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THE RELATIONSHIP BETWEEN FACTORS THAT CONTRIBUTE TO ANXIETY BEFORE CHILDBIRTH

Siskha Maya Herlina[1)]*, Yopi Suryatim Pratiwi[2)], Yadul Ulya[3),] Regina Pricilia Yunika[4)]

[1,2]Midwifery Study Program, Undergraduate Program, INKES Yarsi Mataram, Mataram, Indonesia
[3,4]Midwifery Study Program, Midwife Professional Education, INKES Yarsi Mataram, Mataram, Indonesia
Email: siskhamayah@gmail.com

ABSTRACT

Background: Anxiety before childbirth is one of the psychological problems often experienced by pregnant women, especially in the final trimester. This condition can be influenced by various factors, both internal and external, that affect a mother's readiness to face childbirth.
Method: This quantitative descriptive design involves 45 samples of pregnant women in their third trimester who are approaching labor. The sampling technique uses purposive sampling to examine whether there's a relationship between mothers' age, education, and occupation and anxiety at the community health center in Mataram, West Nusa Tenggara.
Result: The research results show that, out of 45 respondents, the P-value from the Pearson chi-square test is 0.018, which is less than 0.05. Therefore, it can be concluded that there is a significant relationship between the factors causing labor and anxiety before labor.
Conclusion: There is a significant relationship between factors causing childbirth and anxiety before delivery. Factors causing anxiety before delivery include husband support and parity factors. There is a significant relationship between the factors causing labor and anxiety before giving birth. Factors like the age of the pregnant mother, education, and occupation can affect anxiety in pregnant women in the third trimester before giving birth.
Keywords: anxiety factors, childbirth, pregnant women, third trimester

INTRODUCTION

Anxiety during pregnancy is an important psychological issue because pregnancy involves substantial physical, emotional, and psychological changes that require maternal adaptation. Anxiety among pregnant women has been reported to be approximately 10% in developed countries and 25% in developing countries, while anxiety during pregnancy in Indonesia has been reported at approximately 28.7% (Astarini, Erawati, and Mauliku 2022). These findings indicate that anxiety during pregnancy remains a considerable maternal health concern, particularly as women approach childbirth. As pregnancy progresses, concerns related to fetal health, labor pain, potential complications, and maternal safety become increasingly prominent. These concerns are often heightened among primiparous women for whom childbirth represents an entirely new experience, highlighting how previous obstetric history and maternal confidence significantly shape psychological responses (Shakarami et al. 2021).

The psychological landscape of the third trimester is shaped by a complex interplay of factors, including fear of childbirth, concerns about labor pain, uncertainty about the labor process, and personal self-efficacy. Because fear of childbirth is a multidimensional phenomenon that varies across individual perceptions and sociocultural contexts, a proper

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clinical assessment is essential (Nilsson et al., 2018). Furthermore, maternal anxiety extends far beyond temporary emotional discomfort; robust clinical evidence demonstrates its direct ties to adverse perinatal outcomes. Antenatal anxiety is significantly associated with higher odds of preterm birth, low birth weight, and small-for-gestational-age infants, underscoring that maternal psychological distress carries profound physical implications for both mother and child (Grigoriadis et al., 2018).

As women transition into the initial stages of labor, such as the latent phase, unfamiliarity with labor progression often triggers heightened psychological distress. (Scandurra et al. 2022). Consequently, proactive childbirth preparation becomes a vital component of comprehensive antenatal care. Structured prenatal interventions and targeted support effectively help women manage severe fear of childbirth, build robust self-efficacy, and develop realistic expectations regarding labor demands (Rouhe et al. 2018; Stoll et al. 2018). Equipping mothers with accurate knowledge further diminishes uncertainty, creating a stronger foundation for psychological readiness, as supported by recent local findings in Indonesia (Aprilia and Rohmah 2024; Mouliza and Rahawa 2023).

Reviewing the trajectory of scientific literature reveals a progressive shift in maternal health research. Early investigations primarily established the direct biological and developmental impacts of antenatal anxiety on fetal growth and perinatal complications (Grigoriadis et al. 2018). Subsequent studies broadened this scope to examine the multidimensional nature of fear of childbirth, evaluating specialized clinical interventions and the psychological resilience conferred by maternal self-efficacy (Nilsson et al. 2018; Rouhe et al. 2018; Shakarami et al. 2021). More recent works have concentrated on localized informational variables, evaluating how knowledge and specific preparation strategies mitigate anxiety during the final weeks of gestation (Aprilia and Rohmah 2024; Mouliza and Rahawa 2023).

Despite these extensive developments, existing literature predominantly evaluates these critical dimensions in isolation—focusing separately on adverse outcomes, fear scaling, or general preparedness—leaving a gap in understanding how multiple contributing factors interact with anxiety within specific local populations. Building upon this solid empirical foundation, this study aims to investigate the relationship between diverse contributing factors and anxiety before childbirth. Specifically, this research is designed to identify key maternal and informational variables associated with anxiety, providing actionable insights to strengthen early psychological screening, targeted counseling, and comprehensive antenatal midwifery care.

RESEARCH METHOD

This study used a quantitative descriptive design with a cross-sectional approach to describe the relationship between factors causing anxiety and anxiety before giving birth. The study involved a sample of 45 pregnant women in their third trimester in Ampenan Health Center. The factors included husband support, parity, gestational age, education, and the pregnant woman's occupation. The sample was selected using purposive sampling based on the respondents' inclusion and exclusion criteria. Inclusion criteria for respondents included being in the third trimester of pregnancy, having no underlying diseases, and willingness to participate. Exclusion criteria, for example, were having underlying diseases and abnormal fetal presentation. The test used was the chi-square test. The test used was the chi-square test. This study received ethical approval from the Health Research Ethics Committee of Universitas Islam Al-Azhar with ethical clearance number 061/EC-04/FK-06/UNIZAR/VI/2025.

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RESULTS

The results of this study are presented in a table showing the distribution of postpartum mothers' characteristics and a table showing the relationship between factors causing anxiety and the occurrence of anxiety.

Characteristics of a Postpartum Mother

Table 1. Characteristics of a Postpartum Mother

Variable	Frequency (f)	Percentage (%)
Age		
<20 years old	5	11
20-35 years old	32	71
>35 years old	8	18
Total	45	100
Education		
Elementary School	5	11
Middle School	12	27
High School	20	44
University	8	18
Total	45	100
Job		
Working	35	78
Not working	10	22
Total	45	100

Based on Table 1., the majority of postpartum respondents were in the healthy reproductive age group of 20–35 years old (71%). In terms of educational background, most respondents had completed high school (44%), followed by middle school (27%). Regarding employment status, a large proportion of the mothers were currently working (78%).

Relationship Between Factors Causing Anxiety and the Occurrence of Anxiety

Based on Table 2., it shows that out of 45 respondents, the p-value in the Chi-Square test using the Pearson chi-square is 0.018, which means it is less than 0.05. Therefore, it can be concluded that H1 is accepted, indicating a significant relationship between factors causing labor and anxiety before labor.

Table 2. Relationship Between Factors Causing Anxiety and the Occurrence of Anxiety

ANC Visit Compliance	Parity (%)	Family Support (%)	Total (%)	p-value
Causing Factors	8 (17.8)	10 (22.2)	18 (40)	
				0,018
Anxiety	10 (22.2)	17 (37.8)	27 (60)	
Total	18 (40)	27 (50)	45 (100)	

DISCUSSION

Characteristics of a Postpartum Mother

a. Mother's Age

The research results indicate that most pregnant women in the Ampenan Health Center area are in the 20–35 age group (71%), while a smaller portion are under 20 years old (11%). This distribution aligns with contemporary obstetric theory, which emphasizes that the age range of 20 to 35 years is the physiologically and psychologically optimal period for childbearing, significantly reducing risk factors for maternal-fetal complications (Fitriani et al. 2022; Triana et al. 2022). These findings are consistent with

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previous empirical studies, which reported that the vast majority of pregnant women accessing primary health facilities belong to this safe reproductive age cohort, as mothers in this range generally display greater adaptive maturity toward physiological and emotional adaptations during gestation(Astarini et al., 2022; Astria, Nurbaeti, and Rosidati, 2020).

Regarding parity distribution, the researchers assume that parity levels among pregnant women in this area are closely linked to maternal age, marriage duration, and attainment of formal education. The majority of respondents aged 25–32 years with a high school education are likely to have been married long enough to have two or more children. Theoretically, educational background acts as a major determinant of maternal health literacy, influencing reproductive decision-making, birth preparedness, and family planning engagement (Herlina et al. 2025; Sari and Wahyuni 2023). This observation is supported by empirical evidence demonstrating that secondary education levels and extended marriage duration correlate directly with maternal knowledge, parity status, and reproductive behavior (Fatmasanti, Bakri, and Muchtar 2022; Sembiring 2023).

Furthermore, cultural values and family norms in Gorontalo society, which regard children as a vital source of family strength and spiritual blessing, heavily influence the prevalence of multiparity and grandmultiparity. In the researchers' opinion, although most mothers fall within the biologically safe age window (20–35 years), the combination of extended marriage duration, secondary-level education, and deeply rooted local family values creates a unique reproductive health dynamic. Consequently, high parity remains common despite safe maternal age. Therefore, healthcare providers at the Ampenan Health Center should expand beyond standard antenatal screening by providing culturally tailored counseling and family planning education that respect local traditions while mitigating the risks associated with high parity and short birth intervals.

b. Education

The research results indicate that the majority of pregnant women in this study held a high school education (44%), while a smaller proportion had completed elementary school (11%). Statistical analysis confirmed a significant relationship between maternal educational attainment and anxiety levels before childbirth. Theoretically, formal education serves as a fundamental determinant of health literacy, enhancing an individual's cognitive capacity to seek, evaluate, and apply health-related information (Sari and Wahyuni 2023). According to the Cognitive Appraisal Theory of Stress, higher educational attainment allows pregnant women to process physiological changes and labor-related stressors more objectively. This cognitive processing reduces ambiguity and uncertainty, enabling mothers to perceive childbirth as a manageable physiological event rather than a distressing threat.

Maternal educational status directly correlates with anxiety levels during pregnancy, as mothers with higher education demonstrate better emotional regulation and health-seeking behaviors (Fatmasanti et al. 2022)Similarly, education serves as a primary indicator influencing maternal knowledge and childbirth preparedness, with lower education levels often contributing to information deficits and heightened apprehension (Sembiring 2023). Furthermore, secondary and tertiary educational backgrounds act as key supporting factors in strengthening psychological readiness and mitigating pre-childbirth fear among third-trimester pregnant women (Herlina et al. 2025).

In the researchers' opinion, although completing secondary education (high school) provides a solid baseline for basic literacy, formal schooling alone does not automatically guarantee comprehensive maternal health literacy. Pregnant women with a high school education are generally more receptive to antenatal health messages; however, they remain vulnerable to anxiety if exposed to unverified childbirth myths or sensationalized

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birth stories. Conversely, mothers with elementary education face greater vulnerability due to potential health literacy barriers, making them more susceptible to fear caused by a lack of factual knowledge about labor progression and medical interventions. Therefore, healthcare providers, particularly midwives, should tailor antenatal education according to maternal educational levels. Utilizing visual, interactive, and easily understandable educational media during routine antenatal care is essential to bridge the health literacy gap and alleviate pre-childbirth anxiety across all educational backgrounds.

c. Job

The research findings showed that the majority of pregnant women were employed (78%, n=35), while a smaller proportion were non-working (housewives) (22%, n=10). Statistical analysis and literature indicate that employment status plays a complex, dual role in influencing maternal mental health. Theoretically, according to Goode's Role Strain Theory, balancing occupational responsibilities with the physical, emotional, and physiological demands of late pregnancy can create substantial role conflict and fatigue, thereby heightening anxiety levels before delivery. Work-related deadlines, physical strain, and workplace expectations during the third trimester can amplify psychological distress (Fatmasanti et al. 2022; Mayasari 2018). However, employment also provides protective benefits. An analysis of the Indonesian Demographic and Health Survey (IDHS) indicates that working mothers generally exhibit greater financial autonomy, higher health literacy, and better utilization of postnatal care (PNC) services compared to non-working mothers (Cahyono, Suza, and Efendi 2021). Conversely, while non-working mothers may avoid workplace-induced stress and are more accessible for home-care health interventions, they may experience higher financial dependency and social isolation. In the opinion of the researchers, employment acts as a double-edged sword: while financial independence empowers expectant mothers, unmanaged workplace stress during the third trimester exacerbates physical fatigue and pre-childbirth anxiety. Therefore, implementing family-friendly workplace policies and flexible antenatal care scheduling is essential to support pregnant women in the workplace.

In addition to employment status, family income level serves as a primary socioeconomic determinant of maternal psychological preparedness before childbirth. Theoretically, Maslow's Hierarchy of Needs posits that basic financial stability and physical safety must be secured before an individual can achieve emotional calmness and psychological stability. Expectant mothers from lower-income households often face continuous mental strain regarding daily living expenses, delivery costs, newborn supplies, and emergency medical fees (Sutriningsih, Rahmawati, and Wulandari 2024). Empirical evidence strongly supports this association. A statistically significant relationship exists between family income and maternal anxiety levels approaching childbirth (p=0.001), demonstrating that financial limitations directly trigger severe apprehension (Damayanti, Yuliani, and Nurhayati 2021). Furthermore, pregnant women with a family income below the regional minimum wage experience an anxiety level 2.5 times higher than those with an income above the minimum wage (Rini, Trisnawati, and Rahayu 2022). Conversely, pregnant women with adequate income tend to feel calmer and more confident because they can readily afford quality antenatal care (ANC) services, proper nutrition, and emergency preparations. In the researchers' opinion, financial insecurity directly weakens a mother's psychological buffer against labor stress. To address this issue, healthcare providers and policymakers should integrate financial relief interventions (such as national health insurance outreach (e.g., BPJS Kesehatan), subsidized delivery services, and family economic education) into routine maternal health programs to alleviate anxiety among low-income pregnant mothers.

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The Relationship Between Anxiety-Causing Factors and Anxiety Occurrences

The statistical analysis utilizing the Pearson Chi-Square test among 45 respondents yielded a p-value of 0,0018, confirming the acceptance of the alternative hypothesis (H_1). This finding demonstrates a statistically significant relationship between the combined contributing factors—comprising parity, family support, employment status, education level, and antenatal care (ANC) compliance—and the occurrence of pre-childbirth anxiety among third-trimester pregnant women.

Theoretically, pre-childbirth anxiety is a complex, multifactorial psychological response best understood through the Biopsychosocial Model of Health. Rather than operating in isolation, sociodemographic and interpersonal variables interact dynamically to shape a pregnant woman's cognitive appraisal of impending labor. When individual vulnerability factors—such as primigravida status or economic strain—are compounded by low domestic support or inadequate health literacy, maternal psychological distress escalates. This holistic mechanism aligns with recent empirical literature emphasizing that maternal anxiety during the third trimester stems from a cumulative burden of physical demands, gaps in social support, and socioeconomic pressures rather than a single, isolated trigger (Fatmasanti et al. 2022; Herlina et al. 2025).

In the opinion of the researchers, the statistically significant association (p=0,0018) highlights that maternal mental health cannot be effectively addressed through one-dimensional interventions. Even when a pregnant woman belongs to a biologically optimal reproductive age group, unaddressed economic strain or a lack of emotional encouragement from her spouse can still trigger severe pre-delivery apprehension. Therefore, healthcare providers at primary care facilities—particularly midwives and clinical nurses—must implement a multidimensional screening protocol during routine ANC visits. Early identification of cumulative risk factors allows for timely psychoeducational counseling and family-centered support, ultimately fostering psychological resilience and promoting safer birth outcomes for both mother and child.

CONCLUSION

This study demonstrates a statistically significant association between mutually contributing factors—including number of births, family support, employment status, educational background, and adherence to antenatal care (ANC)—and levels of maternal anxiety prior to childbirth. In summary, anxiety prior to childbirth among mothers in the third trimester operates through complex biopsychosocial mechanisms: while formal education and employment offer financial independence and basic health literacy, both also create potential vulnerabilities such as role stress, work-related fatigue, and susceptibility to unverified health information. Combined with factors such as fewer births or limited domestic support, these socioeconomic and interpersonal variables interact dynamically to increase mothers' psychological stress. These empirical insights underscore the critical need for primary health care facilities to adopt a holistic and multidimensional approach to maternal mental health during routine antenatal care. Healthcare providers, particularly midwives and clinical nurses, should integrate early psychological screening protocols into standard ANC visits to identify cumulative risk factors—specifically targeting first-time mothers, working women facing job-related stress, and those with low health literacy.

RECOMMENDATIONS

It is recommended that healthcare workers, especially midwives and nurses, strengthen the implementation of antenatal education, which should not only focus on the physical aspects of pregnancy but also include education about psychological changes

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during pregnancy, the childbirth process, relaxation techniques, stress management, and strategies for coping with anxiety. This educational program should be provided in a structured way from pregnancy until just before delivery. In addition, healthcare facilities need to carry out routine psychological screening for pregnant women during antenatal visits using validated instruments to identify anxiety early. The screening results can be used as a basis for providing counseling and psychological support. Involving husbands and family members also needs to be increased through pregnancy accompaniment programs, such as prenatal classes that include partners and family members. Educating the family on how to provide support is also important.

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