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SELF-ESTEEM OF HIGH-RISK PREGNANT WOMEN

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ABSTRACT

Objective: To analyze the self-esteem of pregnant women admitted to the high-risk ward of a reference hospital in the city of Recife. **Materials and Methods:** This is a cross-sectional, descriptive study with a quantitative approach. The sample population included 112 pregnant women.Data collection was performed through a form adapted from the version in the Brazil of the Rosenberg Self-Esteem Scale (RSES), plus socioeconomic, obstetric and reproductive questions. The sample included pregnant women admitted to the high-risk sector, and excluded pregnant women under age and those who presented inability of understanding and/or verbalization to answer the form. The data analysis was performed by means of descriptive statistics and the results, presented as tables. **Results:** 72.3% had unsatisfactory self-esteem. **Conclusion:** The low self-esteem was elevated in high-risk pregnant women. There is need for updating/training health professionals from high-risk maternity hospitals to identify signs of symptoms of low self-esteem in this population with the purpose of offering a reception and a suitable care.

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INTRODUCTION

Pregnancy is a peculiar period of transition for women due to the hormonal, psychological and social adjustments, making them more susceptible to physical and mental stressful events. This process, although physiological, can bring damage to both the mother as the baby (Santos *et al*., 2015).

Pregnancy can develop, in the woman, unique feelings and perceptions, providing new experiences,in addition to promoting her participation in a new social context, which assigns obligations according to her new role (Zannata; Pereira and Alves, 2017). Some demands required for this mother include their needs to provide the best feelings. However, people surrounding her often do not realize that this

woman/mother has love, affection, care and attention needs.The fact of being pregnant is initially seen as a reason for joy, pride and accomplishment, but, due to modifications that include mood alterations, change in sleep patterns, difficulty conducting her routine, originates negative feelings about the current context she is experiencing. These changes can lead to a low self-esteem (Silva *et al*., 2015; Tomaschewshi-Barlem *et al*., 2016). With the objective of assessing the overall self-esteem, Rosenberg created a scale, which became known as the Rosenberg Self-Esteem Scale (RSES).The scale evaluates the attitude and the positive or negative feeling for oneself, in which low levels of self-esteem are related to the onset of mental disorders, such as depression, anxiety, and somatic complaints, which can bring negative consequences in the maternal interaction and the bond, as well as on the individual development of the human being (Viscardi; Correia, 2017). A high-risk pregnancy occurs when there are extensive modifications that affect the sociobiological condition and may impair its development. The need for multiple medical follow-ups,which pass through frequent hospitalizations and invasive procedures, generates triggering factors of depressive symptoms, such as anxiety, low concentration, fear, irritability, fatigue, loss of appetite, insomnia, among others. Most of the times, this makes high-risk pregnant women more susceptible to developing depressive conditions (Rodrigues *et al*., 2017). In this way, based on theroutine realistic observation of the woman/mother, there came the empathy by this theme, bearing in mind that the guidance and care received often have limited action, emphasizing only a new life to the detriment of the needs of pregnant women as individual beings. This reality, coupled with the few Brazilian studies about self-esteem and quality of life during the pregnancy, justifies the importance of this article.

MATERIALS AND METHODS

This is a descriptive, cross-sectional study, with quantitative approach conducted with pregnant women hospitalized in the high-risk ward of the AgamenonMagalhãesHospital (HAM), located in the city of Recife, Pernambuco, Brazil. Data were collected during the period from April to June 2016. The study population consisted of 112 pregnant women,with sample selection through non-probabilistic sampling, by convenience. The sample included pregnant women admitted to the high-risk sector, and excluded pregnant women under age and those who presented inability of understanding and/or verbalization to answer the form. Data collection occurred using a questionnaire containing socioeconomic, obstetric and reproductive characteristics produced by the researcher responsible for this study, as well as an adapted version of the form in Brazil in 2002 by Claudio Simon Hutz, which addresses the RSES (Hutz; Zanon 2011). The scale consists of ten statements, five positive and five negative, which evaluate the esteem through feelings and self-acceptance.The answers are in Likert format and vary between four points. The positive affirmations have ratings of 1 = strongly disagree, 2 = disagree, 3 = agree and 4 = strongly agree. The negative affirmations are punctuated inversely to the positive. The total score of the scale varies from 10 to 40 points and the higher the score, the higher the self-esteem. A self-esteem is considered satisfactory when greater than or equal to 30 points (Viscori and Correia, 2017). The data were stored in the program Statistical Package for Social Sciences (SPSS®) version 23.0. The data analysis was performed by means of descriptive statistics.

For this purpose, the percentage frequencies and the frequency distributions of the analyzed variables were calculated. The results were discussedbased on assumptions of self-esteem in high-risk pregnant women, presenting them as tables. The participants signed the Informed Consent Form (ICF), ensuring the anonymity and respect to the decision not to participate in or leave at any time the study. The HAM Research Ethics Committee (REC) approved the research projectunder opinion n. 2.299.753 and CAAE: 53579916.2.0000.5197. This study is part of a cutout of Residency Completion Work (RCW) of the UniprofessionalResidency Program in Obstetrical Nursing from the NossaSenhora das Graças Nursing School (FENSG)/University of Pernambuco (UPE), entitled: ANALYSIS OF THE SELF-ESTEEM AND ANXIETY LEVELS IN HIGH-RISK PREGNANT WOMEN, whose author is: Liniker Scolfild Rodrigues da Silva. The same seeks to meet the recommendations of Resolution 466/12 of the National Health Council/Ministry of Health (NHC/MoH).

RESULTS

The study sample comprised 112 adult pregnant women. Regarding the demographic data, the characteristics that stand out are: the most prevalent age group was 21 through 25 years (38.4%), and least prevalent age group was 41 years or older (3.6%); the percentage of other age groups ranged from 9.8% to 18.8%.In relation to marital status, the percentage of unmarried, married, with stable union/livingwith a partner ranged from 28.6% to 36.7%, with only one widow and one with another situation. The highest percentages relating to education were: complete secondary education (42.0%), incomplete primary education (19.6%) and incomplete secondary education (17.9%), and the percentages of other schooling categories ranged from 0.9% (one interviewee) to 7.1%. The family income with the highest frequency corresponded to one minimum wage (MW) with 47.3% of the group, followed by 1 through 2 MW (29.5%) and less than one MW (16.1%); the majority (82.1%) lived in the urban area. Table 1, about the occupation and religion of the interviewees, highlights that: the majority (67.9%) had occupation; of this percentage, the most frequent was housekeeper (40.2%), and other occupancies had percentages that ranged from 0.9% (one interviewee) to 3.6%. Approximately half (50.9%) were evangelical, followed by 34.8% catholic and 14.3% had no religion.

Table 2 describes the obstetric and reproductive history.In relation to the gestational age, 53.6% of the interviewees were at early pre-term, followed by 31.2% at late pre-term, 14.3% were early term and only one was at term; the largest percentage corresponded to the third pregnancy (29.5%), the smallest, to multigravida (20.5%),and first and second pregnancies had 25.0% each; the highest percentage (38.4%) had one delivery; the smallest, 3 through 8 deliveries (14.3%); the percentagesof those who had no delivery or two deliveries were respectively 25.0% and 22.3%.The majority (71.4%) did not have an abortion and the second highest percentage (22.3%) corresponded to those who had had an abortion; the percentage that reported having had vaginal delivery in previous pregnancies was a little less than half (48.2%), and of this percentage, those who had had one vaginal delivery was 29.5%; the percentage which had been submitted to cesarean section was 40.2% and 28.6% of this value underwent one cesarean section. The majority (65.2%) had undesired/ unplanned pregnancy.

Table 1. Distribution of the interviewees according occupation and religion. Recife, Pernambuco (PE), Brazil, 2016. (n=112)

Variables	Samplen (%)
Occupation	
Yes	76(67.9)
No	36(32.1)
Occupation	
Saleswoman	2(1.8)
Freelancer	2(1.8)
Cashier	2(1.8)
Seamstress	4(3.6)
Housekeeper	1(0.9)
Housewife	45(40.2)
Snack bar	1(0.9)
Teacher	1(0.9)
General Cleaning Worker	1(0.9)
Counterwoman	1(0.9)
Cook	2(1.8)
Farmer	3(2.7)
Security Guard	1(0.9)
Community Health Agent	1(0.9)
Hairdresser	1(0.9)
Accounting Assistant	1(0.9)
Call Center	1(0.9)
Daycare Educator	1(0.9)
Pedagogue	1(0.9)
Conductor	1(0.9)
Nursing Technician	1(0.9)
Money-changer	2(1.8)
No occupation	36(32.1)
Religion	
Catholic	39(34.8)
Evangelical	57(50.9)
No religion	16(14.3)

Source: Created by the authors.

Table 2. Distribution of the sample accoridng to obstetric and reproductive history.Recife, Pernambuco (PE), Brazil, 2016. (n=112)

Variables	Sample n(%)
Gestational age	
Early pre-term (< 34 weeks)	60(53.6)
Late pre-term (34 - 36 weeks and 6 days)	35(31.2)
Early term (37 - 38 weeksand 6 days)	16(14.3)
Term (39 - 40 weeks and 6 days)	1(0.9)
Number of pregnancies	
First pregnancy	28(25)
Second pregnancy	28(25)
Third pregnancy	33(29.5)
Multigravida	23(20.5)
Number of deliveries	
0	28(25)
1	43(38.4)
2	25(22.3)
3 - 8	16(14.3)
Number of abortions	
0	80(71.4)
1	25(22.3)
2	4(3.6)
4	3(2.7)
Vaginal delivery route in previous pregnancies	
Yes	54(48.2)
No	58(51.8)
Number of vaginal deliveries	
0	58(51.8)
1	33(29.5)
2	13(11.6)
3 - 7	8(7.1)
Cesareansection	
Yes	45(40.2)
No	67(59.8)
Numberofcesareansections	
0	67(59.8)
1	32(28.6)
2 - 3	13(11.6)
Pregnancy	
Desired / planned	39(34.8)
Undesired / unplanned	73(65.2)

Source: Created by the authors.

In Table 3, of the 10 questions, the majority answered "Agree" in the following ones: " I feel that I'm a person of worth, at least on an equal plane with others" (60.7%); "I feel that I have a number of good qualities" (67.9%); " I am able to do things as well as most other people" (59.8%); and " I wish I could have more respect for myself" (41.1%), and the other questions corresponded to the category "Disagree".

Table 3: Questions according to Rosenberg Self-Esteem Scale (RSES).Recife, Pernambuco (PE), Brazil, 2016. (n=112)

Variables	Samplen(%)
I feel that I'm a person of worth, at least on an equal plane with others	
Strongly disagree	8(7.1)
Disagree	26(23.2)
Agree	68(60.7)
Strongly agree	10(8.9)
I feel that I have a number of good qualities	
Strongly disagree	3(2.7)
Disagree	7(6.2)
Agree	76(67.9)
Strongly agree	26(23.2)
All in all, I am inclined to feel that I am a failure	
Strongly disagree	19(17)
Disagree	75(67)
Agree	6(5.4)
Strongly agree	12(10.7)
I am able to do things as well as most other people	
Strongly disagree	6(5.4)
Disagree	16(14.3)
Agree	67(59.8)
Strongly agree	23(20.5)
I feel I do not have much to be proud of	
Strongly disagree	11(9.8)
Disagree	51(45.5)
Agree	32(28.6)
Strongly agree	18(16.1)
I take a positive attitude toward myself	
Strongly disagree	1(0.9)
Disagree	15(13.4)
Agree	77(68.7)
Strongly agree	19(17)
On the whole, I am satisfied with myself	
Strongly disagree	4(3.6)
Disagree	13(11.6)
Agree	78(69.6)
Strongly agree	17(15.2)
I wish I could have more respect for myself	
Strongly disagree	4(3.6)
Disagree	27(24.1)
Agree	46(41.1)
Strongly agree	35(31.2)
I certainly fell useless at times	
Strongly disagree	21(18.8)
Disagree	46(41.1)
Agree	24(21.4)
Strongly agree	21(18.8)
At times I think I am no good at all	
Strongly disagree	24(21.4)
Disagree	62(55.4)
Agree	13(11.6)
Strongly agree	13(11.6)

Source: Created by the authors.

Table 4 shows, according to Rosemberg Self-Esteem Scale, that most women (72.3%) had unsatisfactory self-esteem and the remaining27.7%, satisfactory self-esteem.

Table 4: Evaluation of the scales of self-esteem (Rosemberg). Recife, Pernambuco (PE), Brazil, 2016. (n=112)

Self-esteem	
Variables	Samplen (%)
Satisfactory	31(27.7)
Unsatisfactory	81(72.3)

Source: Created by the authors.

DISCUSSION

The characteristics of the women participating in this study corroborated the information from other studies. A survey published in 2015 by Santos *et al*. (2015) investigated the self-esteem and quality of life of various pregnant women at units of the Unified Health System in the municipality of Rio Branco - Acre, showing that the majority were over 21 years old, had complete secondary education, income less than two minimum wages.Similarly,Guerra;Valete and Alves (2019) described the demographic profile of high-risk pregnant women, with the majority in the 19-29 years age group. Socioeconomic problems present in pregnant women's life appear bringing numerous consequences, such as low self-esteem, depression, phobia, post-traumatic stress, among others, in addition to harming not only the victim's life, but also the lives of those who surround and/or coexist.In this sense, health professionals, especially in primary care, should practice a qualified listening and reception to assist, whenever possible, the pregnant woman to minimize damages (Oliveira; Mandú, 2015). Regarding the obstetric history, Luz *et al*., (2015), revealed, in their research, that most high-risk pregnant women were multigravidas (65.5%), with no prior abortion (73.1%), had at least one child (34.6%), cesarean section (59.6%), and early pre-term pregnancy course (71.2%). Results that corroborate our study, differing only in relation to the number of previous pregnancies and delivery route. The results showed the prevalence pf unsatisfactory self-esteem (72.3%) in high-risk pregnant women, in line with the results of other studies that showed a high number of high-risk pregnant women with low levels of self-esteem, who have feelings of helplessness, despair, distortion of self-esteem.Theyalso worry about the possible differentiated life condition of their preterm child, marked by limitations, special care and often prejudices (Zanatta; Pereira and Alves, 2017).

These results show, therefore, that a pregnancy brings a number of challenges to be felt and experienced, which increase in high-risk pregnancies, involving, in addition to the physiological situation of pregnancy, the mother-woman-society context as a whole. Not infrequently, they feel insecurity, shyness, frustration and fear of the unknown.Distortions between the roles of woman and mother also stand out, because this relationship routinely occurs with the devaluation of being a woman, being replaced by being a mother, leading to a decreased desire to take care of her appearance, of getting dressed, or even the unawareness of the changes in their in the gestational process (Silva *et al*., 2016; Santos *et al*., 2015). The incidence of unsatisfactory self-esteem in pregnant women in stable union (78.9%) and married (65%) can result from the physical absence of their partners, who, many times cannot attend moments like prenatal care, with fundamental importance to calm them and stay with them. The absence may potentiate the insecurity and fear of the mother, because there is a lack of sharing of afflictions upon the situation of high-risk pregnancy (Semente *et al*., 2016). Another comparative study between normal and high-risk pregnancy expressed higher rates for high-risk pregnant women: at least 56.5% of high-risk pregnant women showed at least minimum rates of depression. This behavioral dynamics is promoted mainly by fear of malformation of the fetus, risk of death and feeling of incompetence in their role of procreation (Rodrigues *et al*., 2017; Tostes; Seidl, 2016). When analyzing the socioeconomic data with the levels of self-esteem, the study of Meireles, (2017), was similar to our work, characterizing the pregnant woman with depression as young (20 - 25 years), complete secondary education (37.3%), with a paid activity (49.3%), Catholic religious practice (56.9%), with latter topic differing from the results found in the present study, which show a predominance of Evangelical religion. Concerning religious practice, during the pregnancy process, the woman goes through conflicting situations, thus seeking means of coping with these situations, including, in this context, the religious practice, which works as an outlet, regardless of its denomination (Silva *et al*., 2015; Dias *et al*., 2018).

The level of schooling presented a significant value in the relationship with unsatisfactory self-esteem, which is similar to a study conducted to evaluate the self-esteem of pregnant women using Rosenberg Self-Esteem Scale, which found a significant relationship between low schooling and unsatisfactory self-esteem, p=0.04; (Almeida; Arrais, 2016). Santos *et al*., (2015), in their study also found the same results with impaired self-esteem in pregnant women with schooling up to secondary education. Novaes *et al*., (2015), presented an obstetric profile in which 48% of the women were in their second or third pregnancy, 38.8% reported history of abortion, and 51.4% did not desire or plan the pregnancy, which corroborate our study, differing only in relation to desired pregnancy. The limitations of this study involved internal and external maternal factors, such as the hospital environment. One of the main points were the psychosocial factors summed to the whole change generated in this period, mainly because of high-risk pregnancy, which hindered certain approaches due to all stress experienced during this process. Another important aspect relates to the hospital environment. The drama of staying certain period within a health unit, when they had to abandon their routine, resulted in negative repercussions, mainly in the dissatisfaction of passing through this situation and the desire to return to their everyday life.

Conclusion

Most high-risk pregnant women showed unsatisfactory self-esteem, manifesting self-deprecating symptoms about their own body, and negative feelings in relation to the development of pregnancy, such as fear, insecurity, making them more susceptible to developing psychiatric disorders. Therefore, there is need to rethink the sexual and social division of family responsibilities and to denaturalize the domination over women, especially pregnant women, allowing them to feel protagonists of their own process of transformation and adaptation, providing the foundations for their physical and emotional development. In short, the health care provided at maternities is sometimes the access door for identifying and receiving women in situations of emotional and/or psychiatric disorders.In this sense, thre is need for updating/traininghealth professionals from maternities (especially those of high risk), especially the nurse, and for usingthe best practices of health care with women asholistic being, so that they can recognize the vulnerabilities of high-risk pregnant women and plan a quality intervention through psychosocial, educational and preventive-clinical approach in the care with women in situation of vulnerability.

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