DEATH ANXIETY AMONG EXPECTANT MOTHERS: THE ROLE OF PERCEIVED SOCIAL SUPPORT AND PERSONALITY TRAITS.

Introduction

Background to the Study

The World Health Organization (WHO, 1948) defines health as state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The definition simply means that for a person to be considered healthy she or he has to be free not only from physical infirmity but also from psychological distress. Psychological distress means an unpleasant emotional experience, mental, social or spiritual nature that interferes with an individual's ability to cope with the challenges of life (Lloyd-Williams, Friedman and Rudd, 2000). Research has shown that perceived social support, personality type may predict psychological distress like death anxiety in expectant mothers (Saisto, 2001). A tacit but important factor in the psychological distress sometimes experienced by expectant mothers is the confrontation with their own or their child's mortality which perhaps causes death anxiety. Collingwood, (2013), observed that women who have suffered adverse outcomes in previous pregnancies are at particular risk of anxiety, especially death anxiety. Going further, Collingwood, (2013) maintained that miscarriages, foetal death, and preterm birth reduce women's quality of life scores and significantly raise their anxiety scores during subsequent pregnancies.

Pregnancy can be both an exciting and worrying time for expectant mothers. Pregnant women experience a range of physical and emotional changes, all of which may trigger anxiety. Fear of the unknown, stress, feelings of insecurity, perceived social support, and daily pressures add to hormonal changes during pregnancy and may make women feel overwhelmed. This is more complicated with the constant worry over the baby's health, making death anxiety a real possibility. Pec and Shoshana, (2010), co-authors of the award winning book, Beyond the Blues: Understanding and Treating Prenatal and Postpartum Mood/Anxiety Disorders have maintained that: "While it is normal to have some worries during pregnancy (for example, will my baby be healthy? or Will I be a good mom?)-women with anxiety find the worry gets in the way of enjoying the pregnancy or fall asleep. Some women experience panic episodes during pregnancy. These are times of extreme anxiety where there may be hot or cold feelings, difficulty breathing or a smothering sensation, numbness or tingling in the fingers or around the mouth, a racing heart, and a feeling of loss of control". Death anxiety is anxiety of which the cause of the anxiety is thoughts of death. Farley, (2010), defined it as feeling of dread, apprehension or solicitude (anxiety) when one thinks of the process of dying, or ceasing to be.

Psychologists had tried to understand what factors might affect the level of anxiety people feel especially among pregnant women. The various factors psychologists have studied in attempting to measure death anxiety include age, gender, religious faith, environment and personal sense of fulfilment (Bassett, 2007). The study of Saisto and Halmesmaki (2003), found that the women having the fear of childbirth are often generally anxious. Anxiety proneness can be seen as an individual characteristic, which reflects the way people anticipate and experience various life events like pregnancy and childbirth (Saisto, 2001). An earlier study by Sontag (1941) indicated that a woman's emotional state could affect her pregnancy. Sontag thus stated "deeply disturbed

maternal emotion produces a marked increase in activity of the foetus". Many researchers have subsequently studied the causes and consequences of maternal anxiety and fear. DiPietro, (2004) collaborated Sontag's finding, maintaining that when we are stressed, a series of chemical changes is set off in our bodies and brains, such as the release of cortisol and adrenaline which help prepare us for danger and are important for our survival. Depietro (2004), also maintained that if we are chronically stressed and anxious, these stress related hormones can remain high for too long and wreak havoc on both the mother and the foetus, as stress hormones in the mother's body do reach the baby. Chronic maternal stress causes change in the blood flow to the baby, hindering proper blood and nutrient supply to the baby's developing organs. In addition, severely stressed mothers may feel overwhelmed and fatigued which might impact their diet and sleep habits and consistency of prenatal care. All of these factors may help explain how maternal stress during pregnancy can have long-term effects on the unborn child, (DiPietro, 2004). According to Hofberg and Brockington, (2001), women who have suffered childhood sexual abuse or rape fear, that the experience of childbirth will revisit the distress and helplessness of abuse. Women who have already suffered during childbirth are afraid of re-traumatisation

The psychological factors among many other aspects of pregnancy may not have received considerable attention and focus in previous research studies especially in Anambra State. Hence, the reason for this study is to create the awareness to this fact and offer necessary recommendations. This is important because the psychological disturbances can adversely affect the course of pregnancy, labour, delivery and subsequent development of the child (Dunkel, 2010). Although, pregnant women may generally have higher anxiety in all trimesters of pregnancy than non-pregnant women (Fitzpatrick, 2006); this may precipitate as psychosomatic symptoms that may be exhibited in different biological forms. Among them, the gastro-intestinal complaints, others may exhibit symptoms related to the Cardio-Vascular or Genito-Urinary functions. It has been found that insomnia, tension, headache, hyperactivity and restlessness are also present among the pregnant women (Ibeagha, 2006). Psychologically, pregnancy consists of three consecutive inter-dependent phases (Saisto, 2001). These are the first 1-3 months known as the first trimester, 4-6 months as second trimester, and the third trimester which is 7^{th} to 9^{th} month of gestation. During the first trimester that is the initial phase, the physical morphology of the women is changed and an unconscious anxiety, fear and sorrow are found to be common. There may also be change of self-image or concept as a result of hormonal and physical changes. During the second trimester, the woman slowly adapts to the morphological dynamics and to the prospective motherhood, and conceptualizes the expected child as an independent being. In the middle of pregnancy, unconscious anxiety is reduced and it is replaced by more of personalized worry about the wellbeing of the child. The final phase of pregnancy, the third trimester, is the time of active preparation for the childbirth, its subsequent development and the new life situations.

Pregnancy is a normal life process but, it brings a lot of changes in many perspectives of a woman's life. The duration of pregnancy averages 266 days (38 weeks) after ovulation which translates to 9 months. It has been regarded as a time of psychological and biological changes with potential emotional challenges. As pregnancy follows similar physiological courses among women, each woman has her own experience during that period and each pregnancy for the same woman will be different and unique. Pregnancy like puberty or menopause is a period of adjustments involving profound psychological as well as somatic changes (Stotland and Stewart,

2001). A pregnant mother's responses to this period may have direct and significant effects on her own outcome and her foetus' Gurung, Dunkel-Schetter, Collins, Rini, and Hobel, (2005). However, it is only during the past century that mental health professionals have begun to contribute to the understanding of the psychological aspects of pregnancy and the psychosocial phases that women pass through on their journey into motherhood, (Gurung, 2005).

Once conception has occurred, there are three distinct psychological phases that most women pass through during their pregnancies. These stages roughly correspond to the three trimesters. The first stage which is considered as the first trimester (1-13 weeks) begins when the woman initially feels either excited or shocked about her pregnancy. Even if the pregnancy is desired intensely, a certain amount of ambivalence i.e. the feeling of uncertainty during the pregnancy and increased emotional expressions are common. The expectant mother develops new and often uncomfortable physical symptoms such as nausea and vomiting associated with feeling sick, irritability, and fatigue. Ultimately, in a wanted pregnancy the fundamental task of the first stage is the acceptance of the pregnancy. Women struggling with this task may show behavioural signs, such as denial of the pregnancy or unusually react to the various bodily changes. The fear of miscarriage has been predominantly expressed by women during the first trimester of pregnancy and thus many women continue to keep the pregnancy secret until they have passed into the second trimester (National Institutes of Health, NIH, 2010).

The second psychological phase of pregnancy or the second trimester (14-28 weeks) is initiated by the experiences of quickening; that is, the foetal movements and by hearing the foetus heartbeat. Gradually, as the pregnancy progresses the expectant mother undeniably realizes that life exists within her. However, with the reduction or disappearance of many unpleasant physical symptoms, the second trimester is considered as the time of relative peace and fulfilment. The most important task for a woman in this stage is initiating an emotional affiliation with, or attachment to the foetus. During this phase the woman may become more extroverted (Stotland and Stewart, 2001). The final psychological stage of pregnancy is considered as the third trimester (29- 38 weeks) which begins when physical discomforts again predominate and the mother has a sense of her infant as viable. During this stage maternal-foetus attachment is expected to be at its highest and "nesting behaviour" starts to occur. During this final stage, expectant mothers again focus on bodily sensations and appearance and it may become an increasing concern for them. At this time in the pregnancy, sleep disturbances, backaches, leg cramps, increased anxiety about the delivery, worry about the health of the foetus, pain and loss of control during delivery are the major concerns of the pregnant women (Stotland and Stewart, 2001).

Pregnancy can be both an exciting and worrying time for parents-to-be. Pregnant women experience a range of physical and emotional changes, all of which may trigger anxiety. Fear of the unknown, stress, feelings of insecurity over work or money, and daily pressures add to hormonal changes during pregnancy and may make women feel overwhelmed. Coupled with the constant worry over the baby's health, death anxiety and depression become a real possibility. Buhler, cited in Ibeagha (2006) outlined the following pregnancy hazards. The hazards may be associated with poor nutrition; infectious diseases, tranquilizer and asprin; LSD (lysergic acid diethylamide) and heroin; tobacco, marijuana, alcohol; radiation, rhesus blood factor, age of the mother; emotional factors, and position of the foetus. Ibeagha (2006) maintained that excessive

stress exposes women to pregnancy hazards, with high risk for preterm labour, spontaneous abortion and for having a mal-formed baby, and so it needs to be avoided. Normal growth and development of the unborn child can be negatively influenced by a number of factors including complications of pregnancy.

According to World Health Organisation report (WHO, 2016), major complications that account for nearly 75% of all maternal deaths are: severe bleeding (mostly bleeding after childbirth); infections (usually after childbirth); high blood pressure during pregnancy (pre-eclampsia and eclampsia); complications from delivery; unsafe abortion. The remainder are caused by or associated with diseases such as malaria, and AIDS during pregnancy. World Health Organization (WHO, 2016) also reported that maternal mortality is unacceptably high. "About 830 women die from pregnancy- or childbirth-related complications around the world every day. It was estimated that in 2015, roughly 303 000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings… The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and almost one third occur in South Asia. More than half of maternal deaths occur in fragile and humanitarian settings. The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries.

There are large disparities between countries, but also within countries, and between women with high and low income and those women living in rural versus urban areas". During the United Nations General Assembly 2015, in New York, UN Secretary-General Ban Ki-moon launched the Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030. The Strategy is a road map for the post-2015 agenda as described by the Sustainable Development Goals and seeks to end all preventable deaths of women, children and adolescents and create an environment in which these groups not only survive, but thrive, and see their environments, health and wellbeing transformed, (WHO, 2016). With the above scenario painted by World Health Organisation report, it is obvious that a pregnant woman is under severe stress; due to many hormonal changes associated with pregnancy and other social and economic factors. With the level of day to day pressure faced by pregnant women, it is easy for them to fall into negative patterns of thinking which have a big impact on how they feel; therefore changing their negative ways of feeling and thinking means focusing on the best coping strategy.

In considering the psychological adaptation to pregnancy, it is important to recognize that even women with normal pregnancies may perceive themselves to be "at risk". Anxiety about the wellbeing of the foetus ranks the highest among their concerns and how a woman adjusts to her role as parent is influenced by many factors such as the way the woman was brought up, the values their parents had for children and parenthood in her family of origin, the expectant mothers' personality or her ability to adapt to change and also the past experiences with pregnancy play an important role in the way a woman adapts to the current pregnancy (Lara-Carrasco et al., 2013). As the women prepares for motherhood, pregnancy is generally considered as the period of adaptation, which happens both physically and psychologically. These changes may occur due to: personality type, number of pregnancy and or perceived social support.

Personality Type

In a general sense, a type is a group or category of things distinguished by the common characteristics of its members. A personality type, therefore, is a category of people who exhibit a particular combination of psychological characteristics, the assumption being that this combination is unique and distinguishes the type from others (Miller, 1991).

Type "A" and Type "B" Personality

The Type A behaviour pattern is an observable set of behaviours or style of life characterized by extremes of hostility, competitiveness, hurry, impatience, restlessness, aggressiveness (sometimes stringently suppressed), explosiveness of speech, and a high state of alertness accompanied by muscular tension (McLeod, 2011). At the other end of this bipolar continuum, Type B persons are more relaxed, cooperative, steady in their pace of activity, and appear more satisfied with their daily lives and the people around them (Pandit, 2016). Type A and Type B personality theory essentially attempts to divide people into one of two categories. 'Type A' personalities are described as being ambitious, driven, impatient, competitive, prone to taking on more than they can handle, proactive, workaholic and straight forward.

On the other hand, Type B personalities are generally described as being more withdrawn, steady, laid back, introverted, creative, reflective and generally more relaxed (Adam, 2017).
The original Type A personality was described in the 1950s by two cardiologists named Meyer Friedman and Ray Rosenman. They looked at the personality type specifically with regards to its role in heart disease and found in a study of people aged 35-59 that these personality traits were indeed related to an increased risk of cardiovascular disease – though not necessarily mortality (Eysenck, 1990). The likely explanation is that Type A personalities are more likely to experience high blood pressure and stress and thus will place more strain on their hearts. A lot of criticisms were levelled against the original study as it failed to take into account potential confounding variables such as diet and exercise. However, a subsequent trial by Friedman and Ulmer (1984) accounted for these factors and still found a correlation. Further they found that providing 'Type A personality counselling' would help to reduce the risk of recurrence in post myocardial infarction patients (Friedman, Thoresen, Gill, Ulmer, Powell, Price, Brown, Thompson, Rabin, Breall, Bourg, Levy and Dixon, 1986) Since then the concept has gained popularity, likely due to its relative, close ties with health and partly due to its simplicity compared to many other personality theories (Adam, 2017).

Type A and B personality is only one among several other categorizations of types of people.
Since ancient times, there has been a great deal of speculation about types of people. One of the earliest, and most influential, personality typologies comes to us from ancient Greece where a number of scholars, such as Aristotle, Galen, and Hippocrates, contributed to the development of a typological theory of temperament based on the doctrine of "humours." It was the Greek physician Hippocrates (460–370 BC) who developed it into a medical theory. He believed certain human moods, emotions and behaviours were caused by an excess or lack of body fluids (called "humours"): blood, yellow bile, black bile, and phlegm, (Osborn and David, 2013). These four were the temperamental categories Galen named "sanguine", "choleric", "melancholic" and "phlegmatic" after the bodily humours, respectively. Each was the result of an excess of one of

the humours that produced, in turn, the imbalance in paired qualities, (Lutz, 2002). The relevance of individual differences to the development and course of physical health problems depends on their association with mechanisms involved in the aetiology and pathogenesis of disease, or with processes that affect the detection, control, and outcome of physical disorders. Evidence that personality traits are related to health behaviours and health outcomes is emerging (Gareth and Martha, 2008). Our traits, those characteristics 'that account for consistent patterns of thinking, feeling and behaving' affect us in important and surprising ways (Pervin, Cervone, and John, 2004).

Another major dimension of personality in current focus is the big five personality. Several independent sets of researchers discovered and defined the five broad factors based on empirical, data-driven research. Ernest Tupes and Raymond Christal advanced the initial model, based on work done at the U.S. Air Force Personnel Laboratory in the late 1950s (Tupes, and Christal, 1961); Digman (1990) proposed his five factor model of personality Goldberg (1993), extended it to the highest level of organizations**.** Decades of research on personality has uncovered five broad dimensions of personality (DeYoung, Quilty, and Peterson, 2007). These so-called Big Five dimensions are called:

- Extraversion (your level of sociability and enthusiasm)
- Agreeableness (your level of friendliness and kindness)
- Conscientiousness (your level of organization and work ethic)
- Emotional Stability (your level of calmness and tranquillity)
- Intellect (your level of creativity and curiosity)

The above personality researchers have proposed that there are five basic dimensions of personality. Evidence of this theory has been growing over the past 50 years, beginning with the research of Fiske, (1949) and later expanded upon by other researchers including Norman (1967), Goldberg (1981), and McCrae, Costa, Ostendorf, Angleitner, Hrebickova, Avia, Sanz, and Sanchez-Bernardos, (2000). The "big five" are broad categories of personality traits. While there is a significant body of literature supporting this five-factor model of personality, researchers don't always agree on the exact labels for each dimension (O'Connor, 2002). However, these five categories are usually described as follows:

1. Openness - This includes traits like being insightful and imaginative and having a wide variety of interests.
2. Conscientiousness - People that have a high degree of conscientiousness are reliable and prompt. Traits include being organized, methodical, and thorough.
3. Extraversion - Extraverts get their energy from interacting with others, while introverts get their energy from within themselves. Extraversion includes the traits of energetic, talkative, and assertive.
4. Agreeableness - These individuals are friendly, cooperative, and compassionate. Traits include being kind, affectionate, and sympathetic.
5. Neuroticism - Neuroticism is also sometimes called Emotional Stability. This dimension relates to one's emotional stability and degree of negative emotions. People that score high on neuroticism often experience emotional instability and negative emotions. Traits include being moody and tense.

These dimensions represent broad areas of personality. Research has demonstrated that these groupings of characteristics tend to occur together in many people. For example, individuals who are sociable tend to be talkative. However, these traits do not always occur together. Personality is complex and varied, and each person may display behaviours across several of these dimensions (Block, 2010). While many personality traits, such as extroversion, are innate, most researchers believe that Type A personality characteristics are more of a reaction to environmental factors, or tendencies toward certain behaviours, and are influenced by culture and job structure (Vijai, 2003). For example:

- Many jobs put heavy demands on time, making it necessary for workers to be very concerned with getting things done quickly if they're to adequately get their jobs done.
- Some workplaces put heavy penalties on mistakes, so efficiency and achievement become extremely important.
- Other jobs just create more stress, making people less patient, more stressed, and more prone to 'Type A' behaviours (Scott, 2016)

Type A personality has been found to moderate negatively the effects of stress. An individual with type A personality is believed to be more vulnerable to stress and stress related problems than type B individual (Friedman, 1996). Type B's have often been characterized as calming personalities, naturally able to draw down stress in interpersonal transactions and organizations. They have been identified as physiologically more likely to live longer, healthier lives, whether due to more moderated activation of stress hormones or less physiologically activated in fight or flight mode save for when necessary (Scott, 2016). Following the connection between type A and type B personalities to both physical and emotional health, (Adam, 2017), the researcher decided to study if this personality typology is a predictor of anxiety among pregnant mothers.

According to Koob, (2015), there is some evidence to suggest that physiological reactions to stress differ among individuals: some are highly reactive, and some are less reactive. For instance, heart rate responses are exaggerated in people who are stress prone. The strength of the reaction, however, does vary depending on how stressful the event is judged to be (Sarafino, 2002). Some researchers Gershuny and Sher, 1998, Zinbarg, Uliaszek and Adler (2008) have found that individual differences in physiological reactivity to stress are stable over time: people who have exaggerated responses on one occasion are likely to do so on other occasions. In addition to studies of the physiological stress response, personality and cognitive predictors of anxiety proneness in individuals have been widely researched (Wilt, Oehlberg and Revelle, 2011, Eysenck, Lister, and Weingartner, 1991) and have been greatly facilitated by the resurgence of the two broad personality type theories or trait theory of type A and B. Some personality types are said to have healthy adaptive skills and serve as a buffer against breaking down from everyday hassles and stressful circumstances (Scott, 2016). In this study personality was viewed from the perspective of personality typology.

Having looked at Personality type as a psychological construct, the effect of personality type on people's coping strategy, including pregnant women, cannot be over ruled. Some studies have shown that some personality factors increase the risk of experiencing psychological difficulties in the antenatal period, and especially negative cognitive styles: pessimism, anger and

rumination; a tendency to be nervous, worried or shy; low self-esteem and low self-efficacy; and high levels of neuroticism or psychoticism (Bayrampour et al., 2015, Bunevicius et al., 2009, Ginsburg et al., 2008, Martini et al., 2015, Zeng et al., 2015). On the contrary, active coping and high self-esteem/self-efficacy have been identified as protective factors (Zeng et al., 2015). That means that because there are different personality types, some pregnant women are more vulnerable to death anxiety, while others may stay healthy and stable throughout the nine months of gestation (Riggio, 2014). With the above notion in mind, it becomes pertinent to study personality type and proneness to death anxiety among pregnant women. This will help determine which personality type predisposes one to death anxiety among pregnant women, so as to provide better understanding and diagnosis to psychotherapists. In view of this, the present researcher intends to carry out this study among pregnant women in select parts of Anambra State.

Social support refers to the emotional and material resources that are provided to an individual through interpersonal communications (Moak and Agrawal, 2010). It is an exchange of resources between at least two individuals; resources perceived by the provider or the recipient to be intended to promote the health of the recipient (Iranzad, Bani, Hasanpour, Mohammadalizadeh and Mirghafourvand, 2014). It is the physical and emotional comfort given to us by our family, friends, co-workers and others. NCI, (2017) defined social support as **"**a network of family, friends, neighbours, and community members that is available in times of need to give psychological, physical, and financial help". Perceived social support is knowing that we are part of a community of people who love and care for us, and value and think well of us (Fairbrother, 2011). According to Okoli, Ezeme and Ofojebe (2019) social support acts as a powerful mediating factor in a range of physical and mental health problems. It operates at different levels: emotional, instrumental and informational levels. Social support can be in different forms like: (a) Emotional support, which implies being told or perceiving that our family and significant others care about us and think well of us. (b) Practical help, this involves practical assistance in cash and/kind that help us to complete our basic day to day activities more efficiently. (c) Sharing of point of view, which means receiving others opinion and points of view in particular situation, so that we can develop a better understanding of our situation and the best way to handle it. (d) Sharing information, it can be very helpful when family, friends or even experts give us factual information about a particular stressful event (Fairbrother, 2011). Many of the people who are a part of our lives can provide social support. These can include our parents, spouse or partner, children, siblings, other family members, friends, co-workers, neighbours, health professionals and sometimes even strangers. We are unlikely to have all of our support needs met by just one person. In general, the best support comes from the people we are closest to. Research has shown that receiving support from people we have close emotional ties to does more for our emotional and physical health than support provided by people we are not particularly close to (Fairbrother, 2011).

Research findings show that increased social support positively influences the pregnancy outcomes. DiPietro, (2004) maintained that some factors might help buffer the effects of stress during pregnancy, and one of such important factor seems to be the mother's perceived level of social support. If the woman feels supported, she is much better prepared in handling the demands of pregnancy than the woman who feels alone, isolated and who lack social support (Ayers, 2007). Pregnancy is one of the critical situations for women in which the need for social

support is felt more than ever and requires precise and effective attention. Undesirable social support of pregnant women has different adverse effects on mothers and their foetus's health (Lowdermilk, Perry, Cashion, 2011). In some studies, maternal social support before and during the pregnancy has been stated as a potential factor in reducing stress, (Honikman, 2006).

Nauert (2013**),** observed that women who receive strong social support from their families are less likely to develop postpartum depression. The perceived social support is the support that is believed to be available in accordance or in contrast to that which is actually available (Ayers, 2007). Supportive relationships may enhance feelings of wellbeing, personal control and positive effect in order to help the women to perceive pregnancy- related changes as less stressful (Collins & Schmidt, 1993). For most women, pregnancy is a time of positive expectation, but may also be a time for psychological and physiological challenges. It is accompanied by hormonal changes and can represent a time of increased vulnerability for the onset or return of depression (Grote, Bridge, and Gavin, 2010). Although pregnancy is a wonderful experience for many women, a variety of Biomedical (medical high risk conditions), Psychological (anxiety) and social factors (lack of support from the spouse or family) may make it a time of stress (Gurung, 2005).

Purpose of the study

The general purpose of the study was to investigate the role of perceived social support and personality traits on death anxiety among expectant mothers, but specifically, this study seeks to study: if perceived social supports will not predict death anxiety among expectants mothers and if personality type will not predict death anxiety among expectant mothers.

Statement of the problem

Researchers postulated that pregnancy, "like puberty or menopause, is a period of crisis involving profound psychological as well as somatic changes" (Stotland and Stewart, 2001). A pregnant mother's responses to this period may have direct and significant effects on both her own outcomes and also her foetus and its development (Gurung et al, 2005). However, it is only during the past century that mental health professionals have begun to contribute to the understanding of the psychological aspects of pregnancy and the psychosocial phases that women pass through on their journey into motherhood (Moak and Agrawal, 2010). The fact that the death of a loved one should threaten selfhood and trigger personal death anxiety may seem self-evident on theoretical grounds, but very little empirical research has focused on the relation of death anxiety to pregnancy (Bonanno, 2005). Empirical study of the relation between death anxiety and pregnancy has been meagre (Tolstikova, Fleming, and Chartier, 2005).

According to adult attachment theory (Mikulincer, Shaver, and Pereg, 2003; Shaver and Tancredy, 2001), chronic grief is more likely to afflict individuals with dysfunctional attachment styles compared with people with a secure attachment style. The theory is based on the assumption that the same motivational system that gives rise to the close emotional bond between parents and their children is responsible for the bond that develops between adults in emotionally intimate relationships (Fraley, 2010). Likewise, in relation to the fear of death, Mikulincer and Florian, (2000) have reported positive correlations between ambivalent and avoidant attachment styles and death salience. In relation to attachment theory, therefore, one might anticipate a significant relationship between fear of death and pregnancy.

With the alarm raised by the World Health Organisation on the unacceptable level of maternal mortality worldwide and almost the entire chunk of that mortality rate (99%) coming from sub Saharan Africa (WHO, 2016), there is urgent need to explore all available means to curtail the danger. As extreme anxiety and death anxiety has been shown to negatively impact on pregnant mothers, (Riggio, 2014), thereby increasing the risk of other health challenges and possible maternal or child death; the researcher therefore explores Perceived social support and personality type A and B, to see if they contribute to predicting death anxiety among pregnant women. The theoretical considerations and the lack of empirical investigation of the predictive values of perceived social supports and personality types on death anxiety among expectant mothers prompted the present research, which was designed to explore the hypothesis that these aforementioned variables may not predict death anxiety among this population of interest. Thus

- Would there be significant relationship of social support with death anxiety in expectant mothers attending antenatal check-ups during antenatal days
- Would there be significant relationship of personality type with death anxiety in expectant mothers of research population.

Significance of the study

The anticipated findings of this study would provide recommendations for the screening, diagnosis, referral and management of women with anxiety disorders. These disorders may alter the mother's physiological and psychological responses, which may result in long-lasting negative effects for the maternal, foetal, and child mortality and morbidity. The study is intended to provide more knowledge and information to health care professionals involved in the care of pregnant women such as General Practitioners, Obstetricians, Midwives and Child Health Nurses. Other relevant professionals include mental health nurses, psychiatrists, clinical psychologists, counsellors, social workers, pharmacists, and dieticians. The result of the study will also be useful to health care providers across the State to establish and maintain collaborative relationships, and to provide comprehensive care of pregnant women with anxiety disorders, (for example death anxiety) in a cost-effective and timely manner.

Operational definition of terms

Social support: perceived social support is the support that is believed to be available in accordance or in contrast to that which is actually available. This is with particular reference to immediate family members especially the partner.

Personality type A and B: this describes two contrasting personality types. Type A is characterized personalities that are more competitive, outgoing, ambitious, impatient and/or aggressive, while more relaxed personalities are labelled Type B.

Expectant mothers: women who are pregnant and attending antenatal clinic

Death anxiety: This refers the fear of and anxiety related to the anticipation, and awareness, of dying, death, and nonexistence of the pregnant mother or the foetus.

Trimesters: the three phases during pregnancy beginning from the first day of conception.

Methods

Participants

The participants were drawn from three major hospitals in Anambra State using purposive technique they are: Regina Caeli Hospital Awka, St Joseph Hospital Adazi, and Visitation Hospital Umuchu. The hospitals were purposively chosen to cover each part of section of the state's geographical divisions of North, Central and Sothern parts of the state. The selection also covers the urban, semi-urban and rural, areas of Anambra state as represented by Regina Ceali, St. Joseph and Visitation hospitals respectively. A total of 205 participants were selected using purposive sampling technique, ie those pregnant women who come to antenatal at the time of the study and were willing to participate. Participants' age range was 18 to 36 years, with mean age of 28.098, and standard deviation of 4.177. 28 (7.8%) had their primary education as highest level of education, 90 (24.1%) had secondary education while 86 (23.2) had their tertiary education. 112 (30.0%) participants were artisans while 93 (24.9%) were professionals in various field. 193 (96.7%) were married, 9(2.1%) participants were divorcees, while only 3 (1.1%) were single unmarried women. The entire participants were Christians; however their specific denominations were not ascertained.

Instruments

To effectively carry out this study the following psychological instruments were used for data collection: Type ABehavior Scale (TABS), The Multidimensional Scale of Perceived Social Support (MSPSS) and Death Anxiety Scale (DAS).

The Type A Behaviour Scale (TABS) was developed by Omoluabi (1997) to measure the characteristics and proneness to Type A behaviour pattern. It is a twenty-eight (28) item inventory which is designed to assess the personality trait called Type A Behaviour Pattern or Type A personality characterized by ambitiousness, aggressiveness, competitiveness, impatience, muscle tension, rapid speech, irritability, hostility and anger. Item score ranges from 1 (never true) to 4 (always true) with 9 items scored in speed/impatience (1,2,3,21,22,24,25,26,27), 9 items scored in job pressure (7,8,9,10,11,12,13,14,28) and 9 items scored in hard-driving (4,5,6,15,16,17,18,19,20). Agbu (1999) provided the Nigerian norm for interpreting scores (male: S-19.05, J-16.56, H-16.99) Scores higher than the norm indicated that the client manifested Type A behaviour pattern, while scores lower than the norms indicated that the client manifested Type B behaviour pattern. The psychometric property as reported by Agbu (1999) showed that TABS has test-retest reliability. With Cronbach alpha internal consistency reliability coefficient of .70, he obtained construct validity coefficient by correlating TABS total score with scores in each of the subscales of PSC (Omoluabi 1987) S= 79, J= 80, H= 76 and PSC = 20.

The Multidimensional Scale for Perceived Social Support is the most widely used Psychological instrument for measuring the perception of social support. The scale assesses self-reported amounts of social support which was developed by Zimet, Dahlem, Zimet and Farley, (1988).The MSPSS is a 12- item questionnaire containing three subscales measuring perceived social support from Friends (e.g., "My friends really try to help me"), Family (e.g., "I can talk about my problems with my family"), and a Significant Other (e.g., "There is a special

person in my life who cares about my feelings"). The items are divided into factor groups relating to the source of the social support, family (3,4,8,11), friends (6,7,9,12) and Significant Other (1,2,5,10). To assess internal reliability, Cronbach's coefficient alpha was calculated for the total MSPSS and for each subscale. Coefficient for the 12- item MSPSS was .93. The Family, Friends, and Significant Other subscales demonstrated α's of .91, .89, and .91 respectively.

Death Anxiety Scale is 15-item inventory designed to measure the concern, fear, apprehension and forebodings people often have about dying. Its purpose is to measure death anxiety as clinical condition. It was developed by Templar in 1970 and was standardized for Nigerian by Omoluabi in 1990. It has test-retest reliability .83 and concurrent validity .45, obtained by correlating DAS with Fear of Personal Death Scale (FPDS) developed by Florian and Kravez, (1983).

Procedure

The researcher obtained permission from the management of the three selected hospitals. Assistance and cooperation was solicited from the nurses in each of the selected hospitals. Purposive sampling method was used to collect data, and data were collected during antenatal days. The antenatal file of participant that participated in particular antenatal day was marked "Y" using blue coloured marker, this is to control for duplication. The researcher distributed the questionnaires to participants in a group and approached them one by one to explain any question(s) that may arise. After collecting back the instruments, the researcher once more gave held a brief interactive session with them in group to review their concerns and any questions arising from the exercise. This helped to allay any extra anxiety that might arise from the research instrument.

Inclusion criteria

1. Pregnant women who have conceived naturally attending antenatal check-ups during first, second and third trimesters.
2. Age between 20 and 35 years.
3. No past or current history of psychiatric illness and/or psychological treatment
4. No medical complication reported in the current pregnancy such as Eclampsia (Hypertension in pregnancy, characterised by seizures), Gestational Diabetes, Anaemia, Hepatic disorders, Infectious diseases and Oligoamnious (serious deficiency of amniotic fluid during pregnancy), or any other significant systemic illness.
5. Able to read and comprehend in English language.
6. Consenting to participate in the study.
7. No evidence or report of drug use (drug abuse)

Design/Statistics

This is a cross-sectional survey design and Linear Regression statistics was employed for data analysis.

Results

Perceived social supports and death anxiety among expectant mothers **Coefficients[a]**

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	10.838	1.814		5.973	.000
	Perceived social supports	.025	.018	.101	1.433	.154

a. Dependent Variable: Death anxiety

The hypothesis states that perceived social supports will not predicts death anxiety among expectants mothers (Beta=.101 $p<0.05$) From table 2.3a therefore, the hypothesis which states that perceived social supports will not predicts death anxiety among expectant mothers is hereby rejected. This means that perceived social supports could predicts death anxiety among the participants.

Personality types and death anxiety among expectant mothers Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	10.838	1.814		5.973	.000
	Type A and B personality	.016	.022	.051	.729	.467

a. Dependent Variable: Death anxiety

This hypothesis states that personality type will not predict death anxiety among expectant mothers. Table above shows that personality type could not predicts death anxiety among expectant mothers (Beta=.051 $p<0.05$) therefore, the hypothesis is accepted, which indicates that personality type does not predicted death anxiety among these participants.

Discussion

The findings of this study show that death anxiety could be predicated on perceived social supports (Beta=.101,$p< .05$). As such it implies that as the individuals perceive social supports from family, friends and significant others the lower the death anxiety she will have while the absence of this perceived social supports could increase death anxiety. Possible explanation for this finding might be that perceived social support is a social desirability. When there is lack or feeling of inadequate social support, the pregnant woman who already has concerns about some

of the uncomfortable symptoms of pregnancy, may become more anxious about her survival and that of the unborn child. The findings therefore conforms with the buffering theory that social support functions as a buffer to stressful life experiences, implying that negative consequences of stressful life events (death anxiety) are mitigated by social support (Cohen and Wills 1985).
This finding is consistent with the study conducted by Singh (2013) among the aged in Manipuris, India. He observed that people living in the more dangerous situations with little social support reported more death anxiety than those living in less dangerous and social friendly situations. Women as compared with men and younger persons as compared with older persons tended to have more death anxiety. Hodson (2004) report that symptoms, particularly of anxiety may resolve when social support and safety increase, Besides, Khan and Aftab (2013), observed perceived social support as a significant predictor of depression. Khan and Aftab, (2013) noted that mere perception of social support is better than the actual support while predicting anxiety and depression. Similarly, Okoli et al. (2019) observed that absence of social support is a predictor of depression. When investigating the positive association between social support and wellbeing, Cohen and Wills (1985) found evidence for a buffering model. According to the model social support protects individuals from the adverse effects that can follow stressful life events like pregnancy by providing interpersonal resources that tend to the needs of the individual during pregnancy times. Glazier, Elgar, Goel and Holzapdel (2004) found that pregnant women perceiving their social support as being inadequate showed stronger symptoms of depression and anxiety during similar stressful situations, than pregnant women perceiving a higher level of social support.

Again the findings of this study shows that personality type will not predict death anxiety among expectant mothers The finding in table 2.3 shows that personality type did not predict death anxiety among expectant mothers (Beta=.051 $p< 0.05$). This implies that there is no predictive relationship between personality type A or B and death anxiety among expectant mothers. Or put differently, Type A or B personality of expectant mothers will not affect their manifestation of death anxiety. The finding was in agreement with the findings of previous studies. Kramer, Lydon, Séguin, Goulet, Kahn, McNamara, Sharma, (2009) carried out a study to ascertain the relationship between coping, stress, state and trait anxiety, Type A/B personality and ante-partum and postpartum health of pregnant women and their foetus. Result revealed that type A and state anxiety were not as strongly related to maternal complications as were stressor number, stressor intensity or trait anxiety. Also, the predicators were generally stronger in the later stages of pregnancy. Result suggests that health during and after pregnancy may be predicted on the basis of psychosocial problems, as well as the time period during which the problems occur. Saisto (2001) conducted a study to examine the personality traits, socioeconomic factors, life and partnership satisfaction and pregnancy or delivery associated anxiety by using questionnaire survey in the 30th week of pregnancy i.e. during the third trimester in 278 women and their partners. The results indicated that the more anxiety, Neuroticism, vulnerability, depression, low self-esteem, dissatisfaction with the partnership and lack of social support the women reported, the more was the pregnancy related anxiety and fear of vaginal delivery no matter the personality type she has.

Implications and Recommendations

1. The simple implication of this study is that whereas personality type A or B did not show relationship with death anxiety among expectant mothers in the research, perceived social support did.
2. Enhanced social support therefore predisposes expectant mothers to less feeling of death anxiety implying greater general health for both the mother and the foetus.
3. It is therefore recommended that clinical psychologists and family therapists should promote social support education in families in general and among couples in particular.

Limitations of the study

The study used pregnant women in three different hospitals in Anambra State, who were attending antenatal only three health centres. The participants that were selected were only those that met the inclusion criteria. The outcome of the study cannot therefore be generalized to other population because of the sample size since it was a major challenge to identify participants who met the inclusion criteria and to secure formal consent of the participants within the time of this study. Besides, the scope of analysis was limited to such factors as perceived social support and personality type could have been stronger by additional factor like: Income level, number of pregnancies, and religious belief.

Recommendation for further studies

Further studies should be carried out with participants being drawn from all the health centres in Anambra State regardless of any criterion. More studies should be conducted using a larger sample of expectant mothers from both private and public health centres in Anambra State. There is need for future studies to include factors like income level, religious belief, etc. Efforts should be directed towards an emic development perceived social support scale for Nigerians.

Conclusion

The study was designed to know whether perceived social support and personality type could predict death anxiety among expectant mothers in Anambra State. The study found that among perceived social support and personality type, it was only perceived social support that predicted death anxiety among expectant mothers which indicates that death anxiety could be predicted on perceived social supports Personality type was not found to predict death anxiety among expectant mothers which means that personality type of an expectant mother has nothing to do with death anxiety during her pregnancy.

Contribution to existing avalanche of knowledge

The study's contributions to the existing corpus of knowledge are as follows:

1. The discovery of the relationship between perceived social supports and death anxiety among expectant mothers in Anambra State
2. The finding that personality type contributes nothing in terms of death anxiety among expectant mothers once social supports are there, which may be from the family, friends and significant others. This finding is very novel in the literature of death anxiety among expectant mothers since it is in contrast with some previous finding associating personality type with death anxiety in expectant mothers.

3. This finding will also help family therapists and counsellors to emphasise more on the importance of social support in families and among spouses and ways to enhance social support feeling among couples.

Compliance with Ethical Standards Conflict of interest:
All authors declare that they have no conflict of interest. All participants filled the consent form to declare their free will to participate in the study. Again, this study was not funded by any person, group or organization.

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