlands maternal distress accounted for 12.3% with 11.7%of them feeling anxious 17.9% depressed and 20.6% stressed.During in pregnancy the woman under goes physiological changes that upset her e.g.enlarged breasts and tummy, clothes not fitting well, not eating well and many others. The transition from girlhood to motherhood is the most stressful and disruptive life transition worsened by bad experiences in labour. It needs a lot of attention to minimise the associated depression and anxiety states (Li et al., 2017)

The bad experiences in labour which include unattended pain complaints which are not attended to and no explanation is given yet analgesia is given as per cervical dilatation distress the woman.

Thirst and heat is common in labour however the woman is not allowed to drink in case may need caesarean section, but if reason not explained this is so distressing to the mother. Theexperience of the effects of abnormal vital signs e.g. elevated blood pressure worry the mother and she may expect a bad outcome of the baby.

The mother has depression and anxiety and the baby has childhood obesity, low birth weight, prematurity and intrauterine growth retardation(Rondó & Souza, 2007)The family may be disrupted and the baby may be neglected since the mother had a bad experience in labour.

From the researcher's perspective there is no special care of women who have undergone distressing labour yet this is detrimental to the mother and baby. Even when discharged no follow up or even review post-

natally.Yet these are the mothers who would present with postpartum problems such as psychosis and self-neglect.

Past research has found that perceived stress may lead to new mother neglecting her own health promoting behaviours in her effort to balance the competing priorities of being a first time mother (Li et al., 2017).

Strategies identified by some researches include that the ante natal package and training curricular of midwivesinclude maternal distress as a topic so that they are equipped to deal with maternal distressas prevention is crucial.

11. Problem Statement

Maternal distress is more than a physical psychological phenomenon, but it encompasses symptoms like isolation aloneness and feeling depleted(Barclay & Lloyd, 1996). As mothers go through pregnancy and labour they go through a lot of unnoticed distress which only manifests post-delivery. There are varying definitions of by various authors making diagnosis of the concept difficult.The variations has led to women being missed in the management process following giving birth.

111. Purpose

The purpose of the concept paper is to describe the concept maternal distress in labour in order to clarify meaning among midwives.

Iv.Significance Of Concept

A concept analysis on maternal distress in labour will foster common understanding among nurse midwives across board. Common understanding will help in coming up with a standardised management protocol such that affected women will not be missed.

At risk mothers will receive specialised care thus working towards reduction of maternal morbidity and mortality. If nurse midwives are clear on the meaning and attributes of what maternal distress in labour entails they become empowered, confident and display sound evidence based practice.

II. LITERATURE REVIEW

Literature review was done as from 5 July2018 to 30 July 2018. Literature was sought from dictionaries, Google scholar and text books. Terms maternal distress in labour, pregnancy and concept analysis were used to search for relevant literature. Fifteen (15) articles were retrieved but the researcher settled for 11.

The researcher rejected some articles because they did not specifically bring out maternal distress in labour but ante-natally and post natally. Articles from 1996 to 2017 were reviewed so as to capture the meaning of maternal distress from as far back .Very few articles discussed maternal distress in labour so onlysettled for 11.

Table1.

Author	Source	Definition	Antecedents	Attributes	Comments
(Barclay&Lloyd, 1996)	Midwifery journal	No	No	Misery and isolation.	Described transition to motherhood distress.
(Edge & Rogers, 2005)	Social science medicine article	No	No	No	Psychological distress associated with pregnancy, child birth and early motherhood.
(Emmanuel & St John, 2010)	Journal of Advanced Nursing. (JAN)	No	Yes	Yes	Antecedence were described.
(Fontein-Kuipers et al., 2015)	Sciforschen Review Article, Vol 1:1	A variety of psychological constructs that occur ante natally and intrapartum.	No	No	Not an analysis of concept but relates to presents of Maternal distress.
Gaza, Veloz et.al. (2017).	Journal of Obstetrics and Gynaecology	Acute somatic symptoms social dysfunction, anxiety.	No	No	Need a tool for diagnosis of MD and management
(Ingstrup et al., 2012)	Journal of Obesity Research Article	Depression or stress during	No	No	Children develop obesity due to

	Vol 20	pregnancy			maternal distress.
(Paarlberg, Vingerhoets, Passchier, Dekker, & Van Geijn, 1995)	Kurja Ch 188.Stress in labour.	Yes	No	No	Preterm delivery leads to maternal distress.
(Pirdel & Pirdel, 2009)	Journal Reproductive Infertility Vol 10,No 3.	Psychological stress and a combination of fear and pain in labour	No	No	Negative pregnancy results cause maternal distress.
(Sawyer & Ayers, 2009)	Article: Post traumatic stress in women after child birth.	Adverse child birth experiences.	No	No	MD caused by severe pain, threat of death and unexpected medical interventions.
(Van Gampelaere et al., 2018)	Article: Maternal distress in the context of child's type 1 diabetes mellitus.	No	No	No	Distress thought to lead to diabetes in the child.
(Wijma, Söderquist, & Wijma, 1997)	Journal: anxiety disorders 11, 587-597.	Post-traumatic Stress occurring in women after birth	No	No	Stress due to delivery

III. METHODOLOGY

The researchers used Walker and Avant, (2011)'s eight steps of concept analysis as outlined below:

1. Selection of the concept.
2. Determining the purpose of the concept analysis.
3. Identifying uses of the concept
4. Determining the defining attributes of the concept.
5. Identifying antecedents of the concept.
6. Identifying the consequences of the concept.
7. Constructing a model case.
8. Identifying the empirical referents of the concept.

1.Define Concept

According to Kuipers et al., (2016) maternal distress is when woman's emotional well-being is affected accompanied by psychological signs and symptoms during pregnancy.Gaza, Veloz et al., (2017) maternal distress is the presence of acute somatic symptoms, social dysfunction and anxiety. Ingstrup et al., (2012) defined maternal distress as feeling depressed or stressed during labour and pregnancy. Kuipers et al.,(2015) defined it as a spectrum consisting of a variety of psychological constructs that occur during antenatal and intrapartum specifically related to pregnancy.

The above definitions did not bring out the attributes antecedence for maternal distress in labour though they brought out the fact that women are distressed by pregnancy itself and the changes that occur.

2.Working Definition

Following the review of literature the researchers define maternal distress in labour as the psychosocial, physical and emotional effects of pregnancy in ante natally through labour and into post-partum. Any effects which are outside the normal physiological function of the pregnant woman is maternal distress as it has detrimental effects to the mother and the baby.

3.Antecedence

According to Walker and Avant, (2011) these are incidents that occur prior to the prevailing of the concept of interest, they have a light touch on the concept. In the context of this paper, the antecedence for maternal distress are outlined below.

3.1. Psychological trauma: This is when the mother has different feelings and thoughts about the outcome of the pregnancy. Emotional effects include deep feelings towards the process of labour and her experiences with midwives.

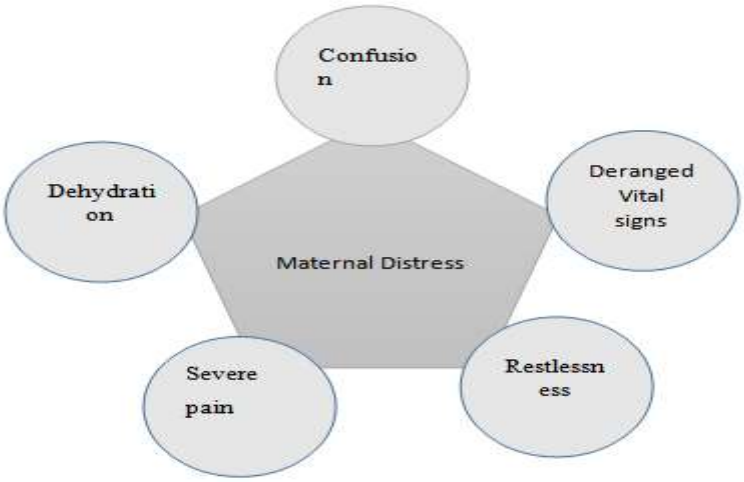
3.2. Physically: The mother is exhausted due to the effects of the labour .Theage of the woman affects her response to the labour and decision making asshe is too young.

3.3. Religion:the pain is too much and cannot scream this is against the church yet others are screaming and are being helped.
3.4. Circumstances: If the pregnancy occurred due to rape and now it is so painful and looks like no one cares this is distressing.
3.5. **Unintended marriage**.Already she is stressed by the marriage where she had to get married for convenience yet she had own plans. The family is not amused and arrogant.
3.6.**Uncontrolled pain**: This worsensmaternal distress as well as unmet physical needs intrapartum e.g. thirst,attitude of nurses and difficult labour all compound to maternal distress
3.7.**Poor maternal nutrition**:This makes her generally weak and may not be able to cope with the labour may be due to the anaemia which may cause fainting attacks.
3.8. Thirst and feeling hot: This is as a result of the effects of labour, she asks for water and she is not given and no one even bothers to explain.
3.9.**Hypertonic uterine contractions**: These make the whole experience uncomfortable. Even the screaming of some mothers aggravate her situation and may even join them (Emmanuel, 2010).

IV. ATTRIBUTES

Attributes are characteristics that keep on appearing which make it possible to measure the concept (Walker and Avant, 2011).In this case this is the characteristic necessary for maternal distress to occur.

Figure 1.



Vital signs which are abnormale.g. very low blood pressure 90/60 mmhg or very high 160/110 mmhg and midwives are running around yet patient is not informed. Anxiety and confusion mounts as she fears for her baby. The nursesshouting at each other including her yet, no explanation is given. When in need e.g. of water for thirst and heat or opening of windows she is denied and this instils fear, acutepsychosis, restlessness and hatred. When she asks for a pain killer for the severe pain no one gives her yet she was told she could get it.
The care should be rendered in privacy with confidentiality but in her case she is in an open ward and everyone can hear what is happening with some patients even commenting.

V. DISCUSSION:

Search terms used may have narrowed the findings of the concept and the concept has not been well discussed before. Conceptual structure of maternal distress describes a woman's response to transition from girlhood to motherhood and not in labour (Barclay et al., 1997).

Conceptualisation of maternal distress acknowledges and normalises feelings of distress through pregnancy and labour and not labelling them as problems.

Maternal distress is a difficult concept to define where there are other confounders within it.The definition of maternal distress was done according to different authors.

The variety of women's responses to the different predisposing factors for maternal distress underscores the individuality of maternal distress. Variability of populations should be considered in practice, education, organisation of care, interventions and research. Individual health care settings and individual populations of pregnant women require appropriate indexes of vulnerability of maternal distress (Emmanuel, 2010).

The general people view maternal distress in labour as a bad omen for the pregnancy as they believe that pregnancy is normal and has a good normal outcome.

The paper aimed to clarify what maternal distress in labour is and help eradicate it if possible and allow midwives to be able to identify a woman with maternal distress and help her as stipulated. The midwives would also work in a manner that does not induce maternal distress.

From the researcher's perspective when maternal distress is documented the midwives on their own can make decisions when they identify maternal distress indicating danger to the mother and the foetus and they will take action expeditiously.

VI. CASES:

Both Chinn & Kramer (2013) and Walker and Avant (2011) emphasise the importance of identifying critical attributes for synthesis of a concept analysis.

6.1. Model Case

This is a case where all attributes related to the concept under study are present (Walker and Avant, 2011). Model case gives a true view of the concept and allows the analyst to compare one case against its opposite.

Miss Maria Choto is single and para 0 gravida1 is admitted in active labour in the evening. She is unbooked pregnancy. Soon after arriving hedrove off to attend to his self-job.

Miss Choto shared a room with another woman who had her partner in. No privacy maintained, environment dirty and noisy.

The midwife attended to her in a hurried manner indicating that she was not amused by her not booking. She further rebuked her when she said that she had no money for booking by saying she should have abstained, or used protection.

On examination she was in active labour, foetal heart heard and regular however she was unsettled because of pain. She pushed with every contraction. Pethidine was not given for pain .She was restless moving up and about, high pitched screaming and pushing with each contraction.

She was unco-operative such that examination could not be done properly. The midwife was put off, left her and attended to others and told her that she would only return when settled. At the height of the process she lost it such that when asked to push or stop she did not comply.The midwife slapped her thighs and tied her to lithotomy poles. Episiotomy was performed without analgesia as she realised the danger for the baby. A live baby girl was delivered finally. Breast feeding was not initiated and no support for motherhood.

Miss Choto had no money for hospital bill so she was detained for two days .The partner did not visit. She had to be given donated clothes for baby on discharge.

6.2 Analysis:

The model case had maternal distress for example unbooked, pain, lack of psychological support from family and midwife, uncooperative, dumped by the partner and many more.

6 3. Borderline Case

This is a case which contains some of the crucial attributes but not all of them (Walker and Avant, 2011).Rita is a 13year old, married woman reports to the hospital in advanced stage of labour accompanied by her mother in law. She booked and had 4 ante natal visits. She attended the health education sessions on each visit. On admission privacy was maintained.

On examination she had been draining liquor for almost a day and says she was waiting for labour pain to start. A prescription for antibiotics was written and the mother in law said she would wait for her son as she had no idea of where to get the drugs.

The recordings on the partogram indicated maternal distress with anuria, respiratory distress, fluctuating blood pressure, proteinuria, ketones, restlessness and some confusion .She requested analgesia as her pain threshold was 9-10 for hours and midwives did not give her.

Rita felt hot thirsty and hot,she asked for water and opening of windows, nothing was done. She sat on the cool floor and was hurriedly asked to get on to the bed. She tried walking around and was labelled unco-operative.

Rita had no idea of what was happening to her. She thought it was a bad omen .She got anxious and anticipated loss of her baby. She hated self for getting pregnant and cursed the baby in utero for causing so much trauma on her. In her horror and confusion she shouted divorce with husband after delivery.

Finally when she had full cervical dilatation she tried to push but was too tired. Midwives reminded her that this is why they were asking her to sit down and reserve energy. For the purpose of saving the baby delivery was assisted with forceps and a generous episiotomy.

She had a baby boy whom she named Nhamo.

6.4. Analysis:
The case contains some of the attributes but not all of them. The mother goes to hospital has good care and good outcome. History taking and physical examination is done.

6.5. Contrary Case:

A 26 year old woman Mrs Maruva reported in labour at a maternity hospital. She was escorted by her mother, her sister and husband as she had returned to her parents' home as per culture for first pregnancy.

She is para 0 gravid1.She booked and had 3 Ante Natal visits hence had some information on labour experiences. She was attended by midwives who assessed her for progress and stage of labour.

For her care she was allocated her own midwife though it was emphasised that other midwives would still attend to her. The environment was conducive and she was even happier when she was allowed to have her cell phone for communication .The husband was offered to stay in. Confidentiality was assured as she decided who should know her progress.

Mrs Maruva had a small purse with a string around her waist which she said it was for delaying progress so that she would not deliver before arriving at hospital. The midwife acknowledged the information and politely asked her to remove it since she was safe now. On assessment by the doctor she was informed that labour would progress well.

Pain management was discussed and she acknowledged that it was a reinforcement from antenatal clinic. She allowed midwives to give her the appropriate analgesia as recommended.

Mrs Maruva was allowed to walk around to aid descent by gravity. She was allowed fluids as she was in early labour. Her labour progressed well, vital signs were within normal ranges, with good urine output.

She delivered normally, a baby boy whom she named Junior to father as she initiated breastfeeding. She was transferred to post- natal ward where she settled comfortably. On the exit interview she applauded the care rendered, indicated return and advise her friends to use the facility.

6.6. Analysis
The above case indicates the good practice that can reduce maternal distress in labour through good care and health education. On admission and throughout the whole process of parturition procedures and examinations were done. Post-delivery care was done, as well as highlight of review date.

Empirical Reference
These are the classes or categories of actual phenomena that by their presence demonstrate maternal distress. They include restlessness, anxiety, confusion, fatigue, enmity, abnormal observations.
Anger, uncooperativeness during procedures, screaming, poor outcome of pregnancy, self-neglect and family.

Concequences:

These are events that occur as a result of maternal distress. They include support, care and advice to women during pregnancy, labour, delivery and post-partum for better outcome. Maternal distress results in psychological, physiological, emotional and social effects.

According to Barclay, et al., 1997, Nicolson , 2008 and Mautherner, 2003 in Emmanuel, E. (2010) Maternal distress may have mental health outcomes ranging from feeling drained and alone to feeling anxious and depressed. Fowlers (1998) highlighted that maternal distress that includes depression, maladaptation, dysfunction or disconnection may have an impact on the level of attachment.Maternal distress in labour can lead to a low quality of life with the woman feeling dissatisfied with her overall sense of well-being.

VII. RECOMMENDATIONS:

The standards and guidelines for training of midwives should include maternal distress because midwives encounter this during their care and practice. The guidelines would direct the management of maternal distressjust like they do when they see cord prolapse. Maternal distress needs to be included in the ante natal package.
A tool should be put in place to be able to diagnose and manage maternal distress.

VIII. CONCLUSION:

Maternal distress in labour can present in several forms with some consequences to the mother and baby. The midwife has to understand maternal distress in labour and be able to recognise and manage it.

Midwives as people who work with pregnant women and have vast experiences of labour distress they should be able to give the support needed and advice during pregnancy, labour and post-partum.

REFERENCES

[1]. Barclay, L. M., & Lloyd, B. (1996). The misery of motherhood: alternative approaches to maternal distress. Midwifery, 12(3), 136–139.
[2]. Chinn, P. L., & Kramer, M. K. (2013). Integrated Theory & Knowledge Development in Nursing-E-Book. Elsevier Health Sciences.
[3]. Edge, D., & Rogers, A. (2005). Dealing with it: Black Caribbean women's response to adversity and psychological distress associated with pregnancy, childbirth, and early motherhood. Social Science & Medicine, 61(1), 15–25.
[4]. Emmanuel, E., & St John, W. (2010). Maternal distress: a concept analysis. Journal of Advanced Nursing, 66(9), 2104–2115.
[5]. Fontein-Kuipers, Y., Ausems, M., Bude, L., Van Limbeek, E., De Vries, R., & Nieuwenhuijze, M. (2015). Factors influencing maternal distress among Dutch women with a healthy pregnancy. Women and Birth, 28(3), e36–e43.
[6]. Ingstrup, K. G., Schou Andersen, C., Ajslev, T. A., Pedersen, P., Sørensen, T. I., & Nohr, E. A. (2012). Maternal distress during pregnancy and offspring childhood overweight. Journal of Obesity, 2012.
[7]. Li, C., Liu, J. C., Xiao, X., Chen, X., Yue, S., Yu, H., Tang, N. J. (2017). Psychological distress and type 2 diabetes mellitus: a 4-year policemen cohort study in China. BMJ Open, 7(1), e014235.
[8]. Murtaja, F. F., & Thabet, A. A. M. (2017). Anxiety and depression among pregnant women in the Gaza Strip. Psychol Cogn Sci Open J, 3(4), 137–144.
[9]. Paarlberg, K. M., Vingerhoets, A. J., Passchier, J., Dekker, G. A., & Van Geijn, H. P. (1995). Psychosocial factors and pregnancy outcome: a review with emphasis on methodological issues. Journal of Psychosomatic Research, 39(5), 563–595.
[10]. Pirdel, M., & Pirdel, L. (2009). Perceived environmental stressors and pain perception during labor among primiparous and multiparous women. Journal of Reproduction & Infertility, 10(3), 217.
[11]. Rondó, P. H., & Souza, M. R. (2007). Maternal distress and intended breastfeeding duration. Journal of Psychosomatic Obstetrics &Gynecology, 28(1), 55–60.
[12]. Sawyer, A., & Ayers, S. (2009). Post-traumatic growth in women after childbirth. Psychology and Health, 24(4), 457–471.
[13]. Van Gampelaere, C., Vervoort, T., Luyckx, K., De Paepe, A., Van Aken, S., & Goubert, L. (2018). Maternal distress in the context of their child's type 1 diabetes: exploring the role of adaptive maternal emotion regulation on child outcomes. Psychology, Health & Medicine, 23(3), 337–346.
[14]. Walker, L. O., & Avant, K. C. (2011). Strategies for theory construction in nursing.
[15]. Wijma, K., Söderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: a cross sectional study. Journal of Anxiety Disorders, 11(6), 587–597.

Agness Murombedzi "Maternal Distress In Labour: Concept Paper. "Quest Journals Journal of Research in Pharmaceutical Science , vol. 04, no. 01, 2018, pp. 41-47